Alliant Health Plans, Inc.
Mental Health Parity Comparative Analysis 2023

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About This Tool

The goal of this self-compliance tool is to help group health plans, plan sponsors, plan administrators, group and individual market health insurance issuers, state regulators, and other parties determine whether a group health plan or health insurance issuer complies with the Mental Health Parity and Addiction Equity Act (MHPAEA) and additional related requirements under the Employee Retirement Income Security Act of 1974 (ERISA) that apply to group health plans. The requirements described in this tool generally apply to group health plans, group health insurance issuers, and individual market health insurance issuers. However, requirements that do not apply as broadly are so noted.

This tool does not provide legal advice. Rather, it gives the user a basic understanding of MHPAEA to assist in evaluating compliance with its requirements. For more information on MHPAEA, or related guidance issued by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments), please visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity.

Furthermore, as directed by Section 13001(a) of the 21st Century Cures Act, this publicly available tool is a compliance program guidance document intended to improve compliance with MHPAEA. DOL will update the self-compliance tool biennially to provide additional guidance on MHPAEA's requirements, as appropriate.

MHPAEA, as a federal law, sets minimum standards for group health plans and issuers with respect to parity requirements. However, many states have enacted their own laws to advance parity between mental health and substance use disorder benefits and medical/surgical benefits by supplementing the requirements of MHPAEA. Insured group health plans and issuers should consult with their state regulators to understand the full scope of applicable parity requirements.

This tool provides a number of examples that demonstrate how the law applies in certain situations and how a plan or issuer might or might not comply with the law. Additional examples are included in the Appendix I. The fact patterns used as examples are intended to help group health plans and health insurance issuers identify and address important MHPAEA issues.

Examples of MHPAEA enforcement actions that the DOL has undertaken are included in the MHPAEA Enforcement Fact Sheets, available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity. Examples of MHPAEA enforcement actions that HHS has taken are included in the Department of Health and Human Services' MHPAEA Reports at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources#mental-health-parity.

Introduction

MHPAEA, as amended by the Patient Protection and Affordable Care Act (the Affordable Care Act), generally requires that group health plans and health insurance issuers offering group or individual health insurance coverage ensure that the financial requirements and treatment limitations on mental health or substance use disorder (MH/SUD) benefits they provide are no more restrictive than those on medical or surgical benefits. This is commonly referred to as providing MH/SUD benefits in parity with medical/surgical benefits.

MHPAEA generally applies to group health plans and group and individual health insurance issuers that provide coverage for MH/SUD benefits in addition to medical/surgical benefits. DOL has primary enforcement authority with regard to MHPAEA over private sector employment-based group health plans, while HHS has primary enforcement authority over non-federal governmental group health plans, such as those sponsored by state and local government employers. HHS also has primary enforcement authority for MHPAEA over issuers selling products in the individual and fully insured group markets in states that have notified HHS' Centers for Medicare & Medicaid Services that they do not have the authority to enforce or are not otherwise enforcing MHPAEA. In all other states, generally the state is responsible for directly enforcing MHPAEA with respect to issuers.

Unless a plan is otherwise exempt, MHPAEA generally applies to both grandfathered and non-grandfathered group health plans and large group health insurance coverage. Also, the Affordable Care Act requires all issuers offering coverage in the individual and small group markets to cover certain essential health benefits (EHB), including MH/SUD benefits. Final rules issued by HHS implementing EHB requirements specify that MH/SUD benefits must be consistent with the requirements of the MHPAEA regulations. *See 45 CFR 156.115(a)(3).*

Under the MHPAEA regulations, if a plan or issuer provides MH/SUD benefits in any classification described in the MHPAEA final regulation, MH/SUD benefits must be provided in every classification in which medical/surgical benefits are provided. Under PHS Act section 2713, as added by the Affordable Care Act, non-grandfathered group health plans and group and individual health insurance coverage are required to cover certain preventive services with no cost-sharing, which include, among other things, alcohol misuse screening and counseling, depression screening, and tobacco use screening. However, the MHPAEA regulations do not require a group health plan or a health insurance issuer that provides MH/SUD benefits only to the extent required under PHS Act section 2713, to provide additional MH/SUD benefits in any classification. *See 29 CFR 2590.712(e)(3)(ii), 45 CFR 146.136(e)(3)(ii), 26 CFR 54.9812-1(e)(3)(ii).*

Definitions

Aggregate lifetime dollar limit means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan or health insurance coverage for any coverage unit.

Annual dollar limit means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a group health plan or health insurance coverage for any coverage unit.

Cumulative financial requirements are financial requirements that determine whether or to what extent benefits are provided based on certain accumulated amounts, and they include deductibles and out-of-pocket maximums. (However, cumulative financial requirements do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements.)

Cumulative quantitative treatment limitations are treatment limitations that determine whether or to what extent benefits are provided based on certain accumulated amounts, such as annual or lifetime day or visit limits.

Financial requirements include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

Medical/surgical benefits means benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law, but not including MH/SUD benefits. Any condition defined by the plan or coverage as being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD) or state guidelines).

Mental health benefits means benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law. Any condition defined by the plan or coverage as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or state guidelines).

NOTE: If a plan defines a condition as a mental health condition, it must treat benefits for that condition as mental health benefits for purposes of MHPAEA. For example, if a plan defines autism spectrum disorder (ASD) as a mental health condition, it must treat benefits for ASD as mental health benefits. Therefore, for example, any exclusion by the plan for experimental treatment that applies to ASD should be evaluated for compliance as a nonquantitative treatment limitation (NQTL) (and the processes, strategies, evidentiary standards, and other factors used by the plan to determine whether a particular treatment for ASD is experimental, as written and in operation, must be comparable to and no more stringently applied than those used for exclusions of experimental treatments of medical/surgical conditions in the same classification). *See FAQs About Mental Health And Substance Use Disorder Parity Implementation And the 21st Century*

Cures Act Part 39, Q1, available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf. Additionally, if a plan defines ASD as a mental health condition, any aggregate annual or lifetime dollar limit or any quantitative treatment limitation (QTL) imposed on benefits for ASD (for example, an annual dollar cap on benefits for Applied Behavioral Analysis (ABA) therapy for ASD of $35,000, or a 50-visit annual limit for ABA therapy for ASD) should also be evaluated for compliance with MHPAEA.

Substance use disorder benefits means benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or state guidelines).

Treatment limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both QTLs, which are expressed numerically (such as 50 outpatient visits per year), and NQTLs, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition.

SECTION A. APPLICABILITY

Question 1. Is the group health plan or group or individual health insurance coverage exempt from MHPAEA? If so, please indicate the reason (e.g. retiree-only plan, excepted benefits, small employer exception, increased cost exception, HIPAA opt-out).

Comments: No

If a group health plan or group or individual health insurance coverage provides either MH/SUD benefits, in addition to medical/surgical benefits, the plan may be subject to the MHPAEA parity requirements. However, **retiree-only group health plans**, self-insured non-federal governmental plans that have elected to exempt the plan from MPHAEA, and group health plans and group or individual health insurance coverage offering only **excepted benefits**, are generally not subject to the MHPAEA parity requirements. (***Note***: if under an arrangement(s) to provide medical care benefits by an employer or employee organization, any participant or beneficiary can simultaneously receive coverage for medical/surgical benefits and MH/SUD benefits, the MHPAEA parity requirements apply separately with respect to each combination of medical/surgical benefits and MH/SUD benefits and all such combinations are considered to be a single group health plan. *See 26 CFR 54.9812-1(e), 29 CFR 2590.712(e), 45 CFR 146.136(e)*).

Under ERISA, the MHPAEA requirements do not apply to **small employers**, defined as employers who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employ at least 1 employee on the first day of the plan year. *See 26 CFR 54.9812-1(f)(1), 29 CFR 2590.712(f)(1), 45 CFR 146.136(f)(1).* However, under HHS final rules governing the Affordable Care Act requirement to provide EHBs, non-grandfathered health insurance coverage in the individual and small group markets must provide all categories of EHBs, including MH/SUD benefits. The final EHB rules require that such benefits be provided in compliance with the requirements of the MHPAEA rules. *45 CFR 156.115(a)(3); see also ACA Implementation FAQs Part XVII, Q6, available at https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xvii.pdf*. In practice, this means that employees in group health plans offered by small employers who purchase non-grandfathered health insurance coverage in the small group market (within the meaning of section 2791 of the PHS Act) that must provide EHBs have coverage that is subject to the requirements of MHPAEA.

MHPAEA also contains an **increased cost exemption** available to group health plans and issuers that meet the requirements for the exemption. The MHPAEA regulations establish standards and procedures for claiming an increased cost exemption. *See 26 CFR 54.9812-1(g), 29 CFR 2590.712(g), 45 CFR 146.136(g).*

Sponsors of self-funded, non-federal governmental plans are permitted to elect to exempt those plans from certain provisions of the PHS Act, including MHPAEA. An exemption election is commonly called a "HIPAA opt-out." The HIPAA opt-out election was authorized under section 2722(a)(2) of the PHS Act (42 USC § 300gg-21(a)(2)). *See also* 45 CFR 146.180. The

procedures and requirements for self-funded, non-federal governmental plans to opt out may be found at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources#Self-Funded%20Non-Federal%20Governmental%20Plans.

Question 2. If not exempt from MHPAEA, does the group health plan or group or individual health insurance coverage provide MH/SUD benefits in addition to providing medical/surgical benefits?

Comments: Yes

Unless the group health plan or group or individual health insurance coverage is exempt from MHPAEA or does not provide MH/SUD benefits, continue to the following sections to examine compliance with requirements under MHPAEA.

SECTION B. COVERAGE IN ALL CLASSIFICATIONS

Question 3. Does the group health plan or group or individual health insurance coverage provide MH/SUD benefits in every classification in which medical/surgical benefits are provided?

Comments: Yes

Under the MHPAEA regulations, if a plan or issuer provides mental health or substance use disorder benefits in any classification described in the MHPAEA final regulation, mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. *See 26 CFR 54.9812-1(c)(2)(ii)(A), 29 CFR 2590.712(c)(2)(ii)(A), 45 CFR 146.136(c)(2)(ii)(A).*

Under the MHPAEA regulations, the six classifications* of benefits are:

1) inpatient, in-network;
2) inpatient, out-of-network;
3) outpatient, in-network;
4) outpatient, out-of-network;
5) emergency care; and
6) prescription drugs.

See 26 CFR 54.9812-1(c)(2)(ii), 29 CFR 2590.712(c)(2)(ii), 45 CFR 146.136(c)(2)(ii).

**See special rules related to the classifications discussed below.*

NOTE: If a plan or coverage generally excludes all benefits for a particular mental health condition or substance use disorder, but nevertheless includes prescription drugs for treatment of that condition or disorder on its formulary, the plan or coverage covers MH/SUD benefits in only one classification (prescription drugs). Therefore, the plan or coverage would generally be required to provide mental health or substance use disorder benefits with respect to that condition or disorder for each of the other five classifications for which the plan also provides medical/surgical benefits. However, if a prescription drug that may be used for a particular MH/SUD condition and may also be used for other unrelated conditions is included on a plan's or coverage's formulary, the drug's inclusion on the formulary alone would not be considered to override the plan or coverage's general exclusion for a particular mental health condition or substance use disorder unless the plan or coverage covers prescription drugs specifically to treat that condition.

ILLUSTRATION: A Plan provides for medically necessary medical/surgical benefits as well as MH/SUD benefits. While the Plan covers medical/surgical benefits in all benefit classifications, it does not cover outpatient services for MH/SUD benefits for either in-network or out-of-network providers. In this example, since the Plan fails to provide MH/SUD benefits in outpatient, in-network and outpatient, out-of-network classifications in which medical/surgical benefits are provided, the Plan fails to meet MHPAEA's parity requirements. The Plan could

come into compliance by covering outpatient services for MH/SUD benefits both in- and out-of-network in a manner comparable to covered medical/surgical outpatient in- and out-of-network services.

Classifying benefits. In determining the classification in which a particular benefit belongs, a group health plan or group or individual market health insurance issuer must apply the same standards to medical/surgical benefits as to MH/SUD benefits. *See 26 CFR 54.9812-1(c)(2)(ii)(A), 29 CFR 2590.712(c)(2)(ii)(A), 45 CFR 146.136(c)(2)(ii)(A).* This rule also applies to intermediate services provided under the plan or coverage. Plans and issuers must assign covered intermediate MH/SUD benefits (such as residential treatment, partial hospitalization, and intensive outpatient treatment) to the existing six classifications in the same way that they assign intermediate medical/surgical benefits to these classifications. For example, if a plan classifies care in skilled nursing facilities and rehabilitation hospitals for medical/surgical benefits as inpatient benefits, it must classify covered care in residential treatment facilities for MH/SUD benefits as inpatient benefits. If a plan treats home health care as an outpatient benefit, then any covered intensive outpatient MH/SUD services and partial hospitalization must be considered outpatient benefits as well. A plan or issuer must also comply with MHPAEA's NQTL rules, discussed in Section F, in assigning any benefits to a particular classification. *See 26 CFR 54.9812-1(c)(4), 29 CFR 2590.712(c)(4), 45 CFR 146.136(c)(4).*

Medication Assisted Treatment (MAT) is subject to MHPAEA

Plans and issuers that offer MAT benefits to treat opioid use disorder are subject to MHPAEA requirements, including the special rule for multi-tiered prescription drug benefits that applies to the medication component of MAT. The behavioral health services components of MAT should be treated as outpatient benefits and/or inpatient benefits as appropriate for purposes of MHPAEA. Plans and issuers should ensure there are NO impermissible QTLs, such as visit limits, or impermissible NQTLs, such as limits on treatment dosage and duration. For example, a limitation providing that coverage of medication for the treatment of opioid use disorder is contingent upon the availability of behavioral or psychosocial therapies or services or upon the patient's acceptance of such services would generally not be permissible unless a comparable process was used to determine limitations for the coverage of medications for the treatment of medical/surgical conditions.

ILLUSTRATION: An issuer did not cover methadone for opioid addiction, though it did cover methadone for pain management. The issuer failed to demonstrate that the processes, strategies, evidentiary standards, and other factors used to develop the methadone treatment exclusion for opioid addiction are comparable to and applied no more stringently than those used for medical/surgical conditions. The issuer re-evaluated the medical necessity of methadone-maintenance treatment programs and developed medical-necessity criteria that mirrors federal guidelines (including the Substance Abuse and Mental Health Services Administration treatment improvement protocol 63 for medication for opioid use disorder) for opioid treatment programs to replace the methadone-maintenance treatment exclusion.

ILLUSTRATION: A plan uses nationally recognized clinical standards to determine coverage for prescription drugs to treat medical/surgical benefits based on the recommendations of a Pharmacy and Therapeutics (P&T) committee. However, the plan deviates from such standards

for buprenorphine/naloxone to treat opioid use disorder based on the P&T committee's recommendations. This deviation should be evaluated for compliance with MHPAEA's NQTL standard in practice, including the determination of (1) whether the P&T committee has comparable expertise in MH/SUD conditions as it has in medical/surgical conditions, and (2) whether the committee's evaluation of the nationally-recognized clinical standards and decision processes to deviate from those standards for MH/SUD conditions is comparable to and no more stringent than the processes it follows for medical/surgical conditions.

Treatment for eating disorders is subject to MHPAEA

Eating disorders are mental health conditions, and treatment of an eating disorder is a "mental health benefit" as that term is defined by MHPAEA. *See ACA Implementation FAQs Part 38, Q1, available at https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-38.pdf*. Section 13007 of the 21st Century Cures Act provides that if a plan or an issuer provides coverage for eating disorders, including residential treatment, they must provide these benefits in accordance with MHPAEA requirements. For example, an exclusion under a plan of all inpatient, out-of-network treatment outside of a hospital setting for eating disorders would generally not be permissible if the plan did not employ a comparable process to determine if a similar limitation on treatment outside hospital settings for medical/surgical benefits warranted. *See FAQs About Mental Health And Substance Use Disorder Parity Implementation And the 21st Century Cures Act Part 39, Q8, available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf*.

Compliance Tips

- If the plan or issuer does not contract with a network of providers, all benefits are out-of-network. If a plan or issuer that has no network imposes a financial requirement or treatment limitation on inpatient or outpatient benefits, the plan or issuer is imposing the requirement or limitation within classifications (inpatient, out-of-network or outpatient, out-of-network), and the rules for parity will be applied separately for the different classifications. *See 26 CFR 54.9812-1(c)(2)(ii)(C), 29 CFR 2590.712(c)(2)(ii)(C), 45 CFR 146.136(c)(2)(ii)(C) Example 1.*
- If a plan or issuer covers the full range of medical/surgical benefits (in all classifications, both in-network and out-of-network), beware of exclusions on out-of-network MH/SUD benefits.
- Benefits for intermediate services (such as non-hospital inpatient and partial hospitalization) must be assigned to classifications using a comparable methodology across medical/surgical benefits and MH/SUD benefits.

***NOTE*: Special rules related to classifications**

1. **Special rule for outpatient sub-classifications:**

   - For purposes of determining parity for outpatient benefits (in-network and out-of-network), a plan or issuer may divide its benefits furnished on an outpatient basis into two sub-classifications: (1) office visits; and (2) all other outpatient items and services, for purposes of applying the financial requirement and treatment limitation rules. *26 CFR 54.9812-1(c)(3)(iii), 29 CFR 2590.712(c)(3)(iii), 45 CFR 146.136(c)(3)(iii).*

     - After the sub-classifications are established, the plan or issuer may not impose any financial requirement or QTL on MH/SUD benefits in any sub-classification (*i.e.*, office visits or non-office visits) that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification using the methodology set forth in the MHPAEA regulations. *See 26 CFR 54.9812-1(c)(3)(i), 29 CFR 2590.712(c)(3)(i), 45 CFR 146.136(c)(3)(i), 45 CFR 146.136(c)(3)(iii).*

   - Other than as explicitly permitted under the final rules, sub-classifications are not permitted when applying the financial requirement and treatment limitation rules under MHPAEA. Accordingly, separate sub-classifications for generalists and specialists are not permitted.

2. **Special rule for prescription drug benefits:**

   - There is a special rule for multi-tiered prescription drug benefits. Multi-tiered drug formularies involve different levels of drugs that are classified based primarily on cost, with the lowest-tier (Tier 1) drugs having the lowest cost-sharing. If a plan or issuer applies different levels of financial requirements to different tiers of prescription drug benefits, the plan complies with the mental health parity provisions if it establishes the different levels of financial requirements based on reasonable factors determined in accordance with the rules for NQTLs and without regard to whether a drug is generally prescribed for medical/surgical or MH/SUD benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up. *See 26 CFR54.9812-1(c)(3)(iii), 29 CFR 2590.712(c)(3)(iii), 45 CFR 146.136(c)(3)(iii).*

3. **Special rule for multiple network tiers:**

   - There is a special rule for multiple network tiers. If a plan or issuer provides benefits through multiple tiers of in-network providers (such as in-network preferred and in-network participating providers), the plan or issuer may divide its benefits furnished on an in-network basis into sub-classifications that reflect network tiers, if the tiering is based on reasonable factors determined in accordance with the rules for NQTLs (such as quality, performance, and market standards) and without regard to whether a provider provides services with respect to medical/surgical benefits or MH/SUD

benefits. After the tiers are established, the plan or issuer may not impose any financial requirement or treatment limitation on MH/SUD benefits in any tier that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the tier.

***NOTE*:** As explained in the Introduction to this section, nothing in MHPAEA requires a non-grandfathered group health plan or health insurance coverage that provides MH/SUD benefits only to the extent required under PHS Act section 2713 to provide additional MH/SUD benefits in any classification.

SECTION C. LIFETIME AND ANNUAL LIMITS

Question 4. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding lifetime and annual dollar limits on MH/SUD benefits?

Comments: Yes

A plan or issuer generally may not impose a lifetime dollar limit or an annual dollar limit on MH/SUD benefits that is lower than the lifetime or annual dollar limit imposed on medical/ surgical benefits. *See 26 CFR 9812-1(b), 29 CFR 2590.712(b), 45 CFR 146.136(b).* (This prohibition applies only to dollar limits on what the plan would pay, and not to dollar limits on what an individual may be charged.) If a plan or issuer does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits, or it includes one that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit on MH/SUD benefits. *26 CFR 54.9812-1(b)(2), 29 CFR 2590.712(b)(2), 45 CFR 146.136(b)(2).*

ILLUSTRATION: Plan Z limits outpatient substance use disorder treatments to a maximum of $1,000,000 per calendar year. With the exception of a $500,000 per year limit on chiropractic services (which applies to less than one-third of all medical/surgical benefits), Plan Z does not impose such annual dollar limits with respect to other outpatient medical/surgical benefits. In this example, Plan Z is in violation of MHPAEA since the outpatient substance use disorder dollar limit is not in parity with outpatient medical/surgical dollar limits.

Compliance Tip

- There is a different rule for cumulative limits other than aggregate lifetime or annual dollar limits discussed later in this checklist at **Question 6.** A plan or issuer may impose annual out-of-pocket dollar limits on participants and beneficiaries if done in accordance with the rule regarding cumulative limits.

***NOTE*:** These provisions are affected by section 2711 of the PHS Act, as amended by the Affordable Care Act. Specifically, PHS Act section 2711 generally prohibits lifetime and annual dollar limits on EHB, which includes MH/SUD services. Accordingly, the parity requirements regarding lifetime and annual dollar limits apply only to the provision of MH/SUD benefits that are not EHBs.

Note also that, for plan years beginning in 2021, the annual limitation on an individual's maximum out-of-pocket (MOOP) costs in effect under the Affordable Care Act is $8,550 for self-only coverage and $17,100 for coverage other than self-only coverage. The annual limitation on out-of-pocket costs is increased annually by the premium adjustment percentage described under Affordable Care Act section 1302(c)(4), and this updated amount is detailed each year in regulations issues by the Department of Health and Human Services.

SECTION D. FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS

Question 5. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding financial requirements or QTLs on MH/SUD benefits?

Comments: Yes

- A plan or issuer may not impose a financial requirement or QTL applicable to MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or QTL of that type that is applied to substantially all medical/surgical benefits in the same classification. *See 26 CFR 54.9812-1(c)(2), 29 CFR 2590.712(c)(2), 45 CFR 146.136(c)(2).*
  - Types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. *See 26 CFR 54.9812-1(c)(1)(ii), 29 CFR 2590.712(c)(1)(ii), 45 CFR 146.136(c)(1)(ii).*
  - Types of QTLs include annual, episode, and lifetime day and visit limits, for example, number of treatments, visits, or days of coverage. *See 26 CFR 54.9812-1(c)(1)(ii), 29 CFR 2590.712(c)(1)(ii), 45 CFR 146.136(c)(1)(ii).*
- The six classifications and the sub-classifications outlined in Section B, above, are the only classifications that may be used when determining the predominant financial requirements or QTLs that apply to substantially all medical/surgical benefits. *See 26 CFR 54.9812-1(c)(2)(ii), 29 CFR 2590.712(c)(2)(ii), 45 CFR 146.136(c)(2)(ii).* A plan or issuer may not use a separate sub-classification under these classifications for generalists and specialists. *See 26 CFR 54.9812-1(c)(3)(iii)(C), 29 CFR 2590.712(c)(3)(iii)(C), 45 CFR 146.136(c)(3)(iii)(C).*

Compliance Tips

- Ensure that the plan or issuer does not impose financial requirements or QTLs that are applicable only to MH/SUD benefits.
- Identify all benefit packages and health insurance coverage to which MHPAEA applies.

Detailed steps for applying this rule:

To determine compliance, each type of financial requirement or QTL within a coverage unit must be analyzed separately within each classification. *See 26 CFR 54.9812-1(c)(2)(i), 29 CFR 2590.712(c)(2)(i), 45 CFR 146.136(c)(2)(i).* Coverage unit refers to the way in which a plan groups individuals for purposes of determining benefits, or premiums or contributions, for example, self-only, family, or employee plus spouse. *See 26 CFR 54.9812-1(c)(1)(iv), 29 CFR 2590.712(c)(1)(iv), 45 CFR 146.136(c)(1)(iv).* If a plan applies different levels of a financial requirement or QTL to different coverage units in a classification of medical/surgical benefits (for example, a $15 copayment for self-only and a $20 copayment for family coverage), the predominant level is determined separately for each coverage unit. *See 26 CFR 54.9812-1(c)(3)(ii), 29 CFR 2590.712(c)(3)(ii), 45 CFR 146.136(c)(3)(ii).*

- **STEP ONE ("substantially all" test):** First determine if a particular type of financial requirement or QTL applies to substantially all medical/surgical benefits in the relevant classification of benefits.

  - Generally, a financial requirement or QTL is considered to apply to substantially all medical/surgical benefits if it applies to at least two-thirds of the medical/surgical benefits in the classification. *See 26 CFR 9812-1(c)(3)(i)(A), 29 CFR 2590.712(c)(3)(i)(A), 45 CFR 146.136(c)(3)(i)(A).* This two-thirds calculation is generally based on the dollar amount of plan payments expected to be paid for the plan year within the classification. *See 26 CFR 54.9812-1(c)(3)(i)(C), 29 CFR 2590.712(c)(3)(i)(C), 45 CFR 146.136(c)(3)(i)(C).* Any reasonable method can be used for this calculation. *See 26 CFR 54.9812-1(c)(3)(i)(E), 29 CFR 2590.712(c)(3)(i)(E), 45 CFR 146.136(c)(3)(i)(E).*

- **STEP TWO ("predominant" test):** If the type of financial requirement or QTL applies to at least two-thirds of medical/surgical benefits in that classification, then determine the predominant level of that type of financial requirement or QTL that applies to the medical/surgical benefits that are subject to that type of financial requirement or QTL in that classification of benefits. (***Note*:** If the type of financial requirement or QTL does not apply to at least two-thirds of medical/surgical benefits in that classification, it cannot apply to MH/SUD benefits in that classification.)

  - Generally, the level of a financial requirement or QTL that is considered the predominant level of that type is the level that applies to more than one-half of the medical/surgical benefits in that classification subject to the financial requirement or QTL. *See 26 CFR 54.9812-1(c)(3)(i)(B)(1), 29 CFR 2590.712(c)(3)(i)(B)(1), 45 CFR 146.136(c)(3)(i)(B)(1).* If there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation, the plan can combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the financial requirement or QTL in the classification. In that case, the least restrictive level within the combination is considered the predominant level. *See 26 CFR 54.9812-1(c)(3)(i)(B)(2), 29 CFR 2590.712(c)(3)(i)(B)(2), 45 CFR 146.136(c)(3)(i)(B)(2).* For a simpler method of compliance, a plan may treat the

least restrictive level of financial requirement or treatment limitation applied to medical/surgical benefits as predominant.

Compliance Tip: Book of Business

- When performing the "substantially all" and "predominant" tests for financial requirements and QTLs, basing the analysis on an issuer's entire book of business is generally not a reasonable method if a plan or issuer has sufficient claims data regarding a specific plan for a reasonable projection of future claims costs for the substantially all and predominant analysis. However, there may be insufficient reliable claims data for a group health plan, in which case the analyses will require utilizing reasonable data from outside the group health plan. A plan or issuer must always use appropriate and sufficient data to perform the analysis in compliance with applicable Actuarial Standards of Practice. *See ACA Implementation FAQs Part 34, Q3, available at* https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-34.pdf.

ILLUSTRATION: Plan Z requires copayments for out-patient, in-network MH/SUD benefits. In order to determine if the plan meets the parity requirements, take the following steps:

1. **STEP ONE: Determine if the particular type of financial requirement applies to substantially all (that is, 2/3 of) medical /surgical benefits in the relevant classification**.

   Based on its prior claims experience, Plan Z expects $1 million in medical/surgical benefits to be paid in the outpatient, in-network classification and $700,000 of those benefits are expected to be subject to copayments. Because the amount of medical/surgical benefits expected to be subject to a copayment, which is $700,000, is at least 2/3 of the $1 million total medical/surgical benefits expected to be paid, a copayment can be applied to outpatient, in-network MH/SUD benefits.

2. **STEP TWO: Determine what level of the financial requirement is predominant (that is, the level that applies to more than half the medical/surgical benefits subject to the financial requirement in the relevant classification).**

   In the outpatient, in-network classification where $1 million in medical/surgical benefits is expected to be paid, $700,000 of those benefits are expected to be subject to copayments. Out of the $700,000, Plan Z expects that 25 percent will be subject to a $15 copayment and 75 percent will be subject to a $30 copayment. Since 75 percent is more than half, the $30 copayment is the predominant level.

   CONCLUSION: Plan Z cannot impose a copayment on MH/SUD benefits in this classification that is higher than $30.

Warning Sign: If a plan or issuer applies a specialist copayment requirement for all MH/SUD benefits within a classification but applies a specialist copayment only for certain medical/surgical benefits within a classification, this may be indicative of noncompliance and warrant further review. See "Compliance Tips" below for further guidance on specialist copay requirements.

Compliance Tips

- Ensure that when conducting the predominant/substantially all tests, the dollar amount of all plan payments for medical/surgical benefits expected to be paid in that classification for the relevant plan year are analyzed.
- A plan may be able to impose the specialist level of a financial requirement or QTL to MH/SUD benefits in a classification (or an office visit sub-classification) if it is the predominant level that applies to substantially all medical/surgical benefits within the office visit sub-classification. For example, if the specialist level of copay is the predominant level of copay that applies to substantially all medical/surgical benefits in the office visit, in-network sub-classification, the plan may apply the specialist level copay to MH/SUD benefits in the office visit, in-network sub-classification. *See 26 CFR 54.9812-1(c)(3), 29 CFR 2590.712(c)(3).*

SECTION E. CUMULATIVE FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS

Question 6. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding cumulative financial requirements or cumulative QTLs for MH/SUD benefits?

Comments: Yes

- A plan or issuer may not apply any cumulative financial requirement or cumulative QTL for MH/SUD benefits in a classification that accumulates separately from any cumulative financial requirement or QTL established for medical/surgical benefits in the same classification. *See 26 CFR 54.9812-1(c)(3)(v), 29 CFR 2590.712(c)(3)(v), 45 CFR 146.136(c)(3)(v).* For example, a plan may not impose an annual $250 deductible on medical/surgical benefits in a classification and a separate $250 deductible on MH/SUD benefits in the same classification.

- Cumulative financial requirements are financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums (but do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements). *See 26 CFR 54.9812-1(a), 29 CFR 2590.712(a), 45 CFR 146.136(a).*

- Cumulative QTLs are treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits. *See 26 CFR 54.9812-1(a), 29 CFR 2590.712(a), 45 CFR 146.136(a).*

ILLUSTRATION: A plan offers three benefit options, all of which provide medical/surgical as well as MH/SUD benefits. For all three benefit options, the plan provides for in-network treatment limitations of 30 days per year with respect to inpatient mental health services, and in-network treatment limitations of 20 visits per year with respect to outpatient mental health services. No such limitations are imposed on outpatient or inpatient, in-network medical/surgical benefits in any of the three benefit options.

In this example, the plan improperly imposes cumulative treatment limitations on the number of visits for outpatient and inpatient, in-network and out-of-network mental health benefits in all three benefit options. The plan could come into compliance by removing the day and visit limits for mental health services.

SECTION F. NONQUANTITATIVE TREATMENT LIMITATIONS

Question 7. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding NQTLs on MH/SUD benefits?

Comments: Yes

An NQTL is generally a limitation on the scope or duration of benefits for treatment. The MHPAEA regulations prohibit a plan or an issuer from imposing NQTLs on MH/SUD benefits in any classification unless, under the terms of the plan or coverage as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, those used in applying the limitation with respect to medical/surgical benefits in the same classification. *See 26 CFR 54.9812-1(c)(4)(i), 29 CFR 2590.712(c)(4)(i), 45 CFR 146.136(c)(4)(i).*

The following is an illustrative, non-exhaustive list of NQTLs:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Prior authorization or ongoing authorization requirements;
- Concurrent review standards;
- Formulary design for prescription drugs;
- For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan or issuer methods for determining usual, customary, and reasonable charges;
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as "fail-first" policies or "step therapy" protocols);
- Exclusions of specific treatments for certain conditions;
- Restrictions on applicable provider billing codes;
- Standards for providing access to out-of-network providers;
- Exclusions based on failure to complete a course of treatment; and
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

See 26 CFR 54.9812-1(c)(4)(ii), 29 CFR 2590.712(c)(4)(ii), 45 CFR 146.136(c)(4)(ii). For additional examples of plan provisions that may operate as NQTLs see *Warning Signs, available at* https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf.

While NQTLs are generally defined as treatment limitations that are not expressed numerically, the application of an NQTL in a numerical way does not modify its nonquantitative character. For example, standards for provider admission to participate in a network are NQTLs because such standards are treatment limitations that typically are not expressed numerically. *See 29 CFR 2590.712 (c)(4)(ii), 45 CFR 146.136(c)(4)(ii).* Nevertheless, these standards sometimes rely on numerical standards, for example, numerical reimbursement rates. In this case, the numerical expression of reimbursement rates does not modify the nonquantitative character of the provider admission standards; accordingly, standards for provider admission, including associated reimbursement rates to which a participating provider must agree, are to be evaluated in accordance with the rules for NQTLs.

A group health plan or issuer may consider a wide array of factors in designing medical management techniques for both MH/SUD benefits and medical/surgical benefits, such as cost of treatment; high cost growth; variability in cost and quality; elasticity of demand; provider discretion in determining diagnosis, or type or length of treatment; clinical efficacy of any proposed treatment or service; licensing and accreditation of providers; and claim types with a high percentage of fraud. Based on application of these or other factors in a comparable fashion, an NQTL, such as prior authorization, may be required for some (but not all) MH/SUD benefits, as well as for some (but not all) medical/ surgical benefits. *See 26 CFR 54.9812-1(c)(4), 29 CFR 2590.712(c)(4), 45 CFR 146.136(c)(4), Example 8.*

> ***NOTE*** – To comply with MHPAEA, a plan or issuer must be able to demonstrate that it follows a comparable process in determining reimbursement rates for in-network and out-of-network providers for both medical/surgical and MH/SUD benefits. For example, if reimbursement rates for medical/surgical benefits are determined by reference to the Medicare Physician Fee Schedule, reimbursement rates for MH/SUD benefits must also be determined comparably and applied no more stringently by reference to the Medicare Physician Fee Schedule. Any variance in rates applied by the plan or issuer to account for factors such as the nature of the service, provider type, market dynamics, or market need or availability (demand) must be comparable and applied no more stringently to MH/SUD benefits than medical/surgical benefits.
>
> ***NOTE*** - Plans and issuers may attempt to address shortages in medical/surgical specialist providers and ensure reasonable patient wait times for appointments by adjusting provider admission standards, through increasing reimbursement rates, and by developing a process for accelerating enrollment in their networks to improve network adequacy. To comply with MHPAEA, plans and issuers must take measures that are comparable to and no more stringent than those applied to medical/surgical providers to help ensure an adequate network of MH/SUD providers, even if ultimately there are disparate numbers of MH/SUD and medical/surgical providers in the plan's network. The Departments note that substantially disparate results—for example, a network that includes far fewer MH/SUD providers than medical/surgical providers—are a red flag that a plan or issuer may be imposing an impermissible NQTL. *See FAQs Part 39, Q6 and Q7, available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf.*

Warning Signs: The following plan provisions related to provider reimbursements may be indicative of noncompliance and warrant further review:

1. *Inequitable reimbursement rates established via a comparison to Medicare:* A plan or issuer generally pays at or near Medicare reimbursement rates for MH/SUD benefits, while paying much more than Medicare reimbursement rates for medical/surgical benefits. For assistance comparing a plan or coverage's reimbursement schedule to Medicare, see the PROVIDER REIMBURSEMENT RATE WARNING SIGNS in Appendix II.

2. *Lesser reimbursement for MH/SUD physicians for the same evaluation and management (E&M) codes:* A plan or issuer reimburses psychiatrists, on average, less than medical/surgical physicians for the same E&M codes.

3. *Consideration of different sets of factors to establish reimbursement rates*: A plan or issuer generally considers market dynamics, supply and demand, and geographic location to set reimbursement rates for medical/surgical benefits, but considers only quality measures and treatment outcomes in setting reimbursement rates for MH/SUD benefits.

In order to determine compliance with MHPAEA, the following analysis should be applied to each NQTL identified under the plan or coverage:

Step One:

- Identify the NQTL.

Comments:
See full document, Alliant Health Plans, Inc. Mental Health Parity Comparative Analysis 2023

Identify in the plan documents all the services (both MH/SUD and medical/surgical) to which the NQTL applies in each classification.

NOTE: NQTLs may also be included in other documents, such as internal guidelines or provider contracts.

Compliance Tips

- Ask for information about what medical/surgical benefits are also subject to these requirements or restrictions.
- If a benefit includes multiple components (*e.g.*, outpatient and prescription drug classifications), and each component is subject to a different type of NQTL (*e.g.*, prior authorization and limits on treatment dosage or duration), each NQTL must be analyzed separately.
- Find out how these requirements are implemented, who makes the decisions, and what the decision-maker's qualifications are.

Determine which benefits are treated as medical/surgical and which are treated as MH/SUD, and analyze the NQTLs under each benefit classification. Plans and issuers should clearly define which benefits are treated as medical/surgical and which benefits are treated as MH/SUD under the plan. Benefits (such as inpatient treatment at a skilled nursing facility or other non-hospital facility and partial hospitalization) must be assigned to classifications using a comparable methodology across medical/surgical benefits and MH/SUD benefits.

Compliance Tip

- Any separate NQTL that applies to only the MH/SUD benefits within any particular classification does not comply with MHPAEA.

NOTE: If a plan classifies covered intermediate levels of care, such as skilled nursing care and residential treatment, as inpatient benefits, and covers room and board for all inpatient medical/surgical care, including skilled nursing facilities and other intermediate levels of care, but imposes a restriction on room and board for MH/SUD residential care, the plan imposes an impermissible restriction only on MH/SUD benefits and therefore violates MHPAEA.[1] The plan could come into compliance by covering room and board for intermediate levels of care for MH/SUD benefits comparably with medical/surgical inpatient treatment.

[1] See 29 CFR 2590.712(c)(iii) Ex. 9.

Step Two:

- Identify the factors considered in the design of the NQTL.

Comments:
See full document, Alliant Health Plans, Inc. Mental Health Parity Comparative Analysis 2023

Examples of factors include but are not limited to the following:

- Excessive utilization;
- Recent medical cost escalation;
- Provider discretion in determining diagnosis;
- Lack of clinical efficiency of treatment or service;
- High variability in cost per episode of care;
- High levels of variation in length of stay;
- Lack of adherence to quality standards;
- Claim types with high percentage of fraud; and
- Current and projected demand for services.

Compliance Tips

- If only certain benefits are subject to an NQTL, such as meeting a fail-first protocol or requiring preauthorization, plans and issuers should have information available to substantiate how the applicable factors were used to apply the specific NQTL to medical/surgical and MH/SUD benefits.
- Determine whether any factors were given more weight than others and the reason(s) for doing so, including evaluating the specific data used in the determination (if any).

Step Three:

- Identify the sources (including any processes, strategies, or evidentiary standards) used to define the factors identified above to design the NQTL.

Comments:
See full document, Alliant Health Plans, Inc. Mental Health Parity Comparative Analysis 2023

Examples of sources of factors include, but are not limited to, the following:

- Internal claims analysis;
- Medical expert reviews;
- State and federal requirements;
- National accreditation standards;
- Internal market and competitive analysis;
- Medicare physician fee schedules; and
- Evidentiary standards, including any published standards as well as internal plan or issuer standards, relied upon to define the factors triggering the application of an NQTL to benefits.

If these factors are utilized, they must be applied comparably to MH/SUD and medical/surgical benefits.

NOTE: Plans and issuers have flexibility in determining the sources of factors to apply to NQTLs (including whether or not to employ a particular source or evidentiary standard), as long as they are applied comparably and no more stringently to MH/SUD benefits than to medical/surgical benefits. For example, a plan utilizes a panel of medical experts, with equivalent expertise in both medical/surgical and MH/SUD benefits, to assess whether preauthorization (an NQTL) is appropriate to apply to certain services, based on the factors of cost and safety. The panel recommends that the plan require preauthorization for electroconvulsive therapy (ECT), because ECT is high cost and its use presents legitimate safety concerns. The plan does not require documentation or studies to support these concerns and instead relies on established medical best practices. As long as the plan similarly relies on established medical best practices to define high cost, identify legitimate safety concerns, and impose preauthorization requirements on medical/surgical benefits in the same classification, then the NQTL is applied comparably and no more stringently to MH/SUD benefits than to medical/surgical benefits.

Compliance Tips

- Evidentiary standards and processes that a plan or issuer relies upon may include any evidence that a plan or issuer considers in developing its medical management techniques, including recognized medical literature and professional standards and protocols (including comparative effectiveness studies and clinical trials), and published research studies.
- If there is any variation in the application of a guideline or standard being relied upon by the plan or issuer, the plan or issuer should explain the process and factors relied upon for establishing that variation.
- If the plan or issuer relies on any experts, the plan or issuer should assess the experts' qualifications and the extent to which the expert evaluations in setting recommendations are ultimately relied upon regarding both MH/SUD and medical/surgical benefits.

NOTE: When identifying the sources of the factors considered in designing the NQTL, also identify any threshold at which each factor will implicate the NQTL. For example, if high cost is identified as a factor used in designing a prior authorization requirement, the threshold dollar amount at which prior authorization will be required for any service should also be identified. You may also wish to consider the following:

- What data, if any, are used to determine if the benefit is "high cost"?
- How, if at all, is the amount that is to be considered "high cost" or the calculation for determining that amount different for MH/SUD benefits as compared to medical/surgical benefits, and how is the difference justified?

Examples of how factors identified based on evidentiary standards may be defined to set applicable thresholds for NQTLs include, but are not limited to, the following:

- Excessive utilization as a factor to design the NQTL when utilization is two standard deviations above average utilization per episode of care.
- Recent medical cost escalation may be considered as a factor based on internal claims data showing that medical cost for certain services increased 10 percent or more per year for two years.
- Lack of adherence to quality standards may be considered as a factor when deviation from generally accepted national quality standards for a specific disease category occurs more than 30 percent of the time based on clinical chart reviews.
- High level of variation in length of stay may be considered as a factor when claims data shows that 25 percent of patients stayed longer than the median length of stay for acute hospital episodes of care.
- High variability in cost per episode may be considered as a factor when episodes of outpatient care are two standard deviations higher in total cost than the average cost per episode 20 percent of the time in a 12-month period.
- Lack of clinical efficacy may be considered as a factor when more than 50 percent

of outpatient episodes of care for specific diseases are not based on evidence-based interventions (as defined by nationally accepted best practices) in a 12-month sample of claims data.

Step Four:

- Are the processes, strategies, and evidentiary standards used in applying the NQTL comparable and no more stringently applied to MH/SUD and medical/surgical benefits, both as written and in operation?

Comments: Yes

Plans and issuers should demonstrate any methods, analyses, or other evidence used to determine that any factor used, evidentiary standard relied upon, and process employed in developing and applying the NQTL are comparable and applied no more stringently to MH/SUD services and medical/surgical services.

Compliance Tips

- If utilization review is conducted by different entities or individuals for medical/surgical and MH/SUD benefits provided under the plan or coverage, ensure that there are measures in place to ensure comparable application of utilization review policies.
- Determine what consequences or penalties apply to the benefits when the NQTL requirement is not met.

These are examples of methods/analyses substantiating that factors, evidentiary standards, and processes are comparable:

- Internal claims database analysis demonstrates that the applicable factors (such as excessive utilization or recent increased costs) were implicated for all MH/SUD and medical/surgical benefits subject to the NQTL.
- Review of published literature on rapidly increasing cost for services for MH/SUD and medical/surgical conditions and a determination that a key factor(s) was present with similar frequency with respect to specific MH/SUD and medical/surgical benefits subject to the NQTL.
- A consistent methodology for analyzing which MH/SUD and medical/surgical benefits had “high cost variability” and were therefore subject to the NQTL.
- Analysis that the methodology for setting usual and customary provider rates for both MH/SUD and medical/surgical benefits were the same, both as developed and applied.
- Internal Quality Control Reports showing that the factors, evidentiary standards, and processes regarding MH/SUD and medical/surgical benefits are comparable and no more stringently applied to MH/SUD benefits.

- Summaries of research or peer-reviewed medical journal articles, if considered in designing NQTLs for both MH/SUD and medical/surgical benefits, demonstrating that the research was utilized similarly for both MH/SUD and medical/surgical benefits.

Compliance Tips

- Look for compliance as written **AND IN OPERATION**.
- Determine whether there are exception processes available and when they may be applied.
- Determine how much discretion is allowed in applying the NQTL and whether such discretion is afforded comparably for processing MH/SUD benefit claims and medical/surgical benefits claims.
- Determine who makes denial determinations and if the decision-makers have comparable expertise with respect to MH/SUD and medical/surgical benefits.
- Check sample claims to determine whether a particular NQTL warrants additional review. A plan may have written processes that are compliant on their face, but those processes may not be compliant in practice.
- Determine average denial rates and appeal overturn rates for concurrent review and assess the parity between these rates for MH/SUD benefits and medical/surgical benefits.
- Document your analysis, as a best practice.

NOTE: While outcomes are NOT determinative of compliance, rates of denials may be reviewed as a warning sign, or indicator of a potential operational MHPAEA parity noncompliance. For example, if a plan has a 34 percent denial rate on concurrent reviews of psychiatric hospital stays in a 12-month period and a 5 percent denial rate on concurrent review for medical hospital stays in that same 12-month period, the concurrent review process for both psychiatric and medical hospital stays should be carefully examined to ensure that the concurrent review standard is not being applied more stringently to MH/SUD benefits than to medical/surgical benefits in operation.

Warning Signs: The following plan provisions related to NQTLs may be indicative of noncompliance and warrant further review:

1. *Prior authorization for medication for opioid use disorder*: A plan or issuer imposes prior authorization for medications for opioid use disorder but does not require prior authorization for comparable medications for medical/surgical conditions.

2. *Different medical necessity review requirements*: A plan or issuer imposes medical necessity review requirements on outpatient MH/SUD benefits after a certain number of visits, despite permitting a greater number of visits before requiring any such review for outpatient medical/surgical benefits.

Compliance Tip

- **Do not focus solely on results.** Look at the **underlying processes and strategies** used in applying NQTLs. Are there arbitrary or discriminatory differences in how the plan or issuer is applying those processes and strategies to medical/surgical benefits versus MH/SUD benefits? While results alone are not determinative of noncompliance, measuring and evaluating results and quantitative outcomes can be helpful to identify potential areas of noncompliance.

SECTION G. DISCLOSURE REQUIREMENTS

Question 8. Does the group health plan or group or individual health insurance issuer comply with the MHPAEA disclosure requirements?

Comments: Yes

- The plan administrator or health insurance issuer must make **available the criteria for medical necessity determinations** made under a group health plan or group or individual health insurance coverage with respect to MH/SUD benefits to any current or potential participant, beneficiary, enrollee, or contracting provider **upon request**. *See 29 CFR 2590.712(d)(1), 45 CFR 146.136 (d)(1).*

  The plan administrator (or health insurance issuer) must make available **the reason for any denial** under a group health plan or group or individual health insurance coverage of reimbursement or payment for services with respect to MH/SUD benefits to any participant, beneficiary, or enrollee, and may do so in a form and manner consistent with the rules in 29 CFR 2560.503-1 (the DOL claims procedure rule) and 29 CFR 2590.715-2719 (internal claims and appeals and external review processes).

  - Pursuant to the internal claims and appeals and external review rules under the Affordable Care Act applicable to all non-grandfathered group health plans and to all non-grandfathered group and individual health insurance coverage, claims related to medical judgment (including MH/SUD) are eligible for external review. The **internal claims and appeals** rules include the right of claimants (or their authorized representatives) to be provided **upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits**. This includes documents with information about the **processes, strategies, evidentiary standards, and other factors used to apply an NQTL** with respect to medical/surgical benefits and MH/SUD benefits under the plan. *See 26 CFR 54.9812-1(d)(3), 29 CFR 2560.5301- 2590.712(d)(3), 45 CFR 146.136(d)(3), 147.136(b).*

- With respect to group health plans that are subject to ERISA, if coverage is denied based on medical necessity, **medical necessity criteria** for the MH/SUD benefits at issue and for medical/surgical benefits in the same classification must be provided **within 30 days of the request** to the participant, beneficiary, provider, or authorized representative of the beneficiary or participant. *See 29 CFR 2520.104b-1; 29 CFR 2590.712(d)(1).*

- If a plan or a plan administrator or health insurance issuer fails to provide these documents, a court may hold it liable for up to $110 a day from the date of failure to provide these documents. *See ERISA Sec. 502(c)(1).*

Compliance Tips

- The reasons for benefit denials include applicable medical necessity criteria as applied to that participant, beneficiary, or enrollee.
- Under ERISA, plans and issuers cannot refuse to disclose information necessary for the parity analysis on the basis that the information is proprietary or has commercial value.
- Under ERISA, plans and issuers can provide summary descriptions of the medical necessity criteria in a layperson's terms.

Make Showing Compliance Simple

Documents or Plan Instruments Participants and Beneficiaries or DOL may Request Include the following:

Under ERISA section 104(b), participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with MHPAEA, and copies must be furnished within 30 days of the request. These documents and plan instruments may include documentation that illustrates how the health plan has determined that any financial requirement, QTL, or NQTL complies with MHPAEA. For example, participants and beneficiaries may request the following:

- An analysis showing that the plan meets the predominant/substantially all tests. The plan may need to provide information regarding the amount of medical/surgical claims subject to a certain type of financial requirement, such as a co-payment, in the prior year for a classification or the plan's basis for calculating claims expected to be subject to a certain type of QTL in the current plan year for a classification, for purposes of determining the plan's compliance with the predominant/substantially all tests;
- A description of an applicable requirement or limitation, such as preauthorization or concurrent review, that the plan applies for MH/SUD benefits and medical/surgical benefits within the relevant classification (for example, in- or out-of-network, or in- or outpatient). These might include references to specific plan documents: for example provisions as stated on specified pages of the summary plan description (SPD), or other underlying guidelines or criteria not included in the SPD that the plan has consulted or relied upon;
- Information regarding factors, such as cost or recommended standards of care, that are relied upon by a plan for determining which medical/surgical or MH/SUD benefits are subject to a specific requirement or limitation. These might include references to specific related factors or guidelines, such as applicable utilization review criteria;
- A description of the applicable requirement or limitation that the plan believes has been used in any given MH/SUD service adverse benefit determination (ABD) within the relevant classification; and
- Medical necessity guidelines relied upon for in- and out-of-network medical/surgical and MH/SUD benefits.

Compliance Tips

- Find out how the plan administrator handles general information requests about coverage limitations as well as specific information or disclosure requests with respect to denied benefit claims.
- Review a sample of appeals files and examine what was disclosed to participants, including the criteria for medical necessity determinations and reasons for claim denials.
- Determine how long it took the plan or the plan administrator to furnish requested documents to participants.

As directed by the 21st Century Cures Act, and in response to comments received from the regulated community, the Departments continue to issue additional guidance regarding disclosures, in particular with respect to NQTLs. Based on requests from various stakeholders for model MHPAEA disclosure forms and for guidance on processes for requesting disclosures in a more uniform, streamlined, or otherwise simplified way, the Departments issued a model disclosure request form (available at https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-disclosure-template.pdf). For the most current version of the form please visit the DOL's dedicated MH/SUD parity webpage, available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity.

This form can, but is not required to, be used to request MHPAEA-related information from group plans and group and individual health insurance issuers, including general information about coverage limitations or specific information that may have resulted in denial of MH/SUD benefit claims.

Compliance Tips

- Participants, beneficiaries, enrollees, dependents, and contracting providers may request information to determine whether benefits under a plan are being provided in parity even in the absence of any specific ABD.
- Group health plans may need to work with insurance issuers providing coverage on behalf of an insured group health plan or with third party administrators administering the plan to ensure that such service providers either directly or in coordination with the plan are providing participants and beneficiaries any documents or information to which they are entitled.
- If a group health plan or group or individual health insurance issuer uses MH/SUD vendors and carve-out service providers, the plan must ensure that all combinations of benefits comport with MHPAEA. Therefore, vendors and carve-out providers should provide documentation of the necessary information to the plan to ensure that all combinations of benefits comport with parity.

NOTE: Compliance with the disclosure requirements of MHPAEA is not determinative of compliance with any other provision of other applicable federal or state law. Be sure that the plan or issuer, in addition to these disclosure requirements, is disclosing all information relevant to medical/surgical, mental health, and substance use disorder benefits as required pursuant to other applicable provisions of law. For example, if a plan document states it covers benefits consistent with generally accepted standards of care (for both medical/surgical and MH/SUD benefits), and the plan has developed internal guidelines that are more restrictive than the generally accepted standards of care for both medical/surgical and MH/SUD benefits, the plan might comply with MHPAEA but fail to comply with Part 4 of ERISA, which requires that the plan be administered in accordance with its plan documents. Plans should be prepared to disclose their medical necessity criteria and should ensure that, to the extent the plan document specifies a specific treatment guideline, it follows that as well.

Compliance Tip

- Under ERISA, ERISA-covered plans must provide an SPD that describes plan provisions related to the use of network providers and describe the composition of the provider network (*i.e.*, a provider directory). The provider directory may be distributed as a separate document from the SPD and, in many circumstances, may be provided electronically. However, the provider directory must be up-to-date, accurate, and complete (using reasonable efforts). *See e.g., 29 CFR 2520.102-3; FAQs About Mental Health And Substance Use Disorder Parity Implementation And the 21st Century Cures Act Part 39, Q10, available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf; ERISA Secs. 102, 104, and 404(a).*

SECTION H. ESTABLISHING AN INTERNAL MHPAEA COMPLIANCE PLAN

Although not required by MHPAEA, an internal compliance plan that promotes the prevention, detection, and resolution of potential MHPAEA violations can help plans and issuers improve compliance with the law. Compliance plans for group health plans or issuers may differ, but many successful compliance plans share the following characteristics:

1. **Conducting effective training and education**. Successful compliance programs provide ongoing training and education to all individuals responsible for ensuring MHPAEA compliance, including those who are responsible for making decisions related to medical/surgical and MH/SUD benefits on behalf of the plan or issuer (such as claims reviewers). EBSA provides many educational materials, webcasts, and in-person compliance assistance events that may assist in these trainings and can also be made available to participants and beneficiaries to inform them of their parity protections under MHPAEA.[2]

2. **Ensuring retention of records and information.** ERISA Section 107 requires the retention of certain documents. These documents should be retained for at least six years after the Form 5500 for the relevant plan year has been filed.

3. **Conducting internal monitoring and compliance reviews on a regular basis.** A plan or issuer may monitor compliance on an ongoing basis by conducting internal reviews for potential non-compliance and identification of problem areas related to MHPAEA and by auditing samples of adverse benefit determinations to assess the application of medical necessity criteria, the level of detail provided to claimants, and the correctness of determinations. Plans and issuers may wish to establish an internal consumer ombudsmen program to assist participants and beneficiaries in navigating their benefits and for elevating complaints of noncompliance. Plans and issuers that delegate management of MH/SUD benefits to another entity should have clear protocols to ensure that the service providers for both medical/surgical and MH/SUD benefits provide documentation of the necessary information to the plan or issuer (and to the entity that adjudicates MH/SUD benefit claims, if necessary) to ensure that all combinations of benefits that a participant or beneficiary can elect comport with MHPAEA and to ensure that plans and issuers are able to comply with disclosure requirements.

4. **Responding promptly to detected offenses and developing corrective action.** If a plan or issuer discovers a violation of MHPAEA, it should take steps to correct the violation promptly, including providing retroactive relief and notice to potentially affected participants and beneficiaries. EBSA Benefits Advisors may be able to assist plans and issuers in voluntarily complying with MHPAEA. They can be contacted at (866) 444-3272.

[2] See https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity.

If a group health plan is audited by DOL investigators for MHPAEA compliance, DOL may ask for at least the following, among other items:

1. Plan materials related to the plan's compliance with MHPAEA, including the following:

    a) Information regarding NQTLs that apply to MH/SUD and/or medical/surgical benefits offered under the plan or coverage.

    b) Records documenting NQTL processes and how the NQTLs are being applied to both medical/surgical and MH/SUD benefits to ensure the plan or issuer can demonstrate compliance with the law, including any materials that may have been prepared for compliance with any applicable reporting requirements under state law. Such records may also be helpful to plans and issuers in responding to inquiries from participants, beneficiaries, enrollees, and dependents regarding benefits under the plan or coverage.

    c) Any documentation, including any guidelines, claims processing policies and procedures, or other standards that the plan or issuer has relied upon as the basis for determining its compliance with the requirement that any NQTL applicable to MH/SUD benefits be comparable to and applied no more stringently than the NQTL as applied to medical/surgical benefits. Plans and issuers should include any available details as to how the standards were applied, and any internal testing, review, or analysis done by the plan or issuer to support the rationale that the NQTL is being applied comparably and no more stringently to MH/SUD benefits than medical/surgical benefits. If the standards that are applied to MH/SUD benefits are more stringent than those in nationally recognized medical guidelines, but the standards that are applied to medical/surgical benefits are not, plans and issuers should include any applicable explanation of the reason(s) for the application of the more stringent standard for MH/SUD benefits.

    d) Samples of covered and denied MH/SUD and medical/surgical benefit claims.

    e) Documents related to MHPAEA compliance with respect to service providers (if a plan delegates management of MH/SUD benefits to another entity).

    f) Any applicable MHPAEA testing completed by the plan or the issuer for financial requirements or QTLs applied to MH/SUD benefits.

In addition to this Self-Compliance Tool, the National Association of Insurance Commissioners (NAIC) has developed tools (such as a Data Collection Tool, which includes a Non-Quantitative Treatment Limitations Chart) to assist issuers in evaluating MHPAEA compliance. For more information regarding NAIC compliance assistance efforts, please visit its website at https://content.naic.org/.

APPENDIX I: ADDITIONAL ILLUSTRATIONS

ILLUSTRATION 1: A Plan covers neuropsychological testing but excludes such testing for certain conditions. In such situations, look to see whether the exclusion is based on evidence addressing, for example, clinical efficacy of such testing for different conditions and the degree to which such testing is used for educational purposes with regard to different conditions. Does the plan rely on criteria and evidence from comparable sources with respect to medical/surgical and mental health conditions? Does the plan have documentation indicating the criteria used and evidence supporting the plan's determination of the diagnoses for which the plan will cover this service and the rationale for excluding certain diagnoses? The result may be that the plan permissibly covers neuropsychological testing for some medical/surgical or mental health conditions, but not for all.

Conclusion: This outcome may be permissible to the extent the plan has based the exclusion of this testing for certain conditions on clinical efficacy and/or other factors if the factors are designed and applied in a comparable manner with respect to the conditions for which testing is covered and those for which it is excluded.

ILLUSTRATION 2: A Plan uses diagnosis related group (DRG) codes in their standard utilization review process to actively manage hospitalization utilization. For all non-DRG hospitalizations (whether due to an underlying medical/surgical condition or a MH/SUD condition), the plan requires precertification for hospital admission and incremental concurrent review. The precertification and concurrent review processes review unique clinical presentation, condition severity, expected course of recovery, quality, and efficiency. The evidentiary standards and other factors used in the development of the concurrent review process are comparable across medical/surgical benefits and MH/SUD benefits, and are well documented. These evidentiary standards and other factors are available to participants and beneficiaries free of charge upon request.

Conclusion: In this example, it appears that, under the terms of the plan as written and in practice, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its precertification and concurrent review of hospitalizations are comparable and applied no more stringently with respect to MH/SUD benefits than those applied with respect to medical/surgical benefits.

ILLUSTRATION 3: A Plan classifies care in skilled nursing facilities and rehabilitation hospitals for medical/surgical conditions as inpatient benefits and likewise treats any covered care in residential treatment facilities for MH/SUD as an inpatient benefit. In addition, the plan treats home health care as an outpatient benefit and treats intensive outpatient and partial hospitalization for MH/SUD services as outpatient benefits.

Conclusion: In this example, the plan assigns covered intermediate MH/SUD benefits to the six classifications in the same way that it assigns comparable intermediate medical/surgical benefits to the classifications.

ILLUSTRATION 4: Master's degree training and state licensing requirements often vary among provider types. The plan consistently applies its standard that any provider must meet the most

stringent licensing requirement standard in the applicable state related to supervised clinical experience requirements in order to participate in the network. Therefore, the plan requires master's-level therapists to have post-degree, supervised clinical experience in order to join its provider network. There is no parallel requirement for master's-level general medical providers because their licensing requires supervised clinical experience. In addition, the plan does not require post-degree, supervised clinical experience for psychiatrists or PhD level psychologists since their licensing already requires supervised training.

Conclusion: The requirement that master's-level therapists must have supervised clinical experience to join the network is permissible, as the plan consistently applies the same standard to all providers even though it may have a disparate impact on certain mental health providers whose state licensing does not require this experience.

ILLUSTRATION 5: A patient with chronic depression has not responded to five different anti-depressant medications and therefore was referred for outpatient treatment with repetitive transcranial magnetic stimulation (TMS). This specific treatment has been approved by the FDA and has been the subject of more than six randomized controlled trials published in peer reviewed journals. The plan denies the treatment as experimental. The plan states that it used the same criteria to deny TMS as it does to approve or deny any MH/SUD or medical/surgical benefits under the plan. The plan identifies its standard for both medical/surgical benefits and MH/SUD benefits as requiring that at least two randomized controlled trials showing efficacy of a treatment be published in peer reviewed journals for any new treatment. However, the plan indicates that while more than two randomized controlled trials regarding TMS have been published in peer reviewed journals, a committee of medical experts involved in plan utilization management reviews reviewed the journals and determined that only one of the articles provided sufficient evidence of efficacy. The plan did not identify what specific standards were used to assess whether a peer review had adequately evidenced efficacy and what the qualifications of the plan's experts are. Lastly, the plan does not impose this additional level of scrutiny with respect to reviewing medical/surgical treatments beyond the initial requirement that the treatment has been the subject of the requisite number and type of trials.

Conclusion: The plan's exclusion fails to comply with MHPAEA's NQTL requirements because, in practice, the plan applies an additional level of scrutiny with respect to MH/SUD benefits and therefore applies the NQTL more stringently to mental health benefits than to medical/surgical benefits without additional justification. To come into compliance, the plan could ensure that that any additional levels of scrutiny are imposed on both medical/surgical and MH/SUD benefits comparably, including by establishing standards for when a peer review has adequately evidenced efficacy, and that the qualifications of the plan's experts are similar for both MH/SUD and medical/surgical benefits.

ILLUSTRATION 6: A plan imposes prior authorization for certain MH/SUD and medical/surgical services. The medical/surgical outpatient services that require prior authorization include habilitative and rehabilitative services such as physical therapy. Physical therapy services were selected for prior authorization because of findings that physical therapists' documentation of medical necessity is often inadequate. In addition, there has been an increase in litigation regarding physical therapy claims. Prior authorization is conducted telephonically and authorization determinations are reviewed by a physician in consultation with

a licensed physical therapist for medical necessity. Authorization determinations are provided verbally and in writing consistent with federal and state timeliness requirements. The number of sessions authorized is tailored to the specific medical/surgical condition treated, consistent with generally accepted national clinical guidelines. Determinations to approve or deny coverage are made by physicians with consultation from a licensed physical therapist.

Psychological testing also requires prior authorization. Psychological testing was selected for prior authorization because of recent Medicare fraud schemes and consistent with the Medicare Improper Payment Reports, which found improper payments with respect to psychological testing claims because of inadequate documentation from psychologists. Prior authorization is conducted telephonically and reviewed by a licensed psychologist for medical necessity. Authorization determinations are provided verbally and in writing consistent with federal and state timeliness requirements. The number of hours authorized for psychological testing are tailored to the age of the client and type of evaluation requested and range from two to five hours for an average evaluation (on the basis of the average number of hours for evaluation as included in generally accepted national clinical guidelines). Determinations to approve or deny coverage are made by licensed psychologists with at least five years of experience in psychological testing.

Conclusion: In this example, under the terms of the plan as written and in practice, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its preauthorization requirements, particularly the use of prior authorization to detect fraud and abuse, are comparable and applied no more stringently with respect to MH/SUD benefits than those applied with respect to medical/surgical benefits.

APPENDIX II:

PROVIDER REIMBURSEMENT RATE WARNING SIGNS

The Departments have noted that, while outcomes are not determinative of a MHPAEA violation, they can often serve as red flags or warning signs to alert the plan or issuer that a particular provision may warrant further review. With respect to provider reimbursement, comparing a plan or issuer's average reimbursement rates for both medical/surgical and MH/SUD providers against an external benchmark of reimbursement rates, such as Medicare, may help identify whether the underlying methodology used to determine the plan's or issuer's reimbursement rates warrants additional review for compliance with MHPAEA. Furthermore, evaluating how medical/surgical and MH/SUD providers are reimbursed for the same or similar services may also help a plan or issuer determine if the plan's or issuer's underlying methodology for provider reimbursement warrants further review.

Accordingly, the following framework for comparison may assist plans and issuers in identifying information they might consider when comparing reimbursement rates for certain MH/SUD and medical/surgical services based on Current Procedural Terminology (CPT) codes. This is not the only framework for analyzing provider reimbursement rates, and it is not determinative of compliance. This framework utilizes Medicare reimbursement rates as its benchmark for comparison. If a plan's or issuer's comparison of reimbursement rates indicates that the reimbursement rate is lower for MH/SUD providers, either as compared to medical/surgical providers or as compared to an external benchmark, such as Medicare, the plan or issuer should consider further review to ensure that the processes, strategies, evidentiary standards, and other factors used with respect to provider reimbursement for MH/SUD benefits are comparable to, and applied no more stringently than, those used with respect to provider reimbursement for medical/surgical benefits. Please see Section F. Nonquantitative Treatment Limitations for information on how to further evaluate provider reimbursement rates for compliance with MHPAEA.

Specialty	CPT Code	Average Plan rate for [insert locality]	Medicare rate for [insert locality]	Plan rate as a percentage of Medicare
Orthopedic Surgery	99203 99213	$ xx.xx $	$ xx.xx $	xx.x%
Cardiologists	99203 99213	$ $	$ $	
Internists MD	99203 99213	$ $	$ $	
Endocrinologists	99203 99213	$ $	$ $	
Gastroenterologist	99203 99213	$ $	$ $	

Specialty	CPT Code	Average Plan rate for [insert locality]	Medicare rate for [insert locality]	Plan rate as a percentage of Medicare
Neurologists	99203 99213	$ $	$ $	
Pediatrician	99203 99213	$ $	$ $	
Dermatologists	99203 99213	$ $	$ $	
Psychiatrists	99203 99213	$ $	$ $	
Psychologists	90832 (based on 1 hr) 90791 (based on ½ hour)	$ $	$ $	
LCSW	90832 (based on 1 hr) 90791 (based on ½ hour)	$ $	$ $	
Podiatrists	99203 99213	$ $	$ $	
Chiropractor	99203 99213	$ $	$ $	
Occupational Therapy	97165 97166 97167 97168	$ $	$ $	
Physical Therapy	97161 97162 97163 97164	$ $	$ $	
Speech Therapy	Initial Office Visit Codes do not exist. Analysis of specific tests or follow- up may be useful to consider.			

Summary of Various Quantitative and Non-Quantitative Treatment Limitations Mental Health Parity and Addiction Equity Act Alliant Health Plans 2023		
Definitions	**General Medical/Surgical**	**Behavioral Health**
	Alliant defines medical/surgical benefits as benefits for the treatment of medical/surgical conditions included in the International Classification of Diseases (ICD) with the exception of the mental disorders classification.	Alliant defines behavioral health benefits as benefits for the treatment of MH/SUD conditions included in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). This includes services rendered by licensed specialists for the treatment of behavioral health conditions.
Classification of Benefits	**General Medical/Surgical**	**Behavioral Health**
Inpatient	Non-emergent medical/surgical services requiring admission to a hospital or other facility and providing lodging and food as well as treatment. The facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific requirements established by Alliant. This includes: • Services rendered by acute care hospitals licensed by the appropriate state agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty.; and • Services rendered by licensed subacute care hospitals and facilities including skilled nursing facilities, long term acute care facilities, and rehabilitation hospitals. To include: • Acute inpatient hospital services • Skilled nursing facilities • Long term acute care facilities • Physical rehabilitation hospitals	Non-emergent MH/SUD services requiring admission to a hospital or other facility and providing lodging and food as well as treatment. The facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific requirements established by Alliant. This includes: • Services rendered by licensed acute care facilities licensed by the appropriate state agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the diagnosis and treatment of mental illness by or under the supervision of physicians and 24-hour nursing services under the supervision of registered nurses; and • Services rendered by licensed subacute care facilities including residential treatment centers. To include: • Mental health/Substance use disorder inpatient facility services • Mental health/Substance use disorder residential treatment services • Mental health/Substance use disorder inpatient professional services • Substance use disorder inpatient detoxification

	• Inpatient professional services	
Outpatient	Non-emergent medical/surgical services not requiring admission to a hospital or other facility. The practitioner or facility must be licensed, registered or approved by the appropriate medical board or commission or meet specific requirements established by Alliant. Outpatient services include, but are not limited to: • Outpatient: PCP or Specialist office visit, Urgent Care, Telehealth • Outpatient: Hospital, ASC, non-emergent Ambulance • Outpatient: Home Health, PT, OT, ST • Outpatient: Imaging, Lab services Alliant further subclassifies outpatient services into office visits and all other outpatient services. Office visits include urgent care, telehealth, and some therapy services dependent on place of service. Alliant classifies both rehabilitation and habilitation as medical/surgical services.	Non-emergent MH/SUD services not requiring admission to a hospital or other facility. The practitioner or facility must be licensed, registered or approved by the appropriate medical board or commission or meet specific requirements established by Alliant. Outpatient services include, but are not limited to: • Outpatient: Practitioner office visit, Telehealth • Outpatient: IOP, PHP • Outpatient: Lab services Alliant further subclassifies outpatient services into office visits and all other outpatient services. Office visits include telehealth, and some therapy services dependent on place of service.
Quantitative Treatment Limitations	**General Medical/Surgical**	**Behavioral Health**
General Visit or Length of Stay Limits	No difference in limits based on provider network participation. Stay limits for Inpatient services are based on medical necessity criteria and clinical documentation of the provider, as well as the availability of services at a lower level of care. Currently the limit for SNF is 60 days per year. Outpatient service limits for rehabilitation, habilitation, and home health are based on evidence-based criteria for length of care needed for specific services. Current limits: Rehabilitation: • PT, OT combined 40 visits per year • ST 40 visits per year	No difference in limits based on provider network participation. Stay limits for Inpatient services are based on medical necessity criteria and clinical documentation of the provider as well as the availability of services at a lower level of care. Currently there is no limit for residential treatment number of days. Outpatient service limits for are based on evidence-based criteria for length of care needed for specific services. Currently there are no limits for IOP or PHP number of days allowable. Custodial care is not a covered service. Based on this information Alliant considers the application of

	Habilitation: • PT, OT, ST combined 40 visits per year Home health is limited to 120 visits per year. Custodial care is not a covered service. Based on this information Alliant considers the application of criteria to be in substantial compliance with Mental Health Parity.	criteria to be in substantial compliance with Mental Health Parity.
Non-Quantitative Treatment Limitations	**General Medical/Surgical**	**Behavioral Health**
Standards for Medical Necessity and Utilization Review	**Medical Necessity** Nationally recognized evidence-based criteria and corporate medical policies that consider regional and local variations in medical practice and member needs are used to determine the medical necessity and clinical appropriateness of utilization decisions. MCG criteria are embedded into the care management system and are available to all medical and behavioral health clinicians. All medical policies can be requested by providers and accessed electronically by staff. The fact that a Physician has prescribed, ordered, recommended, or approved a service or supply does not, in itself, make it Medically Necessary. We consider a health care service Medically Necessary if it is: • Appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient's condition, • Compatible with the standards of acceptable medical practice in the United States, • Not provided solely for the patient's convenience or the convenience of the doctor, health care Provider or Hospital, • Not primarily Custodial Care, and • Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms. For example, a Hospital stay is necessary when treatment cannot be safely provided on an outpatient basis. AHP may choose to develop its own policies, use modified MCG criteria or when a situation occurs where there is no MCG guideline, other approved clinical guidelines may be utilized. Medical and behavioral health policies are created to formalize and document criteria that does not currently exist or to clarify or modify existing criteria. These policies cover technologies and procedures based on sound medical practice that are not addressed by standard MCG criteria or require modification of MCG criteria when deemed necessary. References used to develop policies include, but are not limited to, the following: • Guidelines and practice parameters from nationally recognized condition-specific societies (e.g., NCCN, American Diabetes Association) • Guidelines and practice parameters from medical societies (e.g., American Academy of Allergy Asthma and Immunology) • Cochrane, ICER and other recognized sources emphasizing high quality peer reviewed sources • Actively practicing physician experts Criteria are not intended to be a substitute for practitioner judgment. The Medical Director or designee for AHP, UM consultant group, or	

DE reviews all potential medical necessity denials following currently accepted healthcare practices, considering the unique circumstances of each case. Only a physician or qualified Nurse Practitioner may issue a medical denial. When applying criteria to a member's case, the reviewer will consider at least the following:

- Age
- Comorbidities
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment, when applicable

The reviewer also considers the characteristics of the local delivery system available to specific members, including:

- Availability of inpatient outpatient and transitional facilities
- Availability of outpatient services instead of inpatient services such as ambulatory surgery centers vs. inpatient surgery
- Availability of highly specialized services, such as transplant facilities or cancer centers
- Availability of skilled nursing facilities or home care in the organization's service area to support the patient after hospital discharge
- Local hospitals' ability to provide all recommended services within the estimated length of stay

Prior Authorization, Concurrent Review, Retrospective Review

A prospective review and concurrent review provide opportunities to identify potentially high-dollar and other cases appropriate for additional services, such as Case and Disease Management. Prospective review further allows for redirection to network facilities and providers. There is parity in decision making between medical and behavioral health. Services requiring Prior Authorization are reviewed and available to members and providers via the Alliant website, alliantplans.com, or by calling customer service. An annual notification is distributed to both members and providers directing them to the website or customer service where a list of services requiring Prior Authorization is found.

Information is accepted from any reasonably reliable source that will assist in the certification process. The reviewers request only the information relevant to the case being reviewed and necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services. Numeric diagnosis and/or procedure codes may be requested but are not required for review. The reviewer does not routinely request copies of all medical records on all enrollees reviewed, requiring only the sections of the medical record necessary in that specific case to certify medical necessity or appropriateness of the admission or extension of stay, or frequency or duration of service. Clinical information is gathered consistently for non-behavioral and behavioral health care requests.

The collected information is evaluated using the established criteria (MCG Guidelines, AHP-specific policies). The reviewer ensures the requested service is a covered benefit under the applicable plan and takes into consideration all special circumstances with each request when applying the criteria, i.e., comorbidities, disabilities, special needs. For extensions of initial determinations, the frequency of reviews is based on the severity or complexity of the enrollee's condition or on necessary treatment and discharge planning activities.

If medical criteria are not met, or when criteria are unavailable for the request, the case is referred to the designated Medical Director for review. The designated Medical Director reviews all available criteria and medical information. The designated Medical Director may consult with the requesting provider and outside board- certified consultants, as needed, to render a determination.

	For retrospective review, determinations are based only on the medical information available to the attending physician or ordering provider at the time the medical care was provided. The following reasons may result in the allowance of a medical necessity review. Otherwise, retro reviews shall be reviewed administratively. This information must be supplied in the appeal or given to the intake personnel when a PA is requested. • A Provider was not given member's insurance information due to member incapacitated in some way at the time of service rendered or member gave prior coverage information • A Provider or member was given inaccurate information by an authorized representative of the company related to PA requirement(s) • Provider performed unplanned service in addition to some other planned service due to the discovery of the need to perform the service at the time of service • Based on contract • A request is made by a member that has received services from a provider that is participating with the PHCS network.	
General PA Requirements by Category	No difference in PA requirements based on provider network participation. Participating providers are responsible for requesting a PA when required for specific services, while the member is responsible for requesting a PA when required for Out-of-Network services. General classification of services: ○ Inpatient: Hospital, SNF, LTAC, Hospice, Maternity ○ Outpatient: PCP or Specialist office visit, Urgent Care, Telehealth ○ Outpatient: Hospital, ASC, non-emergent Ambulance ○ Outpatient: Home Health, PT, OT, ST ○ Emergency Room ○ Emergency Transport: Ground Ambulance, Air Ambulance ○ Prescription Drugs When determining which medical/surgical benefits are subject to PA, the following factors are considered: • Cost of the service • Service is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, service, provider type and/or geographic region • Claim volume for service including total paid and denied claims • Services subject to a higher potential for fraud, waste	No difference in PA requirements based on provider network participation. Participating providers are responsible for requesting a PA when required for specific services, while the member is responsible for requesting a PA when required for Out-of-Network services. General classification of services: • Inpatient: Hospital, Residential Treatment • Outpatient: Practitioner office visit, Telehealth • Outpatient: IOP, PHP • Emergency Room • Emergency Transport • Prescription Drugs When determining which behavioral health benefits are subject to PA, the following factors are considered: • Cost of the service • Service is a driver of high cost growth • Variability in cost, quality and utilization based upon diagnosis, service, provider type and/or geographic region • Claim volume for service including total paid and denied claims • Services subject to a higher potential for fraud, waste and/or abuse • Cost of UM and appeals for service if subject to PA • Plan savings if service is subjected to PA Alliant considers the administrative cost of requiring a PA for

	and/or abuse
	• Cost of UM and appeals for service if subject to PA
	• Plan savings if service is subjected to PA
	
	Alliant considers the administrative cost of requiring a PA for certain services when deciding when applying the above factors and if the benefit outweighs the cost a PA is applied.
	
	Selected services that require a PA, not an all-inclusive list:
	• All inpatient admissions require Prior Authorization, including but not limited to:
	  ○ Neonatal Intensive Care Unit admissions Levels II, III, or IV (Revenue codes0172, 0173, or 0174)
	• CT
	• PET
	• MRI
	• MRA
	• Magnetic Resonance Cholangiopancreatography
	• Magnetic Resonance Spectroscopy
	• Myocardial Perfusion Imaging
	• Magnetic Resonance Guidance
	• All covered services related to an approved clinical trial
	• All Dialysis
	• DME:
	  ○ Ambulatory Assistive Devices (excluding crutches, canes and walkers)
	  ○ Continuous Glucose Monitoring
	  ○ Continuous Passive Motion Machines
	  ○ CPAP and BIPAP machines
	  ○ Custom DME
	  ○ Home Ventilators
	  ○ Helmets
	  ○ Hospital Beds and Accessories
	  ○ Infusion Pumps
	  ○ Orthotics
	  ○ Prosthetics (excluding breast prosthetics)
	  ○ Wheelchairs and accessories
	  ○ Wound Vac devices
	• All Hyperbaric Oxygen Therapy
	• Inpatient rehabilitation
		certain services when deciding when applying the above factors and if the benefit outweighs the cost a PA is applied.
		
		Selected services that require a PA:
		• Detoxification
		• Inpatient
		• Intensive Outpatient Treatment Program
		• Partial Hospitalization Program (PHP)
		• Residential Treatment Center services
		• Drug Screens **EXCEPTIONS:** Drug screens billed with a POS 11 (Office) or POS 81 (Independent Laboratory) do **not** require Prior Authorization.

	• Skilled Nursing Facility (SNF)
	• All Observation stays require Prior Authorization, except observation admissions from the Emergency Room do not require Prior Authorization.
	• Outpatient Services, including, but not limited to:
	  ○ Abdominoplasty
	  ○ Arthroscopy
	  ○ Blepharoplasty
	  ○ Brachytherapy
	  ○ Breast Reduction
	  ○ Cardiac Surgery and Procedures
	  ○ Carpal Tunnel Surgery
	  ○ Chemodenervation
	  ○ Cochlear Device
	  ○ Dental Related
	  ○ Electroencephalogram
	  ○ Excess Skin Removal
	  ○ Facial and Ear Revision/Augmentation/Reconstruction
	  ○ Gastrointestinal Capsule Endoscopy
	  ○ Hysterectomy and Related Procedures
	  ○ Implantable Devices
	  ○ Interdental Fixation
	  ○ Joint Repair/Reconstruction/Replacement
	  ○ Mastectomy, except breast cancer diagnoses
	  ○ Mohs Surgery
	  ○ Orchiectomy
	  ○ Pain Management Invasive Procedures (including but not limited to Epidural Steroid, Facet and Botox injections)
	  ○ Panniculectomy
	  ○ Reconstructive Repair Pectus Excavatum
	  ○ Scrotoplasty
	  ○ Sinus and Nasal Surgery
	  ○ Skin Color Correction
	  ○ Sleep Studies
	  ○ Spine Surgery
	  ○ Stomach/Colon Surgery
	  ○ Therapeutic Repetitive Transcranial Magnetic Stimulation (TMS)	

	○ Transplant Related Services/Procedures ○ Treatment of contour defects ○ Pregnancy Reduction(s) ○ Neurostimulator ○ Unlisted Procedure Male Genital System ○ Unlisted Procedure Nervous System ○ Vaginal/Perineum Surgery ○ Venous Surgery ○ Vein Ligation ○ Varicose Vein Treatment ○ Vascular Embolization or Occlusion • Lab services: ○ Genetic ○ Chromosomal ○ DNA ○ Molecular Pathology • Outpatient therapies, except evaluations, PT, OT • Transplants • Non-emergent air ambulance • Pharmacy, select medications and services	
Exclusions for Failure to Complete a Course of Treatment	Alliant does not provide for any exclusions or limitations of benefits due to a member not completing a course of treatment.	
Claims Procedures & Claim Edits	Minimum claims procedures follow the federal guidelines under 29 CFR 2560.503-1. Claim submission, determinations, adverse determinations, and appeals follow the prescribed guidelines. Claim edits are handled through a software system, Optum CES, that is a duly recognized source of industry current coding practices. Claims procedures and edits are agnostic to medical and behavioral health services and are solely based on industry standard coding practices. Claim adjudication and methodology includes identifying claims that do not meet accepted industry/evidentiary standards, internally developed reimbursement policies, and negotiated contract requirements. Sources of industry standards may include: • The most current edition of Current Procedural Terminology (CPT) • The most current edition of the Healthcare Common Procedure Coding System (HCPCS) • The most current edition of the UB-04 Manual and/or other published guidance from the National Uniform Billing Committee (NUBC) • CMS claim processing manuals, including Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) • The most current version of International Classification of Diseases (ICD), currently ICD-10	

- Plan general exclusions and limitations
- Coding guidelines from other sources, for example EncoderPro

Additional sources of evidentiary standards may include:

- Internally developed guidelines reviewed by Medical Professionals, including the Medical Director
- Internal committees (Clinical Quality Improvement, Pharmacy & Therapeutics, Credentialing)
- Office of the Inspector General (OIG) reports
- Current case law related to ERISA, ACA

Level I and Level II Internal Appeals

A member or his/her representative, or a provider acting on behalf of a member, may file an appeal verbally or in writing by one of the following processes.

- An appeal may be filed verbally by contacting Customer Service at (866) 403-2785
- An appeal may be faxed to Customer Service at (866) 634-8917
- An appeal may be filed in writing to the following address:
  Alliant Health Plans
  PO Box 1247
  Dalton, GA 30722

Alliant has two levels of internal appeal. The Level I must be initiated within 180 days of the initial Adverse Benefit Determination. Level II must be initiated within 60 days of the date of denial of the first level of appeal as applicable.

Level I and Level II appeals undergo a full investigation and is conducted by personnel who were not involved in the making of the initial Adverse Benefit Determination. The completion period of the investigation is based on the appeal type.

- Pre-Service Appeals are completed within 15 calendar days of receipt of the appeal or the date all information regarding the appeal has been received.
- Post-Service Appeals are completed within 30 calendar days of receipt of appeal or the date all information regarding the appeal has been received.

If additional information is needed to complete the investigation of a Post-Service Appeal, Alliant will telephone the provider and/or member with the telephone number supplied in the appeal. This contact will happen as soon as possible but within 3 business days of receipt of appeal. Outreach will be attempted 3 times, if contact is not made within the 3 business days Alliant will notify the provider and member to request the missing information. If only a portion of the information is received, Alliant will request the missing information, in writing, within 3 business days of receipt of the partial information.

If additional information is needed to complete the investigation of a Post-Service Appeal, Alliant will notify the provider and/or member in writing, as soon as possible but within 15 business days of receipt of the appeal, of such request for information. If only a portion of the information is received, Alliant will request the missing information, in writing, within 15 business days of receipt of the partial information.

A final written response will be sent to the member and/or provider upon completion of the investigation. If the appeal decision is to uphold the Adverse Benefit Determination, Alliant sends written confirmation of the appeal decision, including an explanation of the

member's right to appeal further. If the adverse benefit determination is overturned and benefits are approved, the notice will be included the EOB or EOP and will include an explanation that an appeal was received and reviewed resulting in additional benefits.

The foregoing procedures and process are mandatory and must be exhausted prior to establishing litigation or arbitration or any administrative proceeding regarding matters within the scope of this Complaint and Appeals section.

The decision of the Level II appeal is considered the Final Adverse Benefit Decision and there are no other internal appeal options. If an appeal is received after the Final Adverse Benefit Decision, this will be returned to the member with a copy of the Level II decision letter and the Appeal Rights and Information document. Any subsequent appeals will be added to the member's records, but a response will not be sent.

External Appeal

After the member has exhausted the Internal Level I and Level II appeal processes, the member or their authorized representative has the right to request an external review at no cost. Member must file a request for an external review within 123 calendar days from the date of the Level II appeal decision notice.

For Administrative/Benefit denials Member may request an external review by contacting the Georgia Office of Commissioner of Insurance and Safety Fire (OCI), Customer Service Division by:

1. Calling OCI toll-free at (800) 656-2298; or
2. Faxing to (404) 657-8548
3. Submitting the request online through the Consumer Portal; or
4. Downloading and printing the Consumer complaint form at www.oci.ga.gov, under Insurance Resources. Member may send the form by mail to the following:

   Office of Commissioner of Insurance
   Customer Service Division
   2 Martin Luther King, Jr. Dr. SE
   Suite 716 West Tower 30334

If member is enrolled in a private employer plan, they may also have the right to bring a civil action under Section 502 (a) of ERISA following the full internal review of the complaint and decision by Alliant Health Plans.

For Medical Necessity denials Member may request an external review by contacting Maximus Federal Services by:

1. Calling Maximus toll-free at (888) 866-6205; or
2. Submitting the request online at: www.externalappeal.cms.gov under the "Request a Review Online" heading; or
3. Downloading and printing the External Review Request form at www.externalappeal.cms.gov, under the "Forms" heading. You may send a written request by fax or mail to the following:

   MAXIMUS Federal Services 3750 Monroe Avenue, Suite 705
   Pittsford, NY 14534
   Fax: (888) 866-6190

Reimbursement Rate Calculation for In-Network & Out-of-Network Services	For Covered Services performed by an In-Network provider the allowed amount is the rate the provider has agreed with Alliant to accept as reimbursement for covered services.	Providers who have not signed a contract with Alliant Out-of-Network Providers. The Maximum Allowable Cost (MAC) rate is determined by Alliant by one of the following methods: • An amount based on Our out-of-network fee schedule/rate, which we have established at our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with Alliant, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or • An amount based on information provided by a third-party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or • An amount negotiated by us or a third- party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or • An amount equal to the total charges billed by the Provider, but only if such charges are less than the MAC calculated by using one of the methods described above. The MAC for out-of-network emergency medical services is calculated as described in Title 33 of the Official Code of Georgia Annotated (OCGA) 33-20E-4. We will calculate the MAC as the greater of: • The verifiable contracted amount paid by all eligible insurers for the provision of the same or similar services as determined by the Georgia Department of Insurance. • The most recent verifiable amount agreed to by Alliant and the non-participating emergency medical provider for the provision of the same services during such time as such Provider was In-Network with Alliant.

		• Such higher amount as Alliant may deem appropriate given the complexity and circumstances of the services provided. The amount paid does not include any amount of coinsurance, copayment, or deductible.

Experimental and/or Investigational Services	Alliant Health Plans (AHP) may exclude coverage of investigational and/or experimental procedures where reliable or detailed clinical evidence of superior clinical outcomes is not present. Experimental and/or Investigational shall mean any drug, biological product, medical treatment/procedure and/or medical device/equipment (herein collectively known as health care services or services) that are not commonly and widely used or accepted by the vast majority of practitioners in the United States, and/or services that lack credible evidence to support positive short-term and/or long-term outcomes from the services rendered; further, the health care services are not reimbursable under the CMS guidelines established for Medicare coverage and/or are health care services which meet any of the following criteria:
	• In any phase of clinical trials;
	• Not of proven benefit for the specific diagnosis or treatment of the coveredpatient's particular condition;
	• Do not constitute acceptable medical practice under the standards of the covered patient's caseand by the standards of a reasonable segment of the medical community or governmental oversight agencies at the time services were rendered, including, but not limited to, the American Medical Association (AMA), the United States Food and Drug Administration ("FDA"), the National Comprehensive Cancer Network (NCCN), and/or the Federal National Library of Medicine-National Institute of Health;
	• Rendered on a research basis as determined by governmental oversight agencies, including,but not limited to, the FDA and the AMA's Council on Medical Specialty Societies.
	• Generally recognized that additional study on its safety and efficacy for the specific diagnosis ortreatment of the covered patient's particular condition is recommended, taking into consideration the medical community or governmental oversight agencies at the time services were rendered, including, but not limited to, the AMA, FDA, NCCN and/or the Federal National Library of Medicine-National Institute of Health.
	A drug, biological product, medical treatment, medical procedure, medical device/equipment or anyother health care service is considered Experimental and/or Investigational if any of the following apply:
	• It cannot be lawfully marketed without the approval of the FDA and the approval for marketing hadnot been given at the time the aforementioned health care services were rendered or furnished to the covered patient;
	• Reliable evidence shows that any of the aforementioned health care services are:
	  ○ the subject of ongoing Phase I, II or III clinical trials; or
	  ○ under study to determine its safety, efficacy, maximum tolerated dose, toxicity and/or itsefficacy as compared with the standard means of treatment or diagnosis; or
	  ○ considered among experts to need further studies or clinical trials to determine its safety,efficacy, maximum tolerated dose, toxicity and/or its efficacy as compared with the standard means of treatment or diagnosis.
	• In the case of a drug, biological product or device/equipment, it is not being used to treat theparticular diagnosis or condition that it has been approved for by the FDA; in other words, it isconsidered off-label use.
	• It does not meet the Technology Assessment Criteria as defined by AHP.
	Reliable evidence includes:	

	• Published reports and articles in authoritative and scientific literature from the medical communityand/or governmental oversight agencies, including, but not limited to, the American Medical Association (AMA), the United States Food and Drug Administration (FDA), the National Comprehensive Cancer Network (NCCN), and/or the Federal National Library of Medicine-National Institute of Health; • The written protocol(s) used by the treating provider/facility or the protocol(s) of another comparable provider/facility that is significantly studying the drug, biological product, medicaltreatment, medical procedure, medical device/equipment or other health care service in question; • The written informed consent used by the treating provider/facility or by another comparableprovider/facility that is significantly studying the drug, biological product, medical treatment, medical procedure, medical device/equipment or other health care service in question.
Network Admission Criteria	In selecting and credentialing providers for the associate networks, Alliant does not discriminate in terms of participation or reimbursement against any health care professional who is acting within the scope of their license or certification. In addition, Alliant does not discriminate against professionals who serve high-risk populations or who specialize in the treatment of costly conditions. If a provider does not meet Health One's criteria, a written notice outlining why the provider is not eligible for participation is sent to the affected provider. The criteria for admission to the network is no more stringent for behavioral health practitioners than for medical/surgical.
Formulary Design and Protocols	**Formulary Design** Factors considered by the PBM committees: • Tiering: When assigning drugs to tiers on the formulary, the same factors are used to assign the drugs without any regard for whether a drug is generally prescribed for medical/surgical benefits or for mental health or substance use disorder benefits. All FDA approved medications for mental health and substance use disorders and for medical surgical conditions are reviewed with the same factors and decision-making process before final formulary status and criteria are determined. Clinical factors are considered first and then financials through separate committees. Clinical considerations include, evidenced based safety and efficacy data from the FDA approved package insert, peer-reviewed medical literature, nationally accepted treatment guidelines, and patient considerations. Financial considerations include net cost, utilization trends, and cost effectiveness of clinically similar medications. The factors regarding each drug is reassessed regularly to ensure that the formulary management is consistent with the latest information. • PA: When establishing prior authorizations for pharmacy services, the same factors are used to assign the drugs without any regard for whether a drug is generally prescribed for medical/surgical benefits or for mental health or substance use disorder benefits. All FDA approved medications for mental health and substance use disorders and for medical surgical conditions are reviewed with the same factors and decision-making process before final formulary status and criteria are determined. Clinical factors are considered first and then financials through separate committees. Clinical considerations include, evidenced based safety and efficacy data from the FDA approved package insert, peer-reviewed medical literature, nationally accepted treatment guidelines, and patient considerations. Financial considerations include net cost, utilization trends, and cost effectiveness of clinically similar medications. The factors regarding each drug is reassessed regularly to ensure that the formulary management is consistent with the latest information. • Step therapy: When imposing any fail-first or step therapy requirements for pharmacy services, the same factors are used to

assign the drugs without any regard for whether a drug is generally prescribed for medical/surgical benefits or for mental health or substance use disorder benefits. All FDA approved medications for mental health and substance use disorders and for medical surgical conditions are reviewed with the same factors and decision-making process before final formulary status and criteria are determined. Clinical factors are considered first and then financials through separate committees. Clinical considerations include, evidenced based safety and efficacy data from the FDA approved package insert, peer-reviewed medical literature, nationally accepted treatment guidelines, and patient considerations. Financial considerations include net cost, utilization trends, and cost effectiveness of clinically similar medications. The factors regarding each drug is reassessed regularly to ensure that the formulary management is consistent with the latest information.

Magellan Rx Management, LLC Precision Formulary Mental Health Parity and Addiction Equity Act Compliance

The Mental Health Parity and Addiction Equity Act ('MHPAEA') requires that health plans sort their benefits into six classifications for review. One of these classifications is prescription drugs. MHPAEA requires that the benefits be reviewed for Quantitative Treatment Limitations (e.g., quantity limits, day/visit limits), financial requirements (e.g. copayments, coinsurance) and nonquantitative treatment limitations ('NQTLs') (e.g. limitations that are not numeric in nature).

There is a special rule for multi-tiered prescription drug benefits in evaluating financial requirements. This provides that if a plan applies different levels of financial requirements to different tiers of prescription drug benefits based on reasonable factors determined in accordance with the rules for NQTLs and without regard to whether a drug is generally prescribed with respect to medical/ surgical benefits or with respect to mental health or substance use disorder benefits, the plan will be deemed to have satisfied the parity requirements for prescription drugs. They note that reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.

Any quantitative treatment limitations are based off of package inserts and FDA approval. These limits can be overridden for medical necessity.

This document focuses on the NQTL analysis for the Magellan Rx Management, LLC formulary.

The MHPAEA rule contained an illustrated list of NQTLs which included the following that are applicable to the prescription drug benefit:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Formulary design for prescription drugs;
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols).

The standard for review of NQTLs is that a health plan cannot impose any non-quantitative treatment limitation for mental health/ substance use disorders unless any processes, strategies, evidentiary standards or other factors used in applying the NQTL are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used in applying the limitation to medical /surgical disorders in the same classification.

The Magellan Pharmacy and Therapeutic (P&T) committees made up of licensed physicians and pharmacists establishes the NQTLs used by the Magellan PBM. When Magellan assigns drugs to tiers, sets step therapy requirements, and when Magellan establishes

	utilization management requirements for the formulary, the same factors are used to assign the drugs without any regard for whether a drug is generally prescribed for medical/surgical conditions or for mental health or substance use disorder conditions. All FDA approved medications for mental health and substance use disorders and for medical surgical conditions are reviewed with the same factors and decision-making process before final formulary status and criteria are determined. Clinical factors are considered first and then financial factors through separate committees. Any new drugs that are approved go through a clinical committee, a financial committee and the P&T committee makes the final approval. Evidentiary standards reviewed include evidenced-based safety and efficacy data from the FDA approved package insert, peer-reviewed medical literature, nationally accepted treatment guidelines, and patient considerations. Evidentiary standards for the cost factors include net cost, utilization trends, and cost effectiveness of clinically similar medications. The evidentiary standards for each drug are reassessed regularly to ensure that the formulary management is consistent with the latest information. Pill limits can be restricted based on clinical criteria. For example, our behavioral health medications are based on FDA recommended limitations. While some of our opioid medications (which don't have FDA max doses) have quantitative limits. These limits can be overridden for medical necessity if an individual's clinical situation warrants this. This same process applies to medications used to treat both medical/surgical and mental health and substance use disorder conditions. There are no differences in the percentage of FDA approved drugs on the PDL for behavioral and medical conditions. Our position is to offer a vast amount of medication options for providers to choose from that are based on evidence-based medicine. Safety and evidence-based medicine are among the primary factors we consider when determining off label coverage. Off label coverage will generally require prior authorization to determine the need and allow our team to research any studies to validate effectiveness. The procedure is the same for medical/surgical and mental health and substance use disorder medications. Brand names with no generics available are approved in the same manner for both medical/surgical and mental health and substance use disorder medications. These approvals are made on a preferred or non-preferred basis. The majority of preferred drugs are on the PDL and will generally adjudicated with no additional review. There are no extra steps for a member to go through for situations where there is a brand name medication with no generic or where brand names are preferred by the state. If a medication is non-preferred, it can still be obtained, however it will require a prior authorization or medical exception review. The process is the same for both medical/surgical and mental health and substance use disorder medications. The plan considers and encourages generic substitutions. Generic substitutions are handled the same for both medical/surgical and mental health and substance use disorder medications. Our only restriction on pharmacy providers is the requirement that they must be in network. Our PBM has a credentialing process that evaluates pharmacies and makes a determination on them having the necessary requirements to join our network.

Network Access	**1.** Access to Providers: a. Where appropriate, Customer Service Representatives assist members seeking referral information. Customer Service Representatives work with the Medical Management Team as needed to assist with referrals. b. The Medical Management Team works with the Customer Service Representatives to determine the scope of a member's needs and assists in identifying the appropriate provider/facility. If in-network services are not available, referrals to out-of-network providers/facilities are considered. **2.** Member Education: a. First time health plan members receive a welcome letter with information on how the plan works and how to best to maximize benefits. **3.** Member Needs and Preferences: a. AHP assesses the cultural, ethnic, racial and linguistic needs of its members by capturing member languages, if reported on the application (electronic or written). This information, when captured is entered in the eligibility portal. b. AHP captures languages that providers speak and publishes this information in its online directory. AHP member linguistic data is compared to US census data and then against languages spoken by in-network providers. Based upon findings, network adjustments are considered. **4.** Providers of Primary Care: a. Establishes quantifiable and measurable standards for the number of each type of provider of primary care. i. Provider Network will make best efforts to provide a PCP Network that is sufficient for Alliant members. The Alliant Health Plans PCP Network consists of Family Practice, General Practice, Internal Medicine and Pediatric providers. Alliant makes a best	**1.** Access to Providers: a. Where appropriate, Customer Service Representatives assist members seeking referral information. Customer Service Representatives work with the Medical Management Team as needed to assist with referrals. b. The Medical Management Team works with the Customer Service Representatives to determine the scope of a member's needs and assists in identifying the appropriate provider/facility. If in-network services are not available, referrals to out-of-network providers/facilities are considered. **2.** Member Education: a. First time health plan members receive a welcome letter with information on how the plan works and how to best to maximize benefits. **3.** Member Needs and Preferences: a. AHP assesses the cultural, ethnic, racial and linguistic needs of its members by capturing member languages, if reported on the application (electronic or written). This information, when captured is entered in the eligibility portal. b. AHP captures languages that providers speak and publishes this information in its online directory. AHP member linguistic data is compared to US census data and then against languages spoken by in-network providers. Based upon findings, network adjustments are considered. **4.** Providers of Behavioral Healthcare: a. Defines the types of providers who serve as high volume behavioral healthcare providers. i. Alliant Health Plans defines high volume behavioral healthcare providers as: Psychiatrists, Psychologists and Licensed Practicing Counselors because these provider types are the most likely to provide care across the continuum of

	effort to have a 1:2,000 ratio of primary care providers to members. Members in a Rural Area may fall outside this standard due to provider availability. *Rural Area* means an area that is not an Urban Area as defined by a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget. b. Establishes quantifiable and measurable standards for the geographic distribution of each type of provider of primary care. Alliant will make best efforts to provide a PCP Network that is sufficient for Alliant members by following the standards of network adequacy that is set by CMS at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2023-Letter-to-Issuers.pdf a. Annually analyzes performance against the standards for the number of each type of provider of primary care. i. Alliant will review a geographic access report annually. The report will show if Alliant is meeting PCP Network adequacy requirements as outlined above. Members in a Rural Area may fall outside this standard due to provider availability. *Rural Area* means an area that is not an Urban Area as defined A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area. b. Annually analyzes performance against the standards for the geographic distribution of each type of provider of primary care. ii. Alliant will review a geographic access report annually. The report will show that Alliant Health Plans is meeting the PCP Network adequacy requirements as outlined above. As noted above, members in a Rural Area may fall outside this standard due to provider availability. *Rural Area* means an area that is not an Urban Area as defined A Metropolitan	behavioral healthcare delivery. b. Establishes quantifiable and measurable standards for the number of each type of high-volume behavioral healthcare provider. i. Provider Network will make best efforts to provide a Behavioral Provider Network that is sufficient for Alliant members. The Alliant Health Plans Behavioral Provider Network consists of (Psychiatrists, Psychologists and Licensed Practicing Counselors) providers. Alliant makes a best effort to have least 2 behavioral health providers to the extent that qualified willing providers are available with a goal of 1:5,000 ratio of high-volume behavioral healthcare providers to members. Members in a Rural Area may fall outside this standard due to provider availability. *Rural Area* means an area that is not an Urban Area as defined defined by the U.S. Census Bureau, Executive Office of Management and Budget. Urban areas are defined as a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). c. Establishes quantifiable and measurable standards for the geographic distribution of each type of high-volume behavioral healthcare provider. i. Provider Network will make best efforts to provide a Behavioral Provider Network located within the service area that is sufficient for members by following the standards of network adequacy that is set by CMS at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2023-Letter-to-Issuers.pdf d. Analyzes performance against the standards annually.

	Statistical Area (MSA) or New England County Metropolitan Area. iii. Based on the analysis, Alliant prioritizes opportunities for improvement identified from analysis of the availability of primary care providers. If Alliant identifies opportunities based on geographic or member-to-provider ratio deficiencies, at least one intervention is implemented, and Alliant measures the effectiveness of the intervention at least annually. **5.** Providers of Specialty Care: a. Defines the types of providers who serve as high volume and high-impact Specialty Care Providers (SCPs). i. Alliant Health Plans defines high volume provider specialists as follows: Obstetrics and Gynecology, Orthopedics, and Dermatology. High volume specialties are determined by claims encounter data. High impact providers are defined as provider types that treat conditions that have high mortality and morbidity rates. Alliant Health Plans considers oncologists to be high-impact providers. b. Establishes quantifiable and measurable standards for the number of each type of high-volume or high-impact SCPs. i. Provider Network will make best efforts to provide a Specialist Network that is sufficient for Alliant members. Alliant makes a best effort to have a 1:5,000 ratio of high-volume or high-impact specialty providers (Obstetrics and Gynecology, Orthopedics, Dermatology and Oncology), to members. Members in a Rural Area, may fall outside this standard due to provider availability. *Rural Area* means an area that is not an Urban Area as defined A Metropolitan Statistical Area (MSA) or	i. Alliant will review a geographic access report annually. The report will show whether Alliant is meeting the Behavioral Health Provider Network adequacy requirements as outlined above. As noted above, members in a Rural Area may fall outside this standard due to provider availability. *Rural Area* means an area that is not an Urban Area as defined (same comment as above – seems incomplete A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area. ii. Based on the analysis, Alliant prioritizes opportunities for improvement identified from analysis of the availability of behavioral healthcare providers. If Alliant identifies opportunities based on geographic or member-to-provider ratio deficiencies, at least one intervention is implemented, and Alliant measures the effectiveness of the intervention at least annually.

	New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget. c. Establishes quantifiable and measurable standards for the geographic distribution of each type of high-volume and high-impact SCPs. i. Provider Network will make best efforts to provide a Specialist Network located within the Alliant Health Plans service area that is sufficient for Alliant members by following the standards of network adequacy that is set by CMS at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2023-Letter-to-Issuers.pdf Executive Office of Management and Budget. d. Analyzes performance against the standards at least annually. i. Alliant will review a geographic access report annually. The report will show whether Alliant Health Plans is meeting the Specialist Network adequacy requirements as outlined above. As noted, Members in a Rural Area may fall outside this standard due to provider availability. *Rural Area* means an area that is not an Urban Area as defined A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area. ii. Based on the analysis, Alliant prioritizes opportunities for improvement identified from analysis of the availability of high-volume and high-impact SCPs. If Alliant identifies opportunities based on geographic or member-to-provider ratio deficiencies, at least one intervention is implemented, and Alliant measures the effectiveness of the intervention at least annually.	

Exhibit A

Medical Necessity Criteria Analysis 2023

Medical Necessity Criteria Formation

Alliant Health Plans' primary source for applying NQTLs is the application of standard MCG guidelines and criteria. Formerly known as Milliman Care Guidelines, MCG guidelines are evidenced-based, research compiled and regularly updated with involvement from appropriate providers with current knowledge relevant to the criteria under review. MCG criteria are based on current clinical principles and processes. They are updated regularly by the criteria developers, with review and input by appropriate, actively practicing physicians and other relevant professionals.

For each guideline, the published professional literature (the National Library of Medicine database via the PubMed search engine) is systematically queried at least annually using specially developed, customized, tested, proprietary search strings. Search strategies are developed to allow efficient yet comprehensive analysis of relevant publications for a given topic and to maximize retrieval of articles with certain desired characteristics pertinent to a guideline.

For each guideline, all retrieved publications are individually reviewed by an MCG clinical editor and assessed in terms of quality, utility, and relevance. Preference is given to publications that:

- Are designed with rigorous scientific methodology.
- Are published in higher-quality journals (ie, journals that are read and cited most often within their field).
- Address an aspect of specific importance to the guideline in question (eg, admission criteria, length of stay).
- Represent an update or contain new data or information not reflected in the current guideline.

An MCG clinical editor evaluates all new evidence and updates the guideline as needed to ensure its continued clinical validity. MCG medical librarians and clinical editors track newly released or updated guidelines from outside sources (eg, medical specialty societies, Cochrane Reviews), as well as new editions of textbooks. Relevant new content is incorporated into all guidelines as appropriate. Each updated guideline is then reviewed by a supervising clinical editor to verify accuracy and appropriateness of all changes.

On an annual basis, each guideline undergoes external review by clinically active experts (eg, board-certified specialist physicians without stated financial conflicts of interest) to confirm the clinical appropriateness, accuracy, validity, and applicability of each guideline. A supervising clinical editor evaluates all comments from these external reviewers and makes necessary changes to the guideline.

Certain content (eg, inpatient goal length of stay) is supported by and validated through utilization analysis using various claims-based databases. These databases include nationally representative samples of inpatients and outpatients. Databases utilized include those developed outside of MCG as well as those that are proprietary to MCG. In terms of guideline development, the purpose of database analysis is to confirm the reasonability and clinical appropriateness of care guidelines' utilization goals and objectives.

MCG content for the clinical care of medical, surgical, and behavioral health patients is developed using the same overall methodology and evidentiary standards and aligns with the principles of regulatory requirements such as the Mental Health Parity and Addiction Equity Act (MHPAEA). Guidance for medical/surgical and mental health and substance-use disorders (MHSUDs) addresses quantitative and non-quantitative limitations in the same manner.

Level of care guidelines for medical/surgical and MHSUD topics include an Optimal Recovery Course with best practice recommendations for day-by-day care within a facility. Guidance about the goal length of stay and other benchmarks is also provided in same manner for medical/surgical and MHSUD content. There are no "fail first" requirements for admission to a level of care in the Behavioral Health Care guidelines.

MCG care guidelines related to procedures, treatments, and medications may require completion of a trial of conservative or other treatment (eg, physical therapy, medications) based on published evidence. These non-quantitative treatment limitations are based solely on the published medical literature and established best practices; limitations on duration or scope of treatment are derived from the best available evidence and are addressed similarly across medical/surgical and behavioral health content.

The following MCG Products are guidelines that Alliant Health Plans uses for Medical Necessity Reviews:

Publication	Publication Name
AC	Ambulatory Care
BHG	Behavioral Health Care
GRG	General Recovery Care
HC	Home Care
ISC	Inpatient & Surgical Care
RFC	Recovery Facility Care

In addition to MCG criteria and guidelines, Alliant Health Plans (AHP) utilizes AHP proprietary medical policy guidelines and AHP Modified MCG guidelines. If no guideline exists for medical criteria review, then the references as noted in the AHP Medical Policy Development Policy are utilized to determine medical necessity.

NOTE: Criteria are not intended to be a substitute for practitioner judgment. The practitioner reviews all potential medical necessity denials following currently accepted healthcare practices, considering the unique circumstances of each case.

Medical Necessity Criteria Prior Authorization Analysis

The approval rate of Mental Health/Substance Use Disorder (MH/SUD) related conditions for pre-service prior authorizations (92.90%) is in parity when comparing the approval rate of Medical/Surgical (MED/SURG) related conditions (89.27%). The approval rate of Mental Health/Substance Use Disorder (MH/SUD) related conditions specific to inpatient prior authorizations (98.53%) is in parity when comparing the approval rate of Medical/Surgical (MED/SURG) related

conditions (97.00%). The approval rate of Mental Health/Substance Use Disorder (MH/SUD) related conditions specific to outpatient prior authorizations (90.57%) is in parity when comparing the approval rate of Medical/Surgical (MED/SURG) related conditions (84.60%)

NOTE: Partial approvals for both MH/SUD and MED/SURG pre-service are included in the overall pre-service approval rate. This "Partial Approval" number is showing in the data because the request for additional days/visits were denied, but the initial request for days/visits were approved (ex. For Partial Hospitalization the initial 15 days pre-service were approved and additional 15 days requested were denied and it appears as Partial Approval in the data). Voided cases, withdrawn, or prior authorization cases which did not require a prior authorization were excluded from the analysis.

MH/SUD Prior Authorization, Concurrent, and Post Service Review

Service Category	Total	Percentage
Inpatient Total	**349**	
Concurrent Review	**336**	
Approved	323	92.55%
Denied	3	0.86%
Non-Covered	1	0.29%
Partial Approval	1	0.29%
Void	8	2.29%
Post-Service	**7**	
Approved	7	100.00%
Pre-Service	**2**	
Approved	1	50.00%
Void	1	50.00%
Pre-Service Appeal Level 1	**1**	
Partial Approval	1	100.00%
Pre-Service Appeal Level 2	**1**	
Partial Approval	1	100.00%
Reconsideration	**2**	
Denied	1	50.00%
Partial Approval	1	50.00%
Outpatient Total	**235**	
Concurrent Review	**5**	
Approved	4	80.00%
Auth Not Required	1	20.00%
Post-Service	**34**	
Approved	20	58.82%
Auth Not Required	4	11.76%
Denied	6	17.65%
Partial Approval	1	2.94%
Void	3	8.82%
Post-Service Appeal Level 1	**2**	
Denied	2	100.00%

Post-Service Appeal Level 2	**1**	
Approved	1	100.00%
Pre-Service	**192**	
Approved	166	86.46%
Auth Not Required	10	5.21%
Denied	11	5.73%
Void	5	2.60%
Reconsideration	**1**	
Denied	1	100.00%
Grand Total (Removed Auth Not Required, Void)		
Approved	527	
Denied	25	
Approval Rate	**95.47%**	

Mental-Health Substance Use Disorder	
Inpatient	
Approved	335
Denied	5
Total	340
Approval Rate	**98.53%**

Mental-Health Substance Use Disorder	
Outpatient	
Approved	192
Denied	20
Total	212
Approval Rate	**90.57%**

Med/Surg Prior Authorization, Concurrent, and Post Service Review

Service Category	Total	Percentage
Inpatient Total	**2936**	
Concurrent Review	**2461**	
Approved	2099	85.29%
Auth Not Required	189	7.68%
Denied	28	1.14%
Partial Approval	63	2.56%
Void	82	3.33%
Post-Service	**115**	

Approved	72	62.61%
Auth Not Required	4	3.48%
Denied	15	13.04%
Partial Approval	5	4.35%
Void	19	16.52%
Post-Service Appeal Level 1	**23**	
Approved	3	13.04%
Denied	5	21.74%
Partial Approval	10	43.48%
Void	5	21.74%
Post-Service Appeal Level 2	**7**	
Approved	1	14.29%
Denied	2	28.57%
Partial Approval	3	42.86%
Void	1	14.29%
Pre-Service	**276**	
Approved	217	78.62%
Auth Not Required	1	0.36%
Denied	23	8.33%
Partial Approval	1	0.36%
Void	34	12.32%
Pre-Service Appeal Level 1	**13**	
Approved	5	38.46%
Denied	1	7.69%
Partial Approval	6	46.15%
Void	1	7.69%
Pre-Service Appeal Level 2	**5**	
Denied	1	20.00%
Partial Approval	4	80.00%
Reconsideration	**36**	
Approved	9	25.00%
Denied	3	8.33%
Partial Approval	23	63.89%
Void	1	2.78%
Outpatient Total	**23387**	
Concurrent Review	**347**	
Approved	141	40.63%
Auth Not Required	186	53.60%
Denied	7	2.02%
Void	13	3.75%
Post-Service	**1712**	
Approved	598	34.93%
Auth Not Required	91	5.32%

Denied	879	51.34%
Non-Covered	8	0.47%
Partial Approval	10	0.58%
Void	126	7.36%
Post-Service Appeal Level 1	**371**	
Approved	95	25.61%
Denied	253	68.19%
Non-Covered	2	0.54%
Partial Approval	11	2.96%
Void	10	2.70%
Post-Service Appeal Level 2	**61**	
Approved	11	18.03%
Denied	44	72.13%
Void	6	9.84%
Pre-Service	**20115**	
Approved	16302	81.04%
Auth Not Required	1406	6.99%
Denied	1678	8.34%
Non-Covered	11	0.05%
Partial Approval	65	0.32%
Void	653	3.25%
Pre-Service Appeal Level 1	**246**	
Approved	91	36.99%
Denied	140	56.91%
Partial Approval	2	0.81%
Void	13	5.28%
Pre-Service Appeal Level 2	**80**	
Approved	31	38.75%
Denied	45	56.25%
Void	4	5.00%
Reconsideration	**454**	
Approved	285	62.78%
Auth Not Required	2	0.44%
Denied	145	31.94%
Partial Approval	6	1.32%
Void	16	3.52%
Urgent Appeal Level 1	**1**	
Denied	1	100.00%
Grand Total (Removed Auth Not Required, Void)		
Approved	20169	
Denied	3291	
Approval Rate	**85.97%**	

Medical-Surgical	
Inpatient	
Approved	2521
Denied	78
Total	2599
Approval Rate	**97.00%**

Medical-Surgical	
Outpatient	
Approved	17648
Denied	3213
Total	20861
Approval Rate	**84.60%**

Application of Medical Necessity Criteria

Alliant Health Plans performs Inter-Rater Reliability (IRR) testing for staff and physician reviewers annually. Medical Management reports IRR testing results annually to the CQIC Committee in the UM Program evaluation. Whenever there is inconsistency in applying the criteria, there is corrective action to demonstrate improved consistency and accuracy among UM decision-making staff.

There were 1:1 coaching opportunities conducted on 1/11/23, 1/19/23, 1/20/23, 2/17/23, 5/10/23, 9/20/23, and 9/25/23 with staff who did not score at or above goal of 90% on a test case. All staff were retested on any IRR that was not passed during the month of September 2023 and achieved a subsequent score above 90% showing passed.

Alliant Health Plans seeks to send out the IRR test cases on a regular cadence – approximately one a quarter. If a staff member does not pass a test case, Alliant Plans offers additional training and monitors their performance on subsequent test cases.

Inter Rater Reliability Results Table and Overall Analysis

Count of User Full Name	Colum																	
	Failed						Failed Total	Passed									Passed Total	Grand Total
Row Labels	01/10/23	02/10/23	02/17/23	05/05/23	09/07/23	09/26/23		01/10/23	02/10/23	02/17/23	05/05/23	05/12/23	09/07/23	09/12/23	09/26/23	10/06/23		
2022-AC-306	8				2	2	12	7					2				9	21
2022-BHC-201A - Auth Only											7						7	7
2022-BHC-304A - Auth Only_archived_03302023	1						1	10									10	11
2022-ISC-307A - Auth Only_archived_03302023	3						3	10									10	13
2023-AC-202					2	2	4						6			1	7	11
2023-AC-407		1	1	3			5		9	1	6	1	1				18	23
2023-BHC-202A - Auth Only													6		1		7	7
2023-BHC-402 - Auth Only									9	1							10	10
2023-ISC-107A - Auth Only					2		2						5	1	1		7	9
2023-ISC-405 - Auth Only											7						7	7
2023-ISC-407 - Auth Only		2			1		3		8	1			1				10	13
Grand Total	12	3	1	3	7	4	30	27	26	3	20	1	21	1	2	1	102	132

IRR Highlights and Results Table Key	
Pass is greater than or equal to 90%	
Fail is less than 90%	
BH Cases are 2022-BHC-201A, 2022-BHC-304A, 2023 BHC-202A, 2023-BHC-402	
Overall Pass Rate	77.27%
MH/SUD Case Rate	97.14%
Med/Surg Case Rate	70.10%
Overall Average IRR Grade out of 132 cases	**92.42%**

*****The overall pass rate for UM decision-making staff consistently applying Medical Necessity Criteria according to Alliant Health Plan Guidelines was 77.27% (to PASS a test case the score had to be 90% on the assessment or above). The overall test case average was 92.42% out of 132 test cases administered in 2023. When comparing Med/Surg Test Cases vs MH/SUD Test cases, the UM decision-making staff scored higher on MH/SUD test cases with a 97.14% Pass Rate versus an 70.10% test case rate for Med/Surg test cases.

Exhibit B

Claim Edits and Appeals Comparative Analysis 2023

Claim edits are handled through a software system, Optum CES, that is a duly recognized source of industry current coding practices. Alliant adheres to the software allowances for all claims. For MH/SUD claims, Alliant has only one contract that allows and prescribes a contradicting combination of a HCPCS and REV code. This is allowed and overridden in the claim processing system.

Claim appeals are analyzed annually to review trends to improve internal processes and reduce both member and provider abrasion. For 2023, Alliant received a total of 4,972 first level claim appeals of which 8 remain open as of the date of analysis, 12/28/23. For the purposes of this analysis only first level appeals and direct to external appeals were included to avoid duplication. We used only those cases fully decided for the analysis, a total of 4,964, and then categorized them based on NCQA requirements and then further divided into Med/Surg and BH/SUD services. A total of 4,947 appeals were categorized as billing and financial, the remaining 17 were attitude and service related, primarily timely filing denials or payment/coding related.

Only 22 claim appeals can be tied directly to BH/SUD services. Claim denials are unrelated to medical necessity denials. Med/Surg claim appeals numbered 1260 for PA, benefit exclusion or limitations, 2378 related to payment/coding, timely filing or other coverage, and the remainder varied.

Med/Surg Appeals by Category	2023
	#
Billing & Financial	4925
Attitude & Service	17
Access	-
Quality of Practitioner Office Site	-
Quality of Care	-
Total	4942

BH/SUD Appeals by Category	2023
	#
Billing & Financial	22
Attitude & Service	-
Access	-
Quality of Practitioner Office Site	-
Quality of Care	-
Total	22

Denial and overturn rates are analyzed to assess parity in treatment of both initial claim adjudication and appeals for Med/Surg and BH/SUD services. For the 4,964 cases for which a decision was made, the denial rates are below. Our overall denial rate was 68.76%. The denial rate for BH/SUD appeals was

significantly lower than for Med/Surg. Alliant will review the higher overturn rate for BH/SUD appeals to improve processes for claim adjudication that may avoid the need for an appeal in the first place.

Category	Denials		Overturns	
	#	Rate per appeal total	#	Rate per appeal total
Med/Surg	3401	68.82%	1541	31.18%
BH/SUD	12	54.55%	10	45.45%
Total	3413	68.76%	1551	31.24%

Exhibit C

Reimbursement Rate Comparative Analysis 2023

Methodology

For Covered Services performed by an In-Network provider, the allowed amount is the rate the provider contracted with Alliant to accept as reimbursement for covered services.

Providers who have not contracted with Alliant are Out-of-Network Providers. The Maximum Allowable Cost (MAC) rate is determined by Alliant by one of the following methods:

- An amount based on Our out-of-network fee schedule/rate, which we have established at our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with Alliant, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
- An amount based on information provided by a third-party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or
- An amount negotiated by us or a third- party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or
- An amount equal to the total charges billed by the Provider, but only if such charges are less than the MAC calculated by using one of the methods described above.

The MAC for out-of-network emergency medical services is calculated as described in Title 33 of the Official Code of Georgia Annotated (OCGA) 33-20E-4. We will calculate the MAC as the greater of:

- The verifiable contracted amount paid by all eligible insurers for the provision of the same or similar services as determined by the Georgia Department of Insurance.
- The most recent verifiable amount agreed to by Alliant and the non-participating emergency medical provider for the provision of the same services during such time as such Provider was In-Network with Alliant.
- Such a higher amount as Alliant may deem appropriate given the complexity and circumstances of the services provided.

The amount paid does not include any amount of coinsurance, copayment, or deductible.

Analysis of Rates

Alliant ran an analysis of rates based on specific claim criteria to identify Emergency, Inpatient, and Outpatient services. These were further broken down into In Network and Out of Network categories. Assumptions were made to exclude certain high-cost Med/Surg procedures and drugs due to the nature of the services and no comparable service offered in the MH/SUD realm. To include them would skew the resulting analysis. See Exhibit 2 below.

Exhibit 2
Mental Health Parity Analysis
Summary of Services

Excluded Services

Service Category Description	Coding
High Cost Drugs (Lines Only)	**Revenue Code:** 636
Implants (Lines Only)	**Revenue Codes:** 274, 276, 278
Labs (Lines Only)	**CPT Codes:** 80001-89999
DME (Lines Only)	**Revenue Codes:** 290-294, 299 **CPT Codes:** E0100-E8002
Spinal Surgeries (Entire Claim)	**CPT Codes:** 63075, 63076, 22548, 22551, 22552, 22554, 22556, 22558, 22585, 22586, 22590, 22595, 22600, 22610, 22612, 22614, 22630, 22632, 22633, 22634, 63001, 36003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048, 63050, 63051, 22856, 22857, 22858, 22861, 22862, 22864, 22865, 0095T, 0098T
OP Surgeries (Entire Claim)	**Revenue Codes:** 360-0369, 0481, 0490-0499, 0750-0759, 0790-0799
Transplants (Entire Claim)	**Abbreviation:** 7726, 7727, 7728, 7729
Cardiology (Entire Claim	**Revenue Codes:** 480, 481, 482, 483, 489

Included Services - Inpatient

Service Category Description	Coding
Inpatient Psych	**Revenue Codes:** 114,124, 134, 144, 154, 204
Inpatient Rehab	**Revenue Codes:** 118, 128, 138, 148, 158
Inpatient Detox	**Revenue Codes:** 116, 126, 136, 146, 156
Residential Treatment - Psych	**Revenue Code:** 1001
Residential Treatment - Chem Dependency	**Revenue Code:** 1002
IP MHSA Services	**DRGs**: 876, 880, 881, 882, 883, 884, 885, 886, 887
IP Medical Services	**DRG** (Based on Type in CMS IPPS Final Rule: Table 5)
IP Surgical Services	**DRG** (Based on Type in CMS IPPS Final Rule: Table 5)
Other Inpatient Services	Inpatient Services Not Mapped to Above Categories

Included Services - Outpatient

Service Category Description	Coding
BH Treatments	**Revenue Code:** 900 **CPT Codes:** 90791, 90792, 90832, 90834, 90837, 90847, 90853, Codes that begin with H
BH Electro Shock	**Revenue Code:** 901
BH Milieu Therapy	**Revenue Code:** 902
BH Play Therapy	**Revenue Code:** 903
Outpatient BH/ Intens Op/ Psych	**Revenue Code:** 905
Outpatient BH/ Intens Op/ Chem Dependency	**Revenue Code:** 906
Partial Hospitalization - Less Intensive BH	**Revenue Code:** 912
Partial Hospitalization - Intensive BH	**Revenue Code:** 913
Individual Psychotherapy	**Revenue Code:** 914
Group Therapy	**Revenue Code:** 915
Family Therapy	**Revenue Code:** 916
Other MHSA Based on Dx	**Primary or Admitting Dx:** F01-F99, O99340, O99341, O99342, O99343, O99344, O99345, R4182, Z1330, Z1339, Z566, Z69010, Z69011, Z69020, Z69021, Z6911, Z6912, Z6981, Z6982, Z818, Z8659
Home Health - Physical Therapy	**Type of Bill:** Begins with 3 **Revenue Codes:** 420, 421, 422, 423, 424, 429
Home Health - Occupational Therapy	**Type of Bill:** Begins with 3 **Revenue Codes:** 430, 431, 432, 433, 434, 439
Home Health - Speech Therapy	**Type of Bill:** Begins with 3 **Revenue Codes:** 440, 441, 442, 443, 444, 449
Home Health - Social Work	**Type of Bill:** Begins with 3 **Revenue Code:** 561
Home Health - Home Health Aid	**Type of Bill:** Begins with 3 **Revenue Code:** 571
Home Health - Home Infusion/ Specialty Drug Admin	**Type of Bill:** Begins with 3 **Revenue Codes:** 550, 551, 552, 553
Home Health - Other	**Type of Bill:** Begins with 3
Physical Therapy	**Revenue Codes:** 420, 421, 422, 423, 424, 429
Occupational Therapy	**Revenue Codes:** 430, 431, 432, 433, 434, 439
Speech Therapy	**Revenue Codes:** 440, 441, 442, 443, 444, 449
Advanced Radiology Services (MRI/ CT/ PET)	**Revenue Codes:** 350, 351, 359, 614, 404
Radiology Services	**CPT Codes:** 70000-79999
Other Outpatient Services	Outpatient Services Not Mapped to Above Categories

Medicare reimbursement rates were used as a benchmark where those rates were available for a service/category of service. If Medicare rates were not available, then % of billed charge was used to compare. First, we ran the % of Medicare analysis, and included the % of billed charges to validate the results. The overall MH/SUD to Med/Surg % of Medicare favored Med/Surg by a significant amount, however this is skewed by the Inpatient MH/SUD low comparison rate. We believe this to be a function of the lower acuity services (e.g., Non-surgical and fewer ancillary services received IP). Using the % of billed charge as validation, the rates all appear comparable and within parity.

Service Category	# Claims	Billed	Paid	Medicare Allowed	% Medicare	% Billed Charge
Emergency – MH/SUD	565	$2,369,361.59	$582,603.36	$215,608.27	405%	37%
Emergency – Med/Surg	14922	$44,403,357.81	$9,632,895.42	$3,392,115.71	413%	32%
Inpatient – MH/SUD	62	$1,899,745.35	$402,219.46	$578,954.35	98%	30%
Inpatient – Med/Surg	1248	$53,025,717.12	$15,214,585.27	$10,771,593.13	155%	31%
Outpatient – MH/SUD	333	$397,514.45	$69,776.37	$51,622.01	175%	23%
Outpatient – Med/Surg	25728	$35,632,536.31	$9,878,318.11	$4,504,718.28	273%	35%
Overall – MH/SUD	**960**	**$4,666,621.39**	**$1,054,599.19**	**$846,184.63**	**181%**	**33%**
Overall – Med/Surg	**41898**	**$133,061,611.24**	**$34,725,798.80**	**$18,668,427.12**	**230%**	**32%**

Second, we ran the % of billed charges for those services without a Medicare rate. The overall comparison using just % of billed charges resulted in a lower overall payment amount, however the service categories appear comparable between MH/SUD and Med/Surg. The outlier is Outpatient MH/SUD; however, we attribute this partially to the fact these are services without a Medicare payable amount and more subject to market variability.

Service Category	# Claims	Billed	Paid	% Billed Charge
Emergency – MH/SUD	259	$989,848.17	$35,641.72	7%
Emergency – Med/Surg	5462	$12,937,430.05	$635,986.19	9%
Inpatient – MH/SUD	541	$7,851,114.23	$1,988,499.73	31%
Inpatient – Med/Surg	2202	$68,414,073.46	$13,415,577.11	21%
Outpatient – MH/SUD	888	$3,670,783.35	$510,374.24	17%
Outpatient – Med/Surg	9620	$23,767,627.93	$4,534,655.09	24%
Overall – MH/SUD	**1688**	**$12,511,745.75**	**$2,534,515.69**	**25%**
Overall – Med/Surg	**17284**	**$105,119,131.44**	**$18,586,218.39**	**20%**

Based on our overall analysis we consider our reimbursement rates to be within parity guidelines and will continue to adjust per CMS updates, No Surprises Act and Price Transparency regulations, as well as market analysis when appropriate.

Exhibit D

Credentialing Comparative Analysis 2023

Credentialing is the process Health One Alliance, on behalf of its subsidiary, Alliant Health Plans, uses to evaluate, and select practitioners and facilities to provide care to our members. Health One's Credentialing Department manages the verification process of provider credentialing applications. Credentialing Representatives collect and verify each applicant's information, including but not limited to education, licenses, practice history, historical sanctions, call coverage, board certification, hospital admitting privileges, and malpractice coverage. The Credentials Committee and Health One Board of Directors reserve the discretionary authority to approve, voluntarily withdraw, or deny applicants' participation, except as otherwise required by law. Applicants applying for participation in Alliant Health Plans' network shall be responsible for and shall have the burden of demonstrating that all the requirements are met. The Credentials Committee meets monthly, and the Board of Directors meets quarterly.

In reviewing the providers that were presented to the 2023 Credentialing Committee, we found no outliers on provider applications. The Credentialing Department presented 2,677 providers to the Committee, with 294 behavioral health providers. The medical/surgical providers included a variety of specialties that includes, but are not limited to, cardiology, family medicine, gastroenterology, obstetrics and gynecology, orthopedics, and pediatrics. The applicants included an assortment of types of providers, MDs, DOs, NPs, PAs, PTs, OTs, etc. Behavioral health providers included specialties psychology, child psychology, psychiatry, behavioral analyst, etc. The provider types include MDs, PsyD, PhD, LCSW, LPC, etc. The number of behavioral health providers presented to the committee is lower compared to the medical/surgical provider. Alliant has been reaching out to providers throughout the state for behavioral health, but there is a lack of providers available in our service area.

Providers Credentialed

Credentialing Committee Month 2023	Medical/Surgical Providers	Behavioral Health Providers	Monthly Totals
January	93	22	115
February	250	37	287
March	162	11	173
April	164	14	178
May	172	35	207
June	286	30	316
July	300	29	329
August	109	11	120
September	245	36	281
October	160	21	181
November	297	33	330
December	145	15	160
Totals	**2,383**	**294**	**2,677**

Annually, the Credentialing Department reviews the credentialing criteria and compares them against those of other payers to determine if our current criteria reflect industry standards. The department performs a quarterly review of the credentialing committee decision to look for any trends in the provider voluntary relinquishment, withdrawal, or termination from participation in the network. The review of the quarterly reports shows there is no differential on behavioral health providers not meeting our credentialing criteria. Alliant has expanded in the South Georgia market and in that expansion the Credentialing Department began to see providers in late 2022 who did not meet our call coverage, specifically for Psychiatrists. The Credentialing Representative brought this issue into the department due to the lack of Psychiatric providers that are available and in-network. In discussing the credentialing criteria and an exception for specific medical/surgical providers (i.e., Radiologist, Urgent Care, Pathologist, etc.) who did not need to have documented call coverage. The change did not go into effect until early 2023, but we held providers from presentation to the committee as a voluntary withdrawal at the end of 2022 to avoid frustration for the providers and their office. Also at the end of 2022, we contracted with a telehealth provider, MDLive, that included behavioral health providers; specifically, Psychiatrists and PhD's. This contract was implemented in 2023.

The highest utilization for voluntary withdrawal providers is for no in-network supervising physicians, but this was an issue for medical/surgical providers. The second highest utilization for voluntary withdrawals to not meet criteria was for incomplete applications.

Voluntary Withdrawal Table

Reason for Voluntary Withdrawal	Med/Surg Provider	Behavioral Health
No HOA approved Accrediting Body	2	1
Did not provide application	2	
No Board Certification	7	1
Does not have GA DEA		1
No state licensure	2	
Licensure Revocation		
Incomplete application	22	1
No INN Supervising Physician	34	
No Certificate of Insurance	5	1
No Nurse Protocol Agreement	3	
No Hospital Privileges/Admitting Arrangements	7	
Suspended License	1	
Did not complete residency	2	
Inadequate Insurance Limits	9	1
No Call Coverage/Hospital Affiliation	3	
No Peer References		1
Failure to Provide Notification of Circumstances	1	

Health One
Initial and Recredentialing Criteria

Physicians
(MD, DO, DPM)

In order to be considered as a Participating Practitioner, Practitioner must establish compliance with the following qualification requirements and responsibilities, as required by Health One and Health One's Credentials Committee. Failure to comply with or satisfy the Health One Network qualification criteria outlined below may result in the Practitioner's voluntary relinquishment, withdrawal or termination from participation in the Health One Network.

EDUCATION

1. The education requirements for a Participating Practitioner are as follows:

    1.1 Practitioner must be a graduate of an accredited school of medicine or osteopathy, completed a Residency at an accredited facility and provide complete information with respect to professional training/activities which shall include, without limitation, the following:

    - Undergraduate Education
    - Medical and/or Professional Education
    - Internships and Residencies
    - Fellowships
    - Licensed Professional References
    - Work History

    Health One has the sole discretion with respect to the determination of the acceptability of such credentials.

    1.2 Practitioner must achieve Board Certification within the lesser of seven (7) years from completion of education (Residency/Fellowship) or the eligibility timeframe defined by each specialty's Board, as required by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine (ABPM) or American Board of Oral and Maxillofacial Surgery (ABOMS); unless Practitioner meets one of the following:

    1.2.1 Practitioner who participated in the Health One Network prior to 1995 who does not hold Board Certification, failed to maintain Board Certification, and is not Board Eligible, may qualify for a Grandfather Waiver of the Board Certification requirements if the Practitioner has exhibited (through evidence to Health One) that he/she has the education, experience and training to provide quality services within Health One. Waivers will be evaluated on a case-by-case basis for participation; or

1.2.2 Practitioner who has not previously been Board Certified, but has been practicing for at least twenty-five (25) consecutive years of medical service in the same or similar specialty since the completion of their Residency/Fellowship, and have exhibited through evidence to Health One that he/she has the education, experience and training to provide quality services within Health One, will be evaluated on a case-by-case basis as a Participating Practitioner; or

1.2.3 Practitioner who was previously Board Certified through a Health One approved board: American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine (ABPM) or American Board of Oral and Maxillofacial Surgery (ABOMS), but the board has since expired and has a minimum of ten (10) consecutive years of clinical practice in the same or similar specialty of their Board Certification and has exhibited through their experience and training to provide quality services within Health One, will be evaluated on a case-by-case basis for participation; or

1.2.4 Practitioner is currently Participating in the Health One Network through a Delegated Credentialing Entity and wishes to direct credential with Health One, but is not Board Certified, shall be permitted as a Participating Practitioner, provided the Practitioner is Eligible and obtains Board Certification within twenty-four (24) months upon the granting as a Participating Practitioner through the direct credentialing of the Network. Provided, however Practitioner's delivery of services in the network has not resulted in material adverse outcomes causing a quality of care issue determined by Health One, which shall be evaluated on a case by case basis.

1.3 Practitioner who has a lapse in Board Certification is subject to automatic review.

LICENSE

2. Practitioner must maintain a current, valid medical license that is not temporary, probationary, suspended, lapsed, expired, revoked, or involuntarily or voluntarily surrendered in the State of Georgia and/or any other state where licensed unless the Practitioner relinquished the license in another state in good standing without any adverse action or being subject to review or investigation. If Practitioner is subject to facility licensure requirements, as set forth by the applicable state laws, Practitioner must maintain a current, valid facility license or permit as required by state law.

DEA

3. Practitioner must hold a current, valid and unrestricted Drug Enforcement Agency (DEA) registration, as appropriate in the State of Georgia and/or any other state in which they actively practice, or provide evidence satisfactory to Health One that the Practitioner does not require such registration in order to deliver appropriate care.

INSURANCE

4. Practitioner shall purchase and maintain, at the sole cost and expense of Practitioner, policies of professional liability in amounts required by Health One. The current minimum amounts set forth by Health One are ONE MILLION DOLLARS ($1,000,000) per occurrence/THREE MILLION DOLLARS ($3,000,000) aggregate. Practitioner shall authorize the carrier to issue to Health One certificate of insurance policies of Practitioner upon request of Health One. Notwithstanding the foregoing, Practitioner shall provide Health One with notification within three (3) days of any cancellation, termination or material alteration of any such insurance policies. Prior to the expiration or cancellation of any such coverage Practitioner shall secure replacement of such insurance coverage upon the same terms, and shall furnish Health One with a certificate of endorsement as described herein. Evidence of the effective policy reflecting such insurance shall be provided with the application.

MALPRACTICE

4.1 Details of any professional liability actions that have resulted in adverse judgments or any financial settlements.

4.2 Details of any pending professional liability actions.

This information shall be reviewed by Health One. The evaluation shall consider the frequency of such actions, the financial impact of such actions, and the clinical circumstances surrounding the alleged acts of malpractice. Practitioners shall not be automatically disqualified from participation in Health One due to a history of judgments and/or settlements. Each case will be evaluated based on its merits. Health One has sole discretion in the determination of the impact of this information for the purposes of credentialing.

ADMITTING PRIVILEGES

5. Practitioner has current and unrestricted admitting privileges or confirmation the Practitioner is able to deliver satisfactory professional services without hospital admitting privileges.

5.1 Provider shall confirm whether his or her application for clinical privileges or medical staff membership, including a change in staff category at any hospital or healthcare facility has ever been reduced, limited, suspended, terminated or have been placed on probation or restriction or whether he or she has ever resigned to avoid disciplinary action, or investigation or whether any related actions or investigations are pending. Provider shall submit any applicable information regarding the same for review and consideration.

PEER REFERENCES

6. Practitioner shall provide the name, address, phone, fax and email address of three professional peers who can provide reliable information based on significant personal

experience as to clinical ability, ethical character and ability to work with others.

CALL COVERAGE

7. In order to assure continuous and quality care to patients, Participating Practitioner in the Health One Network shall provide coverage consistent with the guidelines set forth below for times when they are absent from their medical practice. Notwithstanding the below, it is in Health One's sole and absolute discretion, based on its assessment of the coverage proposal considering patient needs and quality and risk management standards, to approve or disapprove such alternative coverage requests.

   7.1 Practitioner must have made arrangements to allow patients and other practitioners to contact Practitioner (or covering provider) 24 hours a day, 7 days a week. Automatic referrals to the emergency department shall not satisfy the call coverage obligations of a Participating Practitioner.

   7.2 To ensure continuity of patient care, Practitioner must have made arrangements with a practitioner, group, or vendor to provide call coverage on a 24 hour a day, and 7 days a week basis to respond to all calls in a prompt manner.

   7.3 Call Coverage must be provided by a licensed practitioner who is capable of providing services of an urgent or emergency nature which the Practitioner being covered would typically provide for patients in his/her practice. The covering practitioner must bill for services rendered by the call covering practitioner through his/her own Tax ID through a bona-fide locums tenens arrangement when the Participating Practitioner is unavailable

   7.4 If a Practitioner cannot secure coverage from a practitioner, group or vendor and the Practitioner practices in a Rural Area, as defined herein, the Practitioner must submit a request in writing to Health One outlining how they provide the appropriate level of care to their patients or for a hardship waiver of the coverage requirements. *Rural Area* means an area that is not an Urban Area as defined A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget, excluding Whitfield and Murray Counties, Georgia. Health One will consider all such exception requests in a timely manner. In addition, depending upon the patient needs to access healthcare services in the Rural Area, Health One may grant an exception to ensure access to healthcare services for the beneficiaries that receive care from HealthOne Participating Practitioner.

   7.5 Failure by a Practitioner to comply strictly with this policy will result in a written warning being issued to the offending Practitioner by Health One wherein the Participating Practitioner shall have ten (10) days to provide a written plan to cure the deficiency. If Practitioner fails to cure the deficiency within thirty (30) days or a time period that is deemed reasonable by Health One, upon submission of the written plan to cure the deficiency, Practitioner shall fail to maintain qualifications to be eligible as a Participating Practitioner and such participation shall

automatically terminate and be deemed voluntarily withdrawn.

7.6 Decisions on Practitioner participation with the Health One Network or termination of a Participation Agreement based on this Call Coverage Policy involve the business objectives of Health One and not matters of professional competence. Failure to obtain and maintain call coverage will be deemed a voluntary withdrawal from the Health One Network for failure to satisfy the qualification criteria, and therefore, no rights of appeal or national databank reports will be applicable to such decisions.

DISCLOSURE

8. Provider shall confirm the following information and provide the necessary documentation and information to enable the Credentials Committee to fully evaluate the Provider's qualifications to participate in the HealthOne Network. Based on its assessment of the Provider's credentialing information and other facts and circumstances provided through the credentialing process, Health One will consider any and all data, information and circumstances, including any unique factors, related to providers credentialing application to approve or disapprove network participation.

8.1 Provider shall confirm whether he or she has been the subject of an investigation or Adverse Action and provide any applicable documentation regarding same. "Adverse Action" means a voluntary or involuntary termination, loss of, reduction, withdrawal, limitation, restriction, suspension, revocation, denial or non-renewal of membership, clinical privileges, academic affiliation or appointment, or employment, including any adverse action regarding professional licensure registration, certification, any previously successful or currently pending challenges to such licensure registration or certification.

8.2 Provider shall confirm whether he or she has been the subject of any report to a state or federal data bank, state licensing or disciplining entity and provide any applicable documentation regarding same.

8.3 Provider shall confirm whether he or she has ever been suspended, debarred, fined, disciplined, sanctioned or otherwise restricted or excluded from participating in the Medicare or Medicaid program, or any federal, state or private health insurance program.

8.4 Practitioner shall confirm whether he/she has ever been convicted of a felony or been convicted of Medicare, Medicaid or other governmental or private third-party payor fraud or program abuse or have been required to pay civil penalties for the same.

8.5 Provider shall confirm whether he or she has ever been or is currently subject to being arrested, charged, convicted of or entered a plea for a criminal offense (excluding minor traffic violations), subject to criminal charges involving children, a sexual offense, illegal use of drugs or a crime of moral turpitude.

8.6 Provider shall confirm whether he or she has received an adverse quality determination concerning his or her treatment of a patient by a state or federal professional review organization.

9. Practitioner is in good general health.

9.1 Practitioner shall certify on the Application that Practitioner does not have a history of and is not presently abusing drugs or alcohol. A Practitioner with a history of drug or alcohol abuse may be considered for participation in the Health One Network, within the sole and absolute discretion of Health One. In Health One's sole and absolute discretion, Health One may request a Practitioner's personal physician to provide a statement regarding the medical/mental status of the Practitioner and his or her compliance with a rehabilitation, or monitoring program. Practitioner shall execute the necessary authorizations to release the pertinent information to Health One for credentialing purposes.

9.2 Practitioner shall certify on the Application that Practitioner does not have any communicable and/or chronic infectious diseases that may be a potential danger to patients.

NONDISCRIMINATION

10. Practitioner shall pursue and maintain a policy of nondiscrimination. All decisions regarding the treatment of patients should be made without being influenced in any manner by applicant's race, ethnic/national identity, gender, age or sexual orientation.

11. Health One pursues and maintains a policy of nondiscrimination with all practitioners and applicants for panel membership. All decisions regarding panel membership are made without being influenced in any manner by applicant's race, ethnic/national identity, gender, age or sexual orientation.

AUDITS

12. Practitioner shall permit Health One to conduct regular and random on-site audits of his/her practice location, including a review of medical records pertaining to Health One related beneficiaries. Practitioner shall also provide any and all requested documentation to Health One related to the operations of the practice, credentialing materials and response to the audit findings within ten (10) business days upon receipt of the request. Failure to comply with the audits may result in termination or voluntary withdrawal from participation in the Health One Network.

CONTRACT

13. Practitioner shall execute the Health One Practitioner Participation Agreement and abide by the terms of the contract and the full credentialing criteria of Health One.

RELEASE OF INFORMATION

14. Practitioner shall execute the appropriate release to Health One and its agents directing any and all entities that may have information with respect to the ability to practice quality medicine to provide such information to Health One on request. Such entities include, without limitation, hospitals, medical societies, state examining boards, Medicare intermediaries and other third-party payers.

    14.1. Practitioner is required to attest via a unique and identifiable electronic or written signature that all the information submitted is accurate. Provider is further required to authorize Health One to obtain the necessary information from third-parties to complete the credentialing and verification process sufficient to support the credentialing and quality assurance procedures of Health One. Signatures may be electronic in conformance with State law or written original signed copies submitted in paper form.

    14.2. Health One Representatives are authorized by the Credentials Committee to request additional information from the Practitioner and notify them that the application will not be processed unless an accurate and complete application is received within a timely manner. A new application with newly executed releases and attestation statements will be required in order to process the application. Health One reserves the right to act upon any such findings during the credentialing process. Absence, falsification, or material omission of information requested in the application may be grounds for denial or voluntary withdrawal.

    Practitioner has the right to review information submitted to support their credentialing, correct erroneous information, receive the status of their credentialing or recredentialing application, upon request. Health One will respond to a Practitioner's request via phone, fax, letter or email.

VERIFICATION

15. Health One, and its agents, reserves the right to require independent verification of any and all of the Credentialing Criteria.

CHANGES IN INFORMATION NOTIFICATION

16. Practitioner shall be solely responsible for notifying Health One in writing of any changes in the Practitioner's circumstances within three (3) days upon the date of the change in circumstances, including, but not limited to changes in license status, insurance coverage, call coverage, sanctions or changes that would cause any of the information referenced above or submitted through the application to no longer be accurate.

COMPLIANCE

17. Practitioner shall comply with any and all Health One policies and procedures related to the operations and Practitioner participation.

Health One
Initial and Recredentialing Criteria

(Allied Health Professionals)

Advanced Practicing Registered Nurse **(APRN) which includes:**
Certified Nurse Midwives **(CNM)**
Clinical Nurse Specialists **(CNS)**
Clinical Nurse Specialists Psychiatric/Mental Health **(CNS/PMH)**
Certified Registered Nurse Anesthesiologist **(CRNA)**
Nurse Practitioners **(NP)**

Additional Allied Health Professionals:
Audiologists **(AUD)**
Chiropractors **(DC)**
Licensed Athletic Trainers **(LAT)**
Licensed Clinical Social Workers **(LCSW)**
Licensed Marriage and Family Therapist **(LMFT)**
Licensed Professional Counselor **(LPC)**
Master of Social Work **(MSW)**
Physical Therapists **(PT, MPT and DPT)**
Physician Assistants **(PA)**
Psychologists **(PhD and PsyD)**
Occupational Therapists **(OT, MOT and ODT)**
Optometrists **(OD)**
Speech Pathologists **(SP and SLP)**
Registered Dietitian **(RD)**
For purposes of the qualification criteria the above referenced practitioners shall be referred to herein as "Participating Provider" or "Practitioner".

In order to be considered as a Participating Practitioner, Practitioner must establish compliance with the following qualification requirements and responsibilities, as required by Health One and Health One's Credentials Committee. Failure to comply with or satisfy the Health One Network qualification criteria outlined below may result in the Practitioner's voluntary relinquishment, withdrawal or termination from participation in the Health One Network.

Health One shall directly credential Allied Health Professionals as a provider that directly bills for his or her services. Requirements for Practitioners shall comply with the following eligibility requirements and must satisfy the Health One criteria shall be processed in accordance with the policy below.

EDUCATION

1. The education requirements for a Participating Practitioner are as follows:

    1.1. Practitioner shall present official documentation indicating he/she has completed an acceptable training program, or postgraduate training from an accredited professional school, as required by the applicable state licensing or registration agency of the Practitioner's

profession.

- Undergraduate Education
- Medical and/or Professional Education
- Licensed Professional References
- Work History

1.2 Advanced Nurse Practitioners (APRN), shall present official documentation indicating he/she has graduated with a master's degree or doctorate from an accredited professional school or who shall meet those educational, practice, certification requirements, or any combination of such requirements, as specified by the Board and provide complete information with respect to professional training/activities which shall include, without limitation, the following:

- Undergraduate Education
- Medical and/or Professional Education
- Licensed Professional References
- Work History

LICENSE

2. Practitioner is a person with a current, valid professional/medical license that is not temporary, probationary, suspended, lapsed, expired, revoked, or involuntarily or voluntarily surrendered in the State of Georgia and/or any other state where licensed, unless the Practitioner relinquished the license in another state in good standing without any adverse action or being subject to review or investigation.

DEA

3. Eligible practitioners, Advanced Nurse Practitioners (APRN), and Physician Assistants (PA), may hold a current, valid and unrestricted Drug Enforcement Agency (DEA) registration, as appropriate in the State of Georgia and/or any other state in which they actively practice. If an APRN or PA does not write prescriptions, their credentialing file will be notated with this information.

INSURANCE

4. Practitioner shall purchase and maintain, at the sole cost and expense of Practitioner, policies of professional liability in amounts required by Health One. The current minimum amounts set forth by Health One are ONE MILLION DOLLARS ($1,000,000) per occurrence/THREE MILLION DOLLARS ($3,000,000) aggregate. Practitioner shall authorize the carrier to issue to Health One certificate of insurance policies of Practitioner upon request of Health One. Notwithstanding the foregoing, Practitioner shall provide Health One with notification within three (3) days of any cancellation, termination or material alteration of any such insurance policies. Prior to the expiration or cancellation of any such coverage Practitioner shall secure replacement of such insurance coverage upon the same terms, and shall furnish Health One with a certificate of endorsement as described herein. Evidence of the effective policy reflecting such insurance shall be provided with the application.

4.1. Advanced Nurse Practitioners (APRN), Audiologists (AUD), Licensed Clinical Social Workers

(LCSW), Licensed Marriage and Family Therapists (LMFT), Licensed Professional Counselors (LPC), Masters of Social Work (MSW), Occupational Therapists (OT), Optometrists (OD), Physical Therapists (PT), Physician Assistants (PA) and/or Registered Dieticians (RD) are permitted to:

4.1.1. Share insurance limits with their Supervising/Delegating physician at ONE MILLION DOLLARS ($1,000,000) per occurrence/THREE MILLION DOLLARS ($3,000,000) aggregate.

OR

4.1.2. Share insurance limits with their employer/physician entity of the provider practice, provided the physician(s) within the provider practice have their own coverage as required under the Health One Physician Credentialing Criteria.

MALPRACTICE

4.2. Details of any professional liability actions that have resulted in adverse judgments or any financial settlements.

4.3. Details of any pending professional liability actions.

This information shall be reviewed by Health One. The evaluation shall consider the frequency of such actions, the financial impact of such actions, and the clinical circumstances surrounding the alleged acts of malpractice. Practitioners shall not be automatically disqualified from participation in Health One due to a history of judgments and/or settlements. Each case will be evaluated based on its merits. Health One has sole and absolute discretion in the determination of the impact of this information for the purposes of credentialing.

SUPERVISING/DELEGATING PHYSICIAN

Advanced Nurse Practitioner (APRN), and Physician Assistant (PA) Requirement

5.1 In accordance with the applicable laws for the Practitioner's scope of practice, the Supervising/Delegating Physician must be in a comparable specialty area or field as that of the APRN or PA. The APRN or PA and Physician shall provide certification to Health One that both parties practice in comparable specialties. The Supervising/Delegating Physician shall be licensed in the State of Georgia or any other State in which both the Practitioner and Supervising/Delegating Physician actively practice and shall have an office in the corresponding state. The Supervising/Delegating Physician must be a participating member of the Health One Network and must confirm to Health One that he or she shall be immediately available for consultation with the APRN and/or the PA.

5.2 The APRN shall have a valid Nurse Protocol Agreement and shall provide a written attestation of compliance with the Nurse Protocol Agreement. For APRNs that write prescriptions, the Nurse Protocol Agreement shall conform with the limitations set forth by the applicable laws. The Nurse Protocol Agreement will be readily available for review and onsite at Practitioner's office at all times. Upon network's request, Practitioner shall submit a copy of the Nurse Protocol Agreement within the time frame required by HealthOne. In the event the Nurse Protocol Agreement is modified, amended or terminated, Practitioner shall notify HealthOne promptly and no later than three (3) days following such modification, amendment or termination.

5.3 Physician Assistants (PA) shall have a valid Job Description on file in the State of Georgia or any other State in which they actively practice. The Job Description shall be provided to Health One and it must be signed by the Physician Assistant's current Supervising/Delegating Physician within the past 3 years.

PEER REFERENCES

6. Practitioner shall provide the name, address, phone, fax and email address of three professional peers who can provide reliable information based on significant personal experience as to clinical ability, ethical character and ability to work with others.

CALL COVERAGE

Advanced Nurse Practitioner (APRN), and Physician Assistant (PA) Requirement

7. In order to assure continuous and quality care to patients, Participating Practitioner in the Health One Network shall provide coverage consistent with the guidelines set forth below for times when the Practitioner is absent from their medical practice. Notwithstanding the below, it is in Health One's sole and absolute discretion, based on its assessment of the coverage proposal considering patient needs and quality and risk management standards, to approve or disapprove such alternative coverage requests.

   7.1. Practitioner must have made arrangements to allow patients and other practitioners to contact Practitioner (or covering provider) 24 hours a day, 7 days a week. Automatic referrals to the emergency department shall not satisfy the call coverage obligations of a Participating Practitioner.

   7.2. To ensure continuity of patient care, Practitioner must have made arrangements with Supervising/Delegating Physician, group, or vendor to provide call coverage on a 24 hour a day, and 7 days a week basis to respond to all calls in a prompt manner.

   7.3. Call Coverage must be provided by a Supervising/Delegating Physician who (i) practices in the same or similar specialty as deemed reasonable by Health One and (ii) is capable of providing services of an urgent or emergency nature which the Practitioner being covered would typically provide for patients in his/her practice. The covering Practitioner is to be a Supervising/Delegating Physician that is a Participating Practitioner with Health One.

   7.4. Failure by a Practitioner to comply strictly with this policy will result in a written warning being issued to the offending Practitioner by Health One wherein the Participating Practitioner shall have ten (10) days to provide a written plan to cure the deficiency. If Practitioner fails to cure the deficiency within thirty (30) days or a time period that is deemed reasonable by Health One, upon submission of the written plan to cure the deficiency, Practitioner shall fail to maintain qualifications to be eligible as a Participating Practitioner and such participation shall automatically terminate and be deemed voluntarily withdrawn.

   7.5. Decisions on Practitioner participation with the Health One Network or termination of a Participation Agreement based on this Call Coverage Policy involve the business objectives of

Health One and not matters of professional competence. Failure to obtain and maintain call coverage will be deemed a voluntary withdrawal from the Health One Network for failure to satisfy the qualification criteria, and therefore, no rights of appeal or national databank reports will be applicable to such decisions.

DISCLOSURE

8. Practitioner shall confirm the following information and provide the necessary documentation and information to enable the Credentials Committee to fully evaluate the Practitioner's qualifications to participate in the HealthOne Network. Based on its assessment of the Provider's credentialing information and other facts and circumstances provided through the credentialing process, Health One will consider any and all data, information and circumstances, including any unique factors, related to providers credentialing application to approve or disapprove network participation.

   8.1. Practitioner shall confirm whether his or her application for clinical privileges or medical staff membership, including a change in staff category at any hospital or healthcare facility has ever been reduced, limited, suspended, terminated or have been placed on probation or restriction or whether he or she has ever resigned to avoid disciplinary action, or investigation or whether any related actions or investigations are pending. Practitioner shall submit any applicable information regarding the same for review and consideration.

   8.2. Practitioner shall confirm whether he or she has been the subject of an investigation or Adverse Action and provide any applicable documentation regarding same. "Adverse Action" means a voluntary or involuntary termination, loss of, reduction, withdrawal, limitation, restriction, suspension, revocation, denial or non-renewal of membership, clinical privileges, academic affiliation or appointment, or employment, including any adverse action regarding professional licensure registration, certification, any previously successful or currently pending challenges to such licensure registration or certification.

   8.3. Practitioner shall confirm whether he or she has been the subject of any report to a state or federal data bank, state licensing or disciplining entity and provide any applicable documentation regarding same.

   8.4. Practitioner shall confirm whether he or she has ever been suspended, debarred, fined, disciplined, sanctioned or otherwise restricted or excluded from participating in the Medicare or Medicaid program, or any federal, state or private health insurance program.

   8.5. Practitioner shall confirm whether he/she has ever been convicted of a felony or been convicted of Medicare, Medicaid or other governmental or private third-party payor fraud or program abuse or have been required to pay civil penalties for the same.

   8.6. Practitioner shall confirm whether he or she has ever been or is currently subject to being arrested, charged, convicted of or entered a plea for a criminal offense (excluding minor traffic violations), subject to criminal charges involving children, a sexual offense, illegal use of drugs or a crime of moral turpitude.

   8.7. Practitioner shall confirm whether he or she has received an adverse quality determination

concerning his or her treatment of a patient by a state or federal professional review organization.

9. Practitioner is in good general health.

    9.1. Practitioner shall certify on the Application that Practitioner does not have a history of and is not presently abusing drugs or alcohol. A Practitioner with a history of drug or alcohol abuse may be considered for participation in the Health One Network, within the sole and absolute discretion of Health One. In Health One's sole and absolute discretion, Health One may request a Practitioner's personal physician to provide a statement regarding the medical/mental status of the Practitioner and his or her compliance with a rehabilitation, or monitoring program. Practitioner shall execute the necessary authorizations to release the pertinent information to Health One for credentialing purposes.

    9.2. Practitioner shall certify on the Application that Practitioner does not have any communicable and/or chronic infectious diseases that may be a potential danger to patients.

NONDISCRIMINATION

10. Practitioner shall pursue and maintain a policy of nondiscrimination. All decisions regarding the treatment of patients should be made without being influenced in any manner by applicant's race, ethnic/national identity, gender, age or sexual orientation.

11. Health One pursues and maintains a policy of nondiscrimination with all practitioners and applicants for panel membership. All decisions regarding panel membership are made without being influenced in any manner by applicant's race, ethnic/national identity, gender, age or sexual orientation.

AUDITS

12. Practitioner shall permit Health One to conduct regular and random on-site audits of his/her practice location, including a review of medical records pertaining to Health One related beneficiaries. Practitioner shall also provide any and all requested documentation to Health One related to the operations of the practice, credentialing materials and response to the audit findings within ten (10) business days upon receipt of the request. Failure to comply with the audits may result in termination or voluntary withdrawal from participation in the Health One Network.

CONTRACT

13. Practitioner shall execute the Health One Practitioner Participation Agreement and abide by the terms of the contract and the full credentialing criteria of Health One.

RELEASE OF INFORMATION

14. Practitioner shall execute the appropriate release to Health One and its agents directing any and all entities that may have information with respect to the ability to practice quality medicine to provide such information to Health One on request. Such entities include, without limitation, hospitals, medical societies, state examining boards, Medicare intermediaries and other third-party payers.

    14.1. Practitioner is required to attest via a unique and identifiable electronic or written signature that all of the information submitted is accurate. Practitioner is further required to authorize Health One to obtain the necessary information from third-parties to complete the credentialing and verification process sufficient to support the credentialing and quality assurance procedures of Health One. Signatures may be electronic in conformance with State law or written original signed copies submitted in paper form.

    14.2. Health One Representatives are authorized by the Credentials Committee to request additional information from the Practitioner and notify them that the application will not be processed unless an accurate and complete application is received within a timely manner. A new application with newly executed releases and attestation statements will be required in order to process the application. Health One reserves the right to act upon any such findings during the credentialing process. Absence, falsification, or material omission of information requested in the application may be grounds for denial or voluntary withdrawal.

    Practitioner has the right to review information submitted to support their credentialing, correct erroneous information, receive the status of their credentialing or recredentialing application, upon request. Health One will respond to a Practitioner's request via phone, fax, letter or email.

VERIFICATION

15. Health One, and its agents, reserves the right to require independent verification of any and all of the Credentialing Criteria and documentation to support satisfaction of the Credentialing Criteria.

CHANGES IN INFORMATION NOTIFICATION

16. Practitioner shall be solely responsible for notifying Health One in writing of any changes in the Practitioner's circumstances within three (3) days upon the date of the change in circumstances, including, but not limited to changes in license status, insurance coverage, call coverage, sanctions or changes that would cause any of the information referenced above or submitted through the application to no longer be accurate.

COMPLIANCE

17. Practitioner shall comply with any and all Health One policies and procedures related to the

operations and Practitioner participation.

Health One
Initial and Recredentialing Criteria

(Allied)
Behavioral Analyst **(BA)**

In order to be considered as a Participating Practitioner, Practitioner must establish compliance with the following qualification requirements and responsibilities, as required by Health One and Health One's Credentials Committee. Failure to comply with or satisfy the Health One Network qualification criteria outlined below may result in the Practitioner's voluntary relinquishment, withdrawal or termination from participation in the Health One Network.

For purposes of Medicare and Medicaid plans that Health One serves as a delegated credentialing entity, Health One shall directly credential the midlevel provider as a provider that directly bills for his or her services, as applicable and required by the delegated credentialing obligations of Health One. Otherwise, all other Allied Health Providers that satisfy the Health One criteria shall be processed in accordance with the policy below.

EDUCATION

1. The education requirements for a Participating Practitioner are as follows:

   1.1. Practitioner shall present official documentation indicating he/she has completed an acceptable training program, or postgraduate training from an accredited professional school, as required by the applicable state licensing or registration agency of the Practitioner's profession.

   - Undergraduate Education
   - Medical and/or Professional Education
   - Licensed Professional References
   - Work History

LICENSE

2. Practitioner is a person with a current, valid medical license that is not temporary, probationary, suspended, lapsed, expired, revoked, or involuntarily or voluntarily surrendered in the state currently practicing and/or any other state where licensed, unless the Practitioner relinquished the license in another state in good standing without any adverse action or being subject to review or investigation.

   2.1 If the state in which the practitioner is applying for network participation does not offer a medical license (e.g., State of Georgia), practitioner must hold a current, valid certification with the Behavioral Analyst Certification Board.

DEA

3. Eligible practitioners may hold a current, valid and unrestricted Drug Enforcement Agency (DEA)

registration, as appropriate in the State of Georgia and/or any other state in which they actively practice, or provide evidence satisfactory to Health One that the Practitioner does not require such registration in order to deliver appropriate care.

INSURANCE

4. Practitioner shall purchase and maintain, at the sole cost and expense of Practitioner, policies of professional liability in amounts required by Health One. The current minimum amounts set forth by Health One are ONE MILLION DOLLARS ($1,000,000) per occurrence/THREE MILLION DOLLARS ($3,000,000) aggregate. Practitioner shall authorize the carrier to issue to Health One certificate of insurance policies of Practitioner upon request of Health One. Notwithstanding the foregoing, Practitioner shall provide Health One with notification within three (3) days of any cancellation, termination or material alteration of any such insurance policies. Prior to the expiration or cancellation of any such coverage Practitioner shall secure replacement of such insurance coverage upon the same terms, and shall furnish Health One with a certificate of endorsement as described herein. Evidence of the effective policy reflecting such insurance shall be provided with the application.

MALPRACTICE

4.1. Details of any professional liability actions that have resulted in adverse judgments or any financial settlements.

4.2. Details of any pending professional liability actions.

This information shall be reviewed by Health One. The evaluation shall consider the frequency of such actions, the financial impact of such actions, and the clinical circumstances surrounding the alleged acts of malpractice. Practitioners shall not be automatically disqualified from participation in Health One due to a history of judgments and/or settlements. Each case will be evaluated based on its merits. Health One has sole discretion in the determination of the impact of this information for the purposes of credentialing.

PEER REFERENCES

5. Practitioner shall provide the name, address, phone, fax and email address of three professional peers who can provide reliable information based on significant personal experience as to clinical ability, ethical character and ability to work with others.

DISCLOSURE

6. Provider shall confirm the following information and provide the necessary documentation and information to enable the Credentials Committee to fully evaluate the Provider's qualifications to participate in the Health One Network. Based on its assessment of the Provider's credentialing information and other facts and circumstances provided through the credentialing process, Health One will consider any and all data, information and circumstances, including any unique factors, related to providers credentialing application to approve or disapprove network participation.

6.1 Provider shall confirm whether his or her application for clinical privileges or medical staff membership, including a change in staff category at any hospital or healthcare facility has ever been reduced, limited, suspended, terminated or have been placed on probation or restriction or whether he or she has ever resigned to avoid disciplinary action, or investigation or whether any related actions or investigations are pending. Provider shall submit any applicable information regarding the same for review and consideration.

6.2 Provider shall confirm whether he or she has been the subject of an investigation or Adverse Action and provide any applicable documentation regarding same. "Adverse Action" means a voluntary or involuntary termination, loss of, reduction, withdrawal, limitation, restriction, suspension, revocation, denial or non-renewal of membership, clinical privileges, academic affiliation or appointment, or employment, including any adverse action regarding professional licensure registration, certification, any previously successful or currently pending challenges to such licensure registration or certification.

6.3 Provider shall confirm whether he or she has been the subject of any report to a state or federal data bank, state licensing or disciplining entity and provide any applicable documentation regarding same.

6.4 Provider shall confirm whether he or she has ever been suspended, debarred, fined, disciplined, sanctioned or otherwise restricted or excluded from participating in the Medicare or Medicaid program, or any federal, state or private health insurance program.

6.5 Practitioner shall confirm whether he or she has ever been convicted of a felony or been convicted of Medicare, Medicaid or other governmental or private third-party payor fraud or program abuse or have been required to pay civil penalties for the same.

6.6 Provider shall confirm whether he or she has ever been or is currently subject to being arrested, charged, convicted of or entered a plea for a criminal offense (excluding minor traffic violations), subject to criminal charges involving children, a sexual offense, illegal use of drugs or a crime of moral turpitude.

6.7 Provider shall confirm whether he or she has received an adverse quality determination concerning his or her treatment of a patient by a state or federal professional review organization.

7. Practitioner is in good general health.

7.1. Practitioner shall certify on the Application that Practitioner does not have a history of and is not presently abusing drugs or alcohol. A Practitioner with a history of drug or alcohol abuse may be considered for participation in the Health One Network, within the sole and absolute discretion of Health One. In Health One's sole and absolute discretion, Health One may request a Practitioner's personal physician to provide a statement regarding the medical/mental status of the Practitioner and his or her compliance with a rehabilitation, or monitoring program. Practitioner shall execute the necessary authorizations to release the pertinent information to Health One for credentialing purposes.

7.2. Practitioner shall certify on the Application that Practitioner does not have any communicable and/or chronic infectious diseases that may be a potential danger to patients.

NONDISCRIMINATION

8. Practitioner shall pursue and maintain a policy of nondiscrimination. All decisions regarding the treatment of patients should be made without being influenced in any manner by applicant's race, ethnic/national identity, gender, age or sexual orientation.

9. Health One pursues and maintains a policy of nondiscrimination with all practitioners and applicants for panel membership. All decisions regarding panel membership are made without being influenced in any manner by applicant's race, ethnic/national identity, gender, age or sexual orientation.

AUDITS

10. Practitioner shall permit Health One to conduct regular and random on-site audits of his/her practice location, including a review of medical records pertaining to Health One related beneficiaries. Practitioner shall also provide any and all requested documentation to Health One related to the operations of the practice, credentialing materials and response to the audit findings within ten (10) business days upon receipt of the request. Failure to comply with the audits may result in termination or voluntary withdrawal from participation in the Health One Network.

CONTRACT

11. Practitioner shall execute the Health One Practitioner Participation Agreement and abide by the terms of the contract and the full credentialing criteria of Health One.

RELEASE OF INFORMATION

12. Practitioner shall execute the appropriate release to Health One and its agents directing any and all entities that may have information with respect to the ability to practice quality medicine to provide such information to Health One on request. Such entities include, without limitation, hospitals, medical societies, state examining boards, Medicare intermediaries and other third-party payers.

    12.1. Practitioner is required to attest via a unique and identifiable electronic or written signature that all of the information submitted is accurate. Provider is further required to authorize Health One to obtain the necessary information from third-parties to complete the credentialing and verification process sufficient to support the credentialing and quality assurance procedures of Health One. Signatures may be electronic in conformance with State law or written original signed copies submitted in paper form.

    12.2. Health One Representatives are authorized by the Credentials Committee to request additional information from the Practitioner and notify them that the application will not

be processed unless an accurate and complete application is received within a timely manner. A new application with newly executed releases and attestation statements will be required in order to process the application. Health One reserves the right to act upon any such findings during the credentialing process. Absence, falsification, or material omission of information requested in the application may be grounds for denial or voluntary withdrawal.

Practitioner has the right to review information submitted to support their credentialing, correct erroneous information, receive the status of their credentialing or recredentialing application, upon request. Health One will respond to a Practitioner's request via phone, fax, letter or email.

VERIFICATION

13. Health One, and its agents, reserves the right to require independent verification of any and all of the Credentialing Criteria.

CHANGES IN INFORMATION NOTIFICATION

14. Practitioner shall be solely responsible for notifying Health One in writing of any changes in the Practitioner's circumstances within three (3) days upon the date of the change in circumstances, including, but not limited to changes in license status, insurance coverage, call coverage, sanctions or changes that would cause any of the information referenced above or submitted through the application to no longer be accurate.

COMPLIANCE

15. Practitioner shall comply with any and all Health One policies and procedures related to the operations and Practitioner participation.

Health One
Initial and Recredentialing Criteria

Oral and Maxillofacial Surgeons
(DDS, DMD, MD)

In order to be considered as a Participating Practitioner, Practitioner must establish compliance with the following qualification requirements and responsibilities, as required by Health One and Health One's Credentials Committee. Failure to comply with or satisfy the Health One Network qualification criteria outlined below may result in the Practitioner's voluntary relinquishment, withdrawal or termination from participation in the Health One Network.

EDUCATION

1. The education requirements for a Participating Practitioner are as follows:

    1.1 Practitioner must be a graduate of an accredited school of medicine and/or dentistry or osteopathy, completed a Residency at an accredited facility and provide complete information with respect to professional training/activities which shall include, without limitation, the following:

    - Undergraduate Education
    - Medical and/or Professional Education
    - Internships and Residencies
    - Fellowships
    - Licensed Professional References
    - Work History

    Health One has the sole discretion with respect to the determination of the acceptability of such credentials.

    1.2 Practitioner must achieve Board Certification within the lesser of seven (7) years from completion of education (Residency/Fellowship) or the eligibility timeframe defined by each specialty's Board, as required by the American Board of Oral and Maxillofacial Surgery (ABOMS); unless Practitioner meets one of the following:

    1.2.1 Practitioner who participated in the Health One Network prior to 1995 who does not hold Board Certification, failed to maintain Board Certification, and is not Board Eligible, may qualify for a Grandfather Waiver of the Board Certification requirements if the Practitioner has exhibited (through evidence to Health One) that he/she has the education, experience and training to provide quality services within Health One. Waivers will be evaluated on a case-by-case basis for participation; or

    1.2.2 Practitioner who has not previously been Board Certified, but has been practicing for at least twenty-five (25) consecutive years of medical service in the same or similar specialty since the completion of their

Residency/Fellowship, and have exhibited through evidence to Health One that he/she has the education, experience and training to provide quality services within Health One, will be evaluated on a case-by-case basis as a Participating Practitioner; or

1.2.3 Practitioner who was previously Board Certified through a Health One approved board: American Board of Oral and Maxillofacial Surgery (ABOMS), but the board has since expired and has a minimum of ten (10) consecutive years of clinical practice in the same or similar specialty of their Board Certification and has exhibited through their experience and training to provide quality services within Health One, will be evaluated on a case-by-case basis for participation; or

1.2.4 Practitioner is currently Participating in the Health One Network through a Delegated Credentialing Entity and wishes to direct credential with Health One, but is not Board Certified, shall be permitted as a Participating Practitioner, provided the Practitioner is Eligible and obtains Board Certification within twenty-four (24) months upon the granting as a Participating Practitioner through the direct credentialing of the Network. Provided, however Practitioner's delivery of services in the network has not resulted in material adverse outcomes causing a quality of care issue determined by Health One, which shall be evaluated on a case by case basis.

1.3 Practitioner who has a lapse in Board Certification is subject to automatic review.

LICENSE

2. Practitioner must maintain a current, valid medical license that is not temporary, probationary, suspended, lapsed, expired, revoked, or involuntarily or voluntarily surrendered in the State of Georgia and/or any other state where licensed unless the Practitioner relinquished the license in another state in good standing without any adverse action or being subject to review or investigation. If Practitioner is subject to facility licensure requirements, as set forth by the applicable state laws, Practitioner must maintain a current, valid facility license or permit as required by state law.

DEA

3. Practitioner must hold a current, valid and unrestricted Drug Enforcement Agency (DEA) registration, as appropriate in the State of Georgia and/or any other state in which they actively practice, or provide evidence satisfactory to Health One that the Practitioner does not require such registration in order to deliver appropriate care.

INSURANCE

4. Practitioner shall purchase and maintain, at the sole cost and expense of Practitioner, policies of professional liability in amounts required by Health One. The current minimum amounts set forth by Health One are ONE MILLION DOLLARS ($1,000,000) per occurrence/THREE MILLION DOLLARS ($3,000,000) aggregate. Practitioner shall

authorize the carrier to issue to Health One certificate of insurance policies of Practitioner upon request of Health One. Notwithstanding the foregoing, Practitioner shall provide Health One with notification within three (3) days of any cancellation, termination or material alteration of any such insurance policies. Prior to the expiration or cancellation of any such coverage Practitioner shall secure replacement of such insurance coverage upon the same terms, and shall furnish Health One with a certificate of endorsement as described herein. Evidence of the effective policy reflecting such insurance shall be provided with the application.

MALPRACTICE

4.1 Details of any professional liability actions that have resulted in adverse judgments or any financial settlements.

4.2 Details of any pending professional liability actions.

This information shall be reviewed by Health One. The evaluation shall consider the frequency of such actions, the financial impact of such actions, and the clinical circumstances surrounding the alleged acts of malpractice. Practitioners shall not be automatically disqualified from participation in Health One due to a history of judgments and/or settlements. Each case will be evaluated based on its merits. Health One has sole discretion in the determination of the impact of this information for the purposes of credentialing.

ADMITTING PRIVILEGES

5. Practitioner has current and unrestricted admitting privileges or confirmation the Practitioner is able to deliver satisfactory professional services without hospital admitting privileges.

5.1 Provider shall confirm whether his or her application for clinical privileges or medical staff membership, including a change in staff category at any hospital or healthcare facility has ever been reduced, limited, suspended, terminated or have been placed on probation or restriction or whether he or she has ever resigned to avoid disciplinary action, or investigation or whether any related actions or investigations are pending. Provider shall submit any applicable information regarding the same for review and consideration.

PEER REFERENCES

6. Practitioner shall provide the name, address, phone, fax and email address of three professional peers who can provide reliable information based on significant personal experience as to clinical ability, ethical character and ability to work with others.

CALL COVERAGE

7. In order to assure continuous and quality care to patients, Participating Practitioner in the Health One Network shall provide coverage consistent with the guidelines set forth below for times when they are absent from their medical practice. Notwithstanding the below, it is in Health One's sole and absolute discretion, based on its assessment of the coverage proposal considering patient needs and quality and risk management standards, to approve or disapprove such alternative coverage requests.

   7.1 Practitioner must have made arrangements to allow patients and other practitioners to contact Practitioner (or covering provider) 24 hours a day, 7 days a week. Automatic referrals to the emergency department shall not satisfy the call coverage obligations of a Participating Practitioner.

   7.2 To ensure continuity of patient care, Practitioner must have made arrangements with a practitioner, group, or vendor to provide call coverage on a 24 hour a day, and 7 days a week basis to respond to all calls in a prompt manner.

   7.3 Call Coverage must be provided by a licensed practitioner who is capable of providing services of an urgent or emergency nature which the Practitioner being covered would typically provide for patients in his/her practice. The covering practitioner must bill for services rendered by the call covering practitioner through his/her own Tax ID through a bona-fide locums tenens arrangement when the Participating Practitioner is unavailable

   7.4 If a Practitioner cannot secure coverage from a practitioner, group or vendor and the Practitioner practices in a Rural Area, as defined herein, the Practitioner must submit a request in writing to Health One outlining how they provide the appropriate level of care to their patients or for a hardship waiver of the coverage requirements. *Rural Area* means an area that is not an Urban Area as defined A Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget, excluding Whitfield and Murray Counties, Georgia. Health One will consider all such exception requests in a timely manner. In addition, depending upon the patient needs to access healthcare services in the Rural Area, Health One may grant an exception to ensure access to healthcare services for the beneficiaries that receive care from HealthOne Participating Practitioner.

   7.5 Failure by a Practitioner to comply strictly with this policy will result in a written warning being issued to the offending Practitioner by Health One wherein the Participating Practitioner shall have ten (10) days to provide a written plan to cure the deficiency. If Practitioner fails to cure the deficiency within thirty (30) days or a time period that is deemed reasonable by Health One, upon submission of the written plan to cure the deficiency, Practitioner shall fail to maintain qualifications to be eligible as a Participating Practitioner and such participation shall automatically terminate and be deemed voluntarily withdrawn.

   7.6 Decisions on Practitioner participation with the Health One Network or termination of a Participation Agreement based on this Call Coverage Policy involve the business objectives of Health One and not matters of professional competence. Failure to

obtain and maintain call coverage will be deemed a voluntary withdrawal from the Health One Network for failure to satisfy the qualification criteria, and therefore, no rights of appeal or national databank reports will be applicable to such decisions.

DISCLOSURE

8. Provider shall confirm the following information and provide the necessary documentation and information to enable the Credentials Committee to fully evaluate the Provider's qualifications to participate in the HealthOne Network. Based on its assessment of the Provider's credentialing information and other facts and circumstances provided through the credentialing process, Health One will consider any and all data, information and circumstances, including any unique factors, related to providers credentialing application to approve or disapprove network participation.

   8.1 Provider shall confirm whether he or she has been the subject of an investigation or Adverse Action and provide any applicable documentation regarding same. "Adverse Action" means a voluntary or involuntary termination, loss of, reduction, withdrawal, limitation, restriction, suspension, revocation, denial or non-renewal of membership, clinical privileges, academic affiliation or appointment, or employment, including any adverse action regarding professional licensure registration, certification, any previously successful or currently pending challenges to such licensure registration or certification.

   8.2 Provider shall confirm whether he or she has been the subject of any report to a state or federal data bank, state licensing or disciplining entity and provide any applicable documentation regarding same.

   8.3 Provider shall confirm whether he or she has ever been suspended, debarred, fined, disciplined, sanctioned or otherwise restricted or excluded from participating in the Medicare or Medicaid program, or any federal, state or private health insurance program.

   8.4 Practitioner shall confirm whether he/she has ever been convicted of a felony or been convicted of Medicare, Medicaid or other governmental or private third-party payor fraud or program abuse or have been required to pay civil penalties for the same.

   8.5 Provider shall confirm whether he or she has ever been or is currently subject to being arrested, charged, convicted of or entered a plea for a criminal offense (excluding minor traffic violations), subject to criminal charges involving children, a sexual offense, illegal use of drugs or a crime of moral turpitude.

   8.6 Provider shall confirm whether he or she has received an adverse quality determination concerning his or her treatment of a patient by a state or federal professional review organization.

9. Practitioner is in good general health.

9.1 Practitioner shall certify on the Application that Practitioner does not have a history of and is not presently abusing drugs or alcohol. A Practitioner with a history of drug or alcohol abuse may be considered for participation in the Health One Network, within the sole and absolute discretion of Health One. In Health One's sole and absolute discretion, Health One may request a Practitioner's personal physician to provide a statement regarding the medical/mental status of the Practitioner and his or her compliance with a rehabilitation, or monitoring program. Practitioner shall execute the necessary authorizations to release the pertinent information to Health One for credentialing purposes.

9.2 Practitioner shall certify on the Application that Practitioner does not have any communicable and/or chronic infectious diseases that may be a potential danger to patients.

NONDISCRIMINATION

10. Practitioner shall pursue and maintain a policy of nondiscrimination. All decisions regarding the treatment of patients should be made without being influenced in any manner by applicant's race, ethnic/national identity, gender, age or sexual orientation.

11. Health One pursues and maintains a policy of nondiscrimination with all practitioners and applicants for panel membership. All decisions regarding panel membership are made without being influenced in any manner by applicant's race, ethnic/national identity, gender, age or sexual orientation.

AUDITS

12. Practitioner shall permit Health One to conduct regular and random on-site audits of his/her practice location, including a review of medical records pertaining to Health One related beneficiaries. Practitioner shall also provide any and all requested documentation to Health One related to the operations of the practice, credentialing materials and response to the audit findings within ten (10) business days upon receipt of the request. Failure to comply with the audits may result in termination or voluntary withdrawal from participation in the Health One Network.

CONTRACT

13. Practitioner shall execute the Health One Practitioner Participation Agreement and abide by the terms of the contract and the full credentialing criteria of Health One.

RELEASE OF INFORMATION

14. Practitioner shall execute the appropriate release to Health One and its agents directing any and all entities that may have information with respect to the ability to practice quality medicine to provide such information to Health One on request. Such entities

include, without limitation, hospitals, medical societies, state examining boards, Medicare intermediaries and other third-party payers.

14.1. Practitioner is required to attest via a unique and identifiable electronic or written signature that all the information submitted is accurate. Provider is further required to authorize Health One to obtain the necessary information from third-parties to complete the credentialing and verification process sufficient to support the credentialing and quality assurance procedures of Health One. Signatures may be electronic in conformance with State law or written original signed copies submitted in paper form.

14.2. Health One Representatives are authorized by the Credentials Committee to request additional information from the Practitioner and notify them that the application will not be processed unless an accurate and complete application is received within a timely manner. A new application with newly executed releases and attestation statements will be required in order to process the application. Health One reserves the right to act upon any such findings during the credentialing process. Absence, falsification, or material omission of information requested in the application may be grounds for denial or voluntary withdrawal.

Practitioner has the right to review information submitted to support their credentialing, correct erroneous information, receive the status of their credentialing or recredentialing application, upon request. Health One will respond to a Practitioner's request via phone, fax, letter or email.

VERIFICATION

15. Health One, and its agents, reserves the right to require independent verification of any and all of the Credentialing Criteria.

CHANGES IN INFORMATION NOTIFICATION

16. Practitioner shall be solely responsible for notifying Health One in writing of any changes in the Practitioner's circumstances within three (3) days upon the date of the change in circumstances, including, but not limited to changes in license status, insurance coverage, call coverage, sanctions or changes that would cause any of the information referenced above or submitted through the application to no longer be accurate.

COMPLIANCE

17. Practitioner shall comply with any and all Health One policies and procedures related to the operations and Practitioner participation.

Health One
Initial and Recredentialing Criteria

Organizational Providers

In order to be considered a Participating Organizational Provider, Provider must establish compliance with the following qualification requirements and responsibilities, as required by Health One and Health One's Credentials Committee. Failure to comply with or satisfy the Health One Network qualification criteria outlined below may result in the Practitioner's voluntary relinquishment, withdrawal or termination from participation in the Health One Network.

ACCREDITATION

1. Provider must attain Accreditation in accordance with one of the Health One approved Accrediting Bodies as appropriate for their provider type.

LICENSE

2. Provider must hold a current, valid and unrestricted facility license or facility permit as appropriate for the State of Georgia and/or any other state where licensed unless the facility relinquished the license in another state in good standing without any adverse action or being subject to review or investigation. Providers must hold a current, valid and unrestricted facility license in the State of Georgia in order to dispense or provide any clinical services to Georgia residents, unless the State of Georgia does not maintain a license or certification requirement for the provider type.

DEA

3. Provider must hold a current, valid and unrestricted Drug Enforcement Agency (DEA) registration, as appropriate in the State of Georgia and/or any other state in which they actively render services, or provide evidence satisfactory to Health One that the Provider does not require such registration in order to deliver appropriate care.

INSURANCE

4. Provider shall purchase and maintain, at the sole cost and expense of Provider, policies of professional and/or general liability in amounts required by Health One. The current minimum amounts set forth by Health One are ONE MILLION DOLLARS ($1,000,000) per occurrence/THREE MILLION DOLLARS ($3,000,000) aggregate. Provider shall authorize the carrier to issue to Health One certificate of insurance policies of Provider upon request of Health One. Notwithstanding the foregoing, Provider shall provide Health One with notification within three (3) days of any cancellation, termination or material alteration of any such insurance policies. Prior to the expiration or cancellation of any such coverage Provider shall secure replacement of such insurance coverage upon the same terms, and shall furnish Health One with a certificate of endorsement as described herein. Evidence of the effective policy reflecting such insurance shall be provided with the application.

MALPRACTICE

4.1 Details of any professional and/or general liability actions that have resulted in adverse judgments or any financial settlements.

4.2 Details of any pending professional and/or general liability actions.

This information shall be reviewed by Health One. The evaluation shall consider the frequency of such actions, the financial impact of such actions, and the clinical circumstances surrounding the alleged acts of malpractice. Providers shall not be automatically disqualified from participation in Health One due to a history of judgments and/or settlements. Each case will be evaluated based on its merits. Health One has sole discretion in the determination of the impact of this information for the purposes of credentialing.

DISCLOSURE

5. Provider shall confirm the following information and provide the necessary documentation and information to enable the Credentials Committee to fully evaluate the Provider's qualifications to participate in the HealthOne Network:

5.1 Provider shall confirm if anyone in the Provider's staff has been the subject of any report to a state or federal data bank, state licensing or disciplining entity and provide any applicable documentation regarding same.

5.2 Provider shall confirm whether Provider or its authorized representatives has ever been suspended, debarred, fined, disciplined, sanctioned or otherwise restricted or excluded from participating in the Medicare or Medicaid program, or any federal, state or private health insurance program.

5.3 Provider or its authorized representatives have not been convicted of a felony or been convicted of Medicare, Medicaid or other governmental or private third party payor fraud or program abuse or have been required to pay civil penalties for the same.

5.4 Provider shall confirm whether criminal proceedings have ever been initiated against the Providers or its authorized representatives.

5.5 Provider or its authorized representatives shall confirm whether any adverse quality determination concerning Provider treatment of a patient by a state or federal professional review organization.

6. Practitioner is in good general health.

6.1 Practitioner shall certify on the Application that Practitioner does not have a history of and is not presently abusing drugs or alcohol. A Practitioner with a history of drug or alcohol abuse may be considered for participation in the Health One

Network, within the sole and absolute discretion of Health One. In Health One's sole and absolute discretion, Health One may request a Practitioner's personal physician to provide a statement regarding the medical/mental status of the Practitioner and his or her compliance with a rehabilitation, or monitoring program. Practitioner shall execute the necessary authorizations to release the pertinent information to Health One for credentialing purposes.

6.2 Practitioner shall certify on the Application that Practitioner does not have any communicable and/or chronic infectious diseases that may be a potential danger to patients.

NONDISCRIMINATION

7. Provider shall pursue and maintain a policy of nondiscrimination. All decisions regarding the treatment of patients should be made without being influenced in any manner by applicant's race, ethnic/national identity, gender, age or sexual orientation.

8. Health One pursues and maintains a policy of nondiscrimination with all providers and applicants for panel membership. All decisions regarding panel membership are made without being influenced in any manner by applicant's race, ethnic/national identity, gender, age or sexual orientation.

AUDITS

9. Provider shall permit Health One to conduct regular and random on-site audits, including a review of medical records pertaining to Health One related beneficiaries. Provider shall also provide any and all requested documentation to Health One related to the operations of the practice, credentialing materials and response to the audit findings within ten (10) business days upon receipt of the request. Failure to comply with the audits may result in termination or voluntary withdrawal from participation in the Health One Network.

CONTRACT

10. Provider shall execute the Health One Provider Participation Agreement and abide by the terms of the contract and the full credentialing criteria of Health One.

RELEASE OF INFORMATION

11. Provider shall execute the appropriate release to Health One and its agents directing any and all entities that may have information with respect to the ability to practice quality medicine to provide such information to Health One on request. Such entities include, without limitation, hospitals, medical societies, state examining boards, Medicare intermediaries and other third party payers.

11.1 Provider is required to attest via a unique and identifiable electronic or written signature that all of the information submitted is accurate. Provider is further required to authorize Health One to obtain the necessary information from third-

parties to complete the credentialing and verification process sufficient to support the credentialing and quality assurance procedures of Health One. Signatures may be electronic in conformance with State law or written original signed copies submitted in paper form.

11.2 Health One Representatives are authorized by the Credentials Committee to request additional information from the Provider and notify them that the application will not be processed unless an accurate and complete application is received within a timely manner. A new application with newly executed releases and attestation statements will be required in order to process the application. Health One reserves the right to act upon any such findings during the credentialing process. Absence, falsification, or material omission of information requested in the application may be grounds for denial or voluntary withdrawal.

Provider has the right to review information submitted to support their credentialing, correct erroneous information, receive the status of their credentialing or recredentialing application, upon request. Health One will respond to a Provider's request via phone, fax, letter or email.

VERIFICATION

12. Health One, and its agents, reserves the right to require independent verification of any and all of the Credentialing Criteria.

CHANGES IN INFORMATION NOTIFICATION

13. Provider shall be solely responsible for notifying Health One in writing of any changes in the Provider's circumstances within three (3) days upon the date of the change in circumstances, including, but not limited to changes in facility license/permit status, DEA certificate, insurance coverage, sanctions or changes that would cause any of the information referenced above or submitted through the application to no longer be accurate.

COMPLIANCE

14. Provider shall comply with any and all Health One policies and procedures related to the operations and Provider participation.

Health One
Initial and Recredentialing Criteria

Attachment 1
Federally Qualified Health Centers

In order to be considered a Participating Federally Qualified Health Center Provider (FQHC), as an essential community provider, Provider must notify Health One of their FQHC status and verify compliance with the following qualification requirements and responsibilities, as required by Health One and Health One's Credentials Committee. Failure to comply with or satisfy the Health One Network qualification criteria outlined below may result in the Practitioner's voluntary relinquishment, withdrawal or termination from participation in the Health One Network.

REGULATORY REQUIREMENTS

1. Provider must maintain a written agreement with the Centers for Medicare and Medicaid Services (CMS) to serve as an FQHC.

2. Provider must receive a grant under §330 of the Public Health Service (PHS) Act; or receives funding under a contract with the recipient of a §330 grant, and meets the requirements to receive a grant under §330 of the PHS Act; or (a) has been notified in writing that the facility meets the requirements for receiving a §330 grant, even though it is not actually receiving such a grant; or (b) was a comprehensive federally funded health center as of January 1, 1990; or (c) is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an Urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act.

3. FQHC shall provider written evidence that it satisfied the two qualification criteria described above.

Health One
Initial and Recredentialing Criteria

Attachment 2
Hospital Based Rural Health Clinics

In order to be considered a Participating Hospital Based Rural Health Clinic (RHC), as an essential community provider, Provider must notify Health One of their RHC status and verify compliance with the following qualification requirements and responsibilities, as required by Health One and Health One's Credentials Committee. Failure to comply with or satisfy the Health One Network qualification criteria outlined below may result in the Practitioner's voluntary relinquishment, withdrawal or termination from participation in the Health One Network.

REGULATORY REQUIREMENTS

1. Provider must maintain a written agreement with the Centers for Medicare and Medicaid Services (CMS) to serve as a hospital based RHC (hospital based RHCs are owned and operated as an essential part of a hospital participating in the Medicare program. RHCs operate under the licensure, governance and professional supervision of that organization).

2. Provider must meet the statute requirements for RHCs in section 1861 (aa) of the Social Security Act and the clinic must be located in a non-urbanized area as determined by the U.S. Census Bureau, and in an area designated or certified within the previous 4 years by the Secretary, Health and Human Services (HHC), in any one of the 4 types of shortage area designations that are accepted for RHC certification.

    a. Primary Care Geographic Health Professional Shortage Area (HPSA) under Section 332(a)(1)(A) of the Public Health Service (PHS) Act
    b. Primary Care Population-Group HPSA under Section 332(a)(1)(B) of the PHS Act
    c. Medically Underserved Area under Section 330(b)(3) of the PHS Act
    d. Governor-designated and Secretary-certified shortage area under Section 6213(c) of the Omnibus Budget Reconciliation Act (OBRA) of 1989

3. RHCs may provide both primary and preventive services with the goal of improving health access in rural areas.

4. RHCs must be staffed by at least 50% of the time by midlevel practitioners (such as nurse practitioners (NPs) and physician assistants (PAs))

5. RHC shall provide written evidence that it satisfied the four qualification criteria described above.

6. Hospital based RHCs must comply with the Organizational Provider Credentialing Criteria.

Exhibit E

Pharmacy Formulary and Prior Authorization Analysis 2023

Formulary Formation

The Magellan Pharmacy and Therapeutic (P&T) committees made up of licensed physicians and pharmacists establish the NQTLs used by the Magellan PBM. When Magellan assigns drugs to tiers, sets step therapy requirements, and when Magellan establishes utilization management requirements for the formulary, the same factors are used to assign the drugs without any regard for whether a drug is generally prescribed for medical/surgical conditions or for mental health or substance use disorder conditions.

All FDA approved medications for mental health and substance use disorders and for medical surgical conditions are reviewed with the same factors and decision-making process before final formulary status and criteria are determined. Clinical factors are considered first and then financial factors through separate committees. Any new drugs that are approved go through a clinical committee, a financial committee and the P&T committee makes the final approval.

Evidentiary standards reviewed include evidence-based safety and efficacy data from the FDA approved package insert, peer-reviewed medical literature, nationally accepted treatment guidelines, and patient considerations. Evidentiary standards for the cost factors include net cost, utilization trends, and cost effectiveness of clinically similar medications. The evidentiary standards for each drug are reassessed regularly to ensure that the formulary management is consistent with the latest information.

As Cited in the P&T Committee Charter, the committee members make recommendations for the formulary based on, but not limited to, the following:

i. Evaluation and recommendations of nationally recognized and/or respected associations, advisory committees and professional/specialty practice groups including, but not limited to:
   - Food and Drug Administration (FDA);
   - Advisory Committee of Immunization Practices (ACIP);
   - Centers for Disease Control (CDC);
   - American College of Rheumatology (ACR);
   - American Academy of Pediatrics (AAP);
   - National Institute of Health (NIH);
   - American Diabetes Association (ADA);
   - National Cholesterol Education program (NCEP);
   - Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC); and
   - United States Department of Health and Human Services (US DHHS).
     - Which includes Substance Abuse and Mental Health Services Administration (SAMHSA)

Pill limits can be restricted based on clinical criteria. For example, our behavioral health medications are based on FDA recommended limitations. While some of our opioid medications (which don't have FDA max doses) have quantitative limits. These limits can be overridden for medical necessity if an individual's clinical situation warrants this. This same process applies to medications used to treat both medical/surgical and mental health and substance use disorder conditions.

There are no differences in the percentage of FDA approved drugs on the PDL for behavioral and medical conditions. Our position is to offer a vast number of medication options for providers to choose from that are based on evidence-based medicine.

Safety and evidence-based medicine are among the primary factors we consider when determining off label coverage. Off label coverage will generally require prior authorization to determine the need and allow our team to research any studies to validate effectiveness. The procedure is the same for medical/surgical and mental health and substance use disorder medications.

Brand names with no generics available are approved in the same manner for both medical/surgical and mental health and substance use disorder medications. These approvals are made on a preferred or non-preferred basis. The majority of preferred drugs are on the PDL and will generally adjudicate with no additional review. There are no extra steps for a member to go through for situations where there is a brand name medication with no generic or where brand names are preferred by the state.

If a medication is non-preferred, it can still be obtained, however it will require a prior authorization or medical exception review. The process is the same for both medical/surgical and mental health and substance use disorder medications.

The plan considers and encourages generic substitutions. Generic substitutions are handled the same for both medical/surgical and mental health and substance use disorder medications.

Our only restriction on pharmacy providers is the requirement that they must be in network. Our PBM has a credentialing process that evaluates pharmacies and makes a determination on them having the necessary requirements to join our network.

Formulary Analysis by Tier

Alliant's formulary covers approximately 44,741 individual NDCs. This translates to approximately 4,086 individual brand[1] names, or 2505 unique active ingredients[2]. For this analysis, brand name generally means grouping the label names together irrespective of dosage form and strength. For example, the escitalopram oxalate brand name groups the 5 mg, 10 mg, 20 mg and 5 mg / 5 ml solution. Note that the source brand (ex: Lexapro) would be counted separately. FDB HSN was utilized to estimate the unique active ingredient.

Analysis by Brand Name: Behavioral health (BH) medications account for 3.84% of the brand names. 24.84% of BH brand names require a prior authorization (PA) or step therapy (ST) for coverage, compared to 24.66% of non-BH medications that require either PA or ST. 24.69% of the overall combined formulary requires either PA or ST.

Analysis by NDC: Behavioral health (BH) medications account for 10.52% of the formulary NDCs covered. 7.50% of BH NDCs require a prior authorization (PA) or step therapy (ST) for coverage, compared to 13.69% of non-BH medications that require either PA or ST. 13.04% of the overall combined formulary NDC requires either PA or ST.

Analysis by HSN: Behavioral health (BH) medications account for 3.95% of the formulary HSNs covered. 30.30% of BH HSNs require a prior authorization (PA) or step therapy (ST) for coverage, compared to 30.64% of non-BH medications that require either PA or ST. 30.66% of the overall combined formulary requires either PA or ST.

Type	Distinct Count of BRAND NAME	%	Distinct Count of NDC	%	Distinct Count of FDB HSN	%
BH	**157**	**3.84%**	**4707**	**10.52 %**	**99**	**3.95%**
No PA or ST Applies	**120**	**76.43 %**	**4354**	**92.50 %**	**79**	**79.80 %**
1 | Generics	91	75.83%	4265	97.96%	72	91.14%
2 | Preferred Brands	2	1.67%	2	0.05%	1	1.27%
3 | Non-Preferred Brands	28	23.33%	87	2.00%	25	31.65%
PA or ST Applies	**39**	**24.84 %**	**353**	**7.50%**	**30**	**30.30 %**
1 | Generics	7	17.95%	188	53.26%	6	20.00%
2 | Preferred Brands	1	2.56%	6	1.70%	1	3.33%
3 | Non-Preferred Brands	27	69.23%	146	41.36%	22	73.33%
4 | Specialty	4	10.26%	13	3.68%	4	13.33%
NON-BH	**3934**	**96.28 %**	**40034**	**89.48 %**	**2415**	**96.41 %**
No PA or ST Applies	**2988**	**75.95 %**	**34554**	**86.31 %**	**1776**	**73.54 %**
1 | Generics	1338	44.78%	27334	79.11%	994	55.97%
2 | Preferred Brands	523	17.50%	2886	8.35%	169	9.52%
3 | Non-Preferred Brands	920	30.79%	2437	7.05%	788	44.37%
4 | Specialty	245	8.20%	1897	5.49%	177	9.97%
PA or ST Applies	**970**	**24.66 %**	**5480**	**13.69 %**	**740**	**30.64 %**
1 | Generics	55	5.67%	780	14.23%	50	6.76%
2 | Preferred Brands	42	4.33%	180	3.28%	35	4.73%
3 | Non-Preferred Brands	152	15.67%	454	8.28%	138	18.65%
4 | Specialty	725	74.74%	4066	74.20%	548	74.05%
Grand Total	**4086**	**100.00 %**	**44741**	**100.00 %**	**2505**	**100.00 %**

Type	Distinct Count of BRAND NAME	%	Distinct Count of NDC	%	Distinct Count of FDB HSN	%
No PA or ST Applies	3104	75.97%	38908	86.96%	1850	73.85%
PA or ST Applies	1009	24.69%	5833	13.04%	768	30.66%
Grand Total	**4086**	**100.00%**	**44741**	**100.00%**	**2505**	**100.00%**

Prior Authorization Analysis

The approval rate of behavioral health meds (62.29%) is higher than the overall (60.99%) and non-behavioral health (60.95%) approval rate.

Analysis limitations:
-Unable to determine if a request was considered as concurrent renewal
-If a Prior Authorization request for a BH health medication was for a non-BH indication or vice versa.

DATA:

Overall Formulary approval rate of 60.99%

- Behavioral Health Drugs approval rate of 62.29%
- Behavioral Health Drugs denials:
    - Approximately 25% of BH denials are for non-formulary products with a formulary alternative. Ex: branded Lexapro (plan covers generic), or the tablet form of venlafaxine (plan covers the capsule).
    - Approximately 63% of BH denials are for drugs for which there are step therapy or prior authorization protocols, and member did not meet criteria.
    - The remaining 12% is a mix of quantity limit exceptions requests, usually where the request is for a dose above the recommended labeled dosing and/or requesting split dosing where a higher strength is available (ex: Vyvanse 30mg BID instead of Vyvanse 60mg QD), and cost reduction requests.
- Non-Behavioral Health Drugs approval rate of 60.95%

Disposition	BH	%	NON-BH	%	Total	Total %
Approved	327	62.29%	10316	60.95%	10643	60.99%
Denied	198	37.71%	6609	39.05%	6807	39.01%
Grand Total	525	100.00%	16925	100.00%	17450	100.00%

Additional Comments on Analysis

- All 4 covered specialty medications considered BH-Drugs require a prior authorization due to a combination of route of administration, limited distribution network, coordination of coverage under medical and pharmacy benefit, and cost.
    - NUPLAZID
    - SPRAVATO
    - SUBLOCADE
    - VIVITROL
- The reason for some of the difference in percentages is due in part to the size of the denominator (BH vs non-BH) and that many of the products in this category are different formulations of the same active ingredient that have different durations of action, ex: Abilify (tablets), Abilify Mycite, Abilify Maintena.

Analysis Methodology:

Used the following formulary drug categories to identify NDCs in scope.

Behavioral/Mental Health: STC = 7 and 11

Opioid Use Disorder: HIC3 = H3W, H3T, and HSN = 001745

Substance Use Disorder: HIC3 =J3A, H3T, H7N, J3C, C0D, and HSN = 000113

[1] Brand name = This groups drugs by strength and label name. Example: all generic atorvastatin strengths are rolled up and counted as 1. Brand and generic are counted separately as they do not share the same brand name.

[2] Unique active ingredient is estimated using FDB HSN

Exhibit F

Network Access/Adequacy Comparative Analysis 2023

Introduction

Health One Alliance and Alliant Health Plans (HOA/AHP) provide coverage and cost share advantages for members choosing to access care from in-network providers. This is true across all benefit categories. To ensure members can appropriately access care, including mental health care, HOA/AHP employs a multitude of network evaluation mechanisms. Based on the continual feedback of ongoing network evaluations, improvement measures are taken, and exception processes are permitted.

Methods of Evaluation

HOA/AHP use the following evaluation tools to make best efforts to meet or exceed CMS QHP Network Adequacy standards:

Evaluation Method	Description
External Constituent Feedback	HOA/AHP collect provider referrals from Client Services call feedback, Medical Management provider requests, Broker requests, and complaint data. Using the referrals, we identify and recruit additional providers to fill gaps and increase network saturation.
Out-of-Network Utilization and Limited Treatment Agreement (LTA) requests	HOA/AHP review claims data from out-of-network utilization to identify potential providers for recruitment. Additionally, if an LTA is requested or granted, we work towards a full agreement to ensure network access to that provider for other members as well.
Geo Access Reporting	Every effort is made to report annually, HOA/AHP assess the network in comparison to census data to determine network saturation.
Quest Analytics	HOA/AHP have contracted with Quest Analytics to gain access to the Quest Enterprise Services tool which provides continual access to data summaries, adequacy analyses, impact analyses, opportunity analyses and exception packages.
State and Federal Regulations	HOA/AHP complies with state and federal regulations regarding network maintenance and adequacy.
CAHPS and QHP Survey Data	HOA/AHP conducts CAHPS and QHP surveys no less than annually in order to garner feedback from members on network adequacy.

Evaluation Results

Examples of evaluation results are provided below.

Evaluation Method: External Constituent Feedback

Client Services Call Feedback	Client Services Representatives are armed with an internal provider search function to help callers find the types of providers needed. In the event a member is unable to find a provider or get an appointment and the CSR cannot find resolution, the CSR reaches out to the Provider Relations team for assistance. The PR team then uses their resources and relationships, both internal and external, to collaborate and find the appropriate provider, making the

	recommendation for an appointment, provider outreach and/or provider recruitment.
Medical Management Provider Requests	Provider Relations Representatives receive requests for provider recruitment from Medical Management through various avenues. Medical Management may identify needs and request provider recruitment during collaboration with Provider Relations in reoccurring Focused Case Review meetings and through the Limited Treatment Agreement process. Medical Management also sends emails to Provider Relations with requests for provider recruitment when needs are identified during day-to-day Case Management and Utilization Management tasks. Additionally, Provider Relations regularly monitors a Medical Management SharePoint list of providers Medical Management needs to add to PR recruitment efforts.
Broker Provider Requests	Provider Relations Representatives receive requests for provider recruitment from the Business Development team's communication with Brokers. Brokers may identify needs through member/client interaction and request provider recruitment to satisfy the identified need.

Complaint Data	During 2023, AHP received a total of 9 complaints regarding Access to care, **none** of which were regarding Access to behavioral health treatment. Our Performance Goal is <2 per 1,000 members. The number of complaints is well within the acceptable performance range. The tables below encompass both Med/Surg and MH/SUD complaint data. Population used: 42,303 Exchange members, 10,746 Commercial.

Complaint Category-Commercial LOB	2023	
	#	Per 1000
Billing & Financial	4	.37
Attitude & Service	6	.59
Access	3	.28
Quality of Practitioner Office Site	0	-
Quality of Care	0	-
Total	13	1.2

Complaint Category-Exchange LOB	2023	
	#	Per 1000
Billing & Financial	22	.52
Attitude & Service	28	.66
Access	6	.14
Quality of Practitioner Office Site	0	-
Quality of Care	5	.12
Total	61	1.44

For 2023, the commercial LOB received only one (1) behavioral health complaint categorized as Quality of Care from a member who had difficulty with a MH/SUD provider. The investigation into the allegation concluded no Quality of Care issue occurred.

Alliant will continue to monitor the recording of complaints in the claims system to ensure behavioral health complaints are identified appropriately.

Evaluation Method: Out-of-Network Utilization and Limited Treatment Agreement (LTA) requests

<table>
<tr><td>OON Utilization</td><td>Alliant analyzed 2023 claims data:

<table>
<tr><th>Med/Surg OON claims</th><th>MH/SUD OON Claims</th></tr>
<tr><td>4,132</td><td>776</td></tr>
<tr><td>77.9 per 1000 members</td><td>14.6 per 1000 members</td></tr>
</table>

While Alliant has OON benefits under its PPO option, the deductible is prohibitive ($20,000 Ind./$40,000 Fam.) and there is no Maximum Out of Pocket Limit. Utilization per 1000 members for Med/Surg of 77.9 represents primarily Emergency services and Ancillary services that fall under the No Surprises regulations. Out of Network utilization for MH/SUD services is significantly less at just under 19% of the number of Med/Surg per 1000 measure. Population used: 42,303 Exchange members, 10,746 Commercial, totaling 53,049.</td></tr>
<tr><td>LTA Requests</td><td>Members may request out-of-network care due to geographic location and availability of specific specialty care. A total of 95 LTAs were granted, 77 within the state of Georgia, 18 in another state. Analysis of LTAs for 2023:

<table>
<tr><th>Service</th><th colspan="2">Georgia</th><th colspan="2">All other states</th></tr>
<tr><td>Med/Surg Total</td><td>55</td><td>71% of Total</td><td>15</td><td>83% of Total</td></tr>
<tr><td>Dialysis</td><td>7</td><td>13%</td><td>0</td><td>-</td></tr>
<tr><td>Home Health/Hospice</td><td>6</td><td>11%</td><td>0</td><td>-</td></tr>
<tr><td>Surgical IP/OP</td><td>16</td><td>29%</td><td>5</td><td>33%</td></tr>
<tr><td>DME</td><td>3</td><td>6%</td><td>4</td><td>27%</td></tr>
<tr><td>PT/OT</td><td>4</td><td>7%</td><td>0</td><td>-</td></tr>
<tr><td>Other OP/Visit</td><td>19</td><td>34%</td><td>6</td><td>40%</td></tr>
<tr><td>MH/SUD Total</td><td>22</td><td>29% of Total</td><td>3</td><td>17% of Total</td></tr>
<tr><td>Inpatient</td><td>9</td><td>41%</td><td>0</td><td>-</td></tr>
<tr><td>Outpatient/Visit</td><td>13</td><td>59%</td><td>3</td><td>100%</td></tr>
<tr><td>Other</td><td>-</td><td></td><td>0</td><td>-</td></tr>
</table>
The majority of Med/Surg services requiring an LTA within Georgia were for services received in the southern part of state where Alliant has a less robust network of providers. The LTA process is an avenue to enter into long term contracts for both Med/Surg and MH/SUD services when we identify network access issues for certain services. By far the MH/SUD services in Georgia were also in the southern part of the state (rural areas) with the majority being outpatient or partial hospitalization treatment for behavioral care where available providers are sparse. Acute care/inpatient services for MH/SUD was higher than Med/Surg as we included OP Surgery in the Med/Surg numbers to reflect acute or high level needs.

Med/Surg services via LTAs outside of Georgia were primarily acute or high needs for Outpatient care or DME. Most services were from providers directly adjacent to</td></tr>
</table>

	Alliant's service area in Tennessee, North Carolina, and Florida. The MH/SUD LTA providers were primarily at specialty Outpatient locations for acute behavioral care.

Evaluation Method: Geo Access Reporting

HOA/AHP contracts with Quest Analytics to evaluate geographical access to healthcare providers based on census data. Each county in our service area is evaluated for an extensive selection of provider specialties, including behavioral medicine providers. In the 2023 analysis all required facility and specialty provider types were evaluated for Access and Density to meet adequacy guidelines based on time, distance, member/provider ratio. Our network met most standards in all counties. Alliant uses the QHP-CCIIO adequacy standards since over 90% of our membership is in the Individual market, mostly on the Exchange.

QHP - Alliant GA

Network Assessment

Network: QHP

Template: CCIIO QHP 2024 Time And Distance

Census: National Proxy Census (2022.4)

View Cloud Results

Current Service Area

County				Pass Percentages		Gaps		Access			Membership Risk
State Name	County Display	County Class	Membership Count	% Pass Both	% Pass by Exception	Total	Fillable	Met	Not Met	Index	#
Georgia	11010 - Atkinson	Rural	189	97.7	0	1	1	43	1	99	---
Georgia	11020 - Baker	CEAC	260	100	0	0	0	44	0	100	---
Georgia	11030 - Baldwin	Micro	209	100	0	0	0	44	0	100	---
Georgia	11040 - Banks	Micro	119	97.7	0	1	1	43	1	99.2	---
Georgia	11050 - Barrow	Metro	566	100	0	0	0	44	0	100	---
Georgia	11070 - Ben Hill	Micro	198	100	0	0	0	44	0	100	---
Georgia	11080 - Berrien	Rural	110	100	0	0	0	44	0	100	---
Georgia	11090 - Bibb	Metro	768	100	0	0	0	44	0	100	---
Georgia	11100 - Bleckley	Micro	130	97.7	0	1	1	43	1	97.7	---
Georgia	11120 - Brooks	Rural	164	100	0	0	0	44	0	100	---
Georgia	11150 - Burke	Rural	244	00000000001	0	5	5	39	5	92.5	---
Georgia	11161 - Calhoun	Rural	192	100	0	0	0	44	0	100	---
Georgia	11190 - Carroll	Metro	697	90.9	0	4	2	40	4	94.9	---
Georgia	11200 - Catoosa	Metro	408	100	0	0	0	44	0	100	---
Georgia	11240 - Chattooga	Micro	147	97.7	0	1	0	43	1	97.7	---
Georgia	11260 - Clarke	Metro	600	97.7	0	1	1	43	1	97.7	---
Georgia	11270 - Clay	Rural	207	100	0	0	0	44	0	100	---
Georgia	11281 - Clinch	CEAC	289	100	0	0	0	44	0	100	---
Georgia	11291 - Coffee	Micro	245	95.5	0	2	2	42	2	95.5	---
Georgia	11300 - Colquitt	Micro	257	100	0	0	0	44	0	100	---
Georgia	11310 - Columbia	Metro	840	88.7	0	5	5	39	5	92.7	---
Georgia	11311 - Cook	Micro	101	95.5	0	2	2	42	2	96.5	---
Georgia	11330 - Crawford	Rural	148	100	0	0	0	44	0	100	---
Georgia	11340 - Crisp	Micro	230	100	0	0	0	44	0	100	---
Georgia	11341 - Dade	Micro	169	97.7	0	1	0	43	1	98.9	---
Georgia	11350 - Dawson	Micro	139	100	0	0	0	44	0	100	---
Georgia	11360 - Decatur	Rural	147	93.2	0	3	3	41	3	96.8	---
Georgia	11380 - Dodge	Rural	108	97.7	0	1	1	43	1	97.7	---
Georgia	11381 - Dooly	Rural	125	100	0	0	0	44	0	100	---

Georgia	11390 - Dougherty	Metro	447	100	0	0	0	44	0	100	---
Georgia	11410 - Early	Rural	107	88.6	0	5	5	39	5	94.4	---
Georgia	11420 - Echols	CEAC	387	100	0	0	0	44	0	100	---
Georgia	11430 - Elbert	Micro	109	93.2	0	3	2	41	3	95.9	---
Georgia	11440 - Emanuel	Rural	255	86.4	0	6	6	38	6	90.1	---
Georgia	11450 - Fannin	Micro	259	100	0	0	0	44	0	100	---
Georgia	11460 - Floyd	Metro	535	97.7	0	1	1	43	1	99.1	---
Georgia	11462 - Franklin	Micro	132	97.7	0	1	1	43	1	97.7	---
Georgia	11471 - Gilmer	Micro	172	100	0	0	0	44	0	100	---
Georgia	11480 - Glascock	Rural	140	95.5	0	2	2	42	2	95.5	---
Georgia	11500 - Gordon	Metro	366	95.5	0	2	1	42	2	97.9	---
Georgia	11510 - Grady	Micro	131	93.2	0	3	3	41	3	94.6	---
Georgia	11520 - Greene	Micro	159	95.5	0	2	2	42	2	96.7	---
Georgia	11540 - Habersham	Micro	268	100	0	0	0	44	0	100	---
Georgia	11550 - Hall	Metro	1186	97.7	0	1	1	43	1	99.2	---
Georgia	11560 - Hancock	Rural	285	97.7	0	1	1	43	1	99.1	---
Georgia	11570 - Haralson	Micro	182	95.5	0	2	1	42	2	98.1	---
Georgia	11581 - Hart	Micro	288	95.5	0	2	2	42	2	96.7	---
Georgia	11590 - Heard	Rural	152	100	0	0	0	44	0	100	---
Georgia	11600 - Houston	Metro	901	100	0	0	0	44	0	100	---
Georgia	11601 - Irwin	Rural	198	100	0	0	0	44	0	100	---
Georgia	11610 - Jackson	Metro	426	95.5	0	2	0	42	2	95.5	---
Georgia	11612 - Jeff Davis	Rural	184	90.9	0	4	4	40	4	90.9	---
Georgia	11620 - Jefferson	Rural	172	95.5	0	2	2	42	2	95.5	---
Georgia	11630 - Jenkins	Rural	170	00000000001	0	5	5	39	5	89.9	---
Georgia	11650 - Jones	Micro	160	100	0	0	0	44	0	100	---
Georgia	11651 - Lamar	Micro	105	97.7	0	1	1	43	1	97.7	---
Georgia	11652 - Lanier	Rural	133	100	0	0	0	44	0	100	---
Georgia	11670 - Lee	Micro	334	100	0	0	0	44	0	100	---
Georgia	11690 - Lincoln	Rural	162	93.2	0	3	2	41	3	93.2	---
Georgia	11700 - Lowndes	Metro	643	59.1	0	18	14	26	18	63.7	---
Georgia	11701 - Lumpkin	Micro	179	100	0	0	0	44	0	100	---
Georgia	11720 - Madison	Micro	163	97.7	0	1	1	43	1	98.9	---
Georgia	11730 - Marion	Rural	192	100	0	0	0	44	0	100	---
Georgia	11702 - McDuffie	Micro	117	93.2	0	3	2	41	3	94.4	---
Georgia	11741 - Miller	Rural	126	95.5	0	2	2	42	2	98.3	---
Georgia	11750 - Mitchell	Rural	114	100	0	0	0	44	0	100	---
Georgia	11760 - Monroe	Micro	129	97.7	0	1	1	43	1	97.7	---
Georgia	11771 - Morgan	Micro	210	95.5	0	2	2	42	2	96.5	---
Georgia	11772 - Murray	Micro	263	100	0	0	0	44	0	100	---
Georgia	11800 - Oconee	Micro	175	100	0	0	0	44	0	100	---
Georgia	11801 - Oglethorpe	Rural	179	100	0	0	0	44	0	100	---
Georgia	11811 - Peach	Micro	146	100	0	0	0	44	0	100	---
Georgia	11812 - Pickens	Micro	358	100	0	0	0	44	0	100	---
Georgia	11821 - Pike	Micro	108	95.5	0	2	2	42	2	96.5	---
Georgia	11830 - Polk	Micro	263	100	0	0	0	44	0	100	---
Georgia	11831 - Pulaski	Rural	194	100	0	0	0	44	0	100	---
Georgia	11832 - Putnam	Micro	118	100	0	0	0	44	0	100	---
Georgia	11834 - Rabun	Rural	174	100	0	0	0	44	0	100	---
Georgia	11835 - Randolph	Rural	126	97.7	0	1	1	43	1	97.7	---
Georgia	11840 - Richmond	Metro	1102	95.5	0	2	2	42	2	95.5	---
Georgia	11842 - Schley	Rural	126	100	0	0	0	44	0	100	---

Georgia	11851 - Seminole	Rural	173	86.4	0	6	6	38	6	90.4	---
Georgia	11861 - Stephens	Micro	152	100	0	0	0	44	0	100	---
Georgia	11870 - Sumter	Micro	149	100	0	0	0	44	0	100	---
Georgia	11881 - Taliaferro	CEAC	256	100	0	0	0	44	0	100	---
Georgia	11884 - Telfair	Rural	136	95.5	0	2	2	42	2	96.9	---
Georgia	11885 - Terrell	Rural	172	100	0	0	0	44	0	100	---
Georgia	11890 - Thomas	Micro	229	95.5	0	2	2	42	2	95.5	---
Georgia	11900 - Tift	Micro	230	100	0	0	0	44	0	100	---
Georgia	11902 - Towns	Micro	197	97.7	0	1	1	43	1	98.9	---
Georgia	11911 - Turner	Rural	158	100	0	0	0	44	0	100	---
Georgia	11912 - Twiggs	Rural	182	100	0	0	0	44	0	100	---
Georgia	11913 - Union	Micro	111	100	0	0	0	44	0	100	---
Georgia	11921 - Walker	Metro	416	90.9	0	4	2	40	4	94.9	---
Georgia	11930 - Walton	Metro	562	95.5	0	2	1	42	2	96.9	---
Georgia	11941 - Warren	Rural	111	95.5	0	2	1	42	2	95.5	---
Georgia	11950 - Washingtoı	Rural	204	97.7	0	1	1	43	1	97.7	---
Georgia	11962 - Wheeler	Rural	122	93.2	0	3	3	41	3	93.2	---
Georgia	11963 - White	Micro	171	100	0	0	0	44	0	100	---
Georgia	11970 - Whitfield	Metro	712	100	0	0	0	44	0	100	---
Georgia	11971 - Wilcox	Rural	152	100	0	0	0	44	0	100	---
Georgia	11972 - Wilkes	Rural	101	95.5	0	2	1	42	2	95.5	---
Georgia	11973 - Wilkinson	Rural	199	100	0	0	0	44	0	100	---
Georgia	11980 - Worth	Rural	112	100	0	0	0	44	0	100	---

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Since the study was completed, we have contracted with more available providers. We have several hospitals that actually provide Outpatient Infusion/Chemotherapy and Diagnostic Radiology services that are not recognized in the report since they are not stand-alone facilities. We believe in this case we meet the standard. Speech Therapy and Inpatient Psychiatric hospitals are not services widely available in rural areas and there is limited opportunity to contract. In fact, the majority of counties that fall below the standards in multiple Med/Surg and MH/SUD specialties are very rural with few if any providers to contract with.

We use the results of the analysis to inform recruitment efforts. Alliant executes new provider/group contracts each calendar/plan year. While we have not historically tracked the source for implementing a provider contract, source tracking began in early 2023 so that we can better quantify in the future.

Evaluation Method: State and Federal Regulations
HOA/AHP monitor state and federal regulations, such as adequacy requirements, to remain compliant and ensure members can easily access needed care. HOA/AHP recognizes and adheres to adequacy standards as defined under 45 CFR 156.230 for Qualified Health Plans. Working to adhere to applicable regulations informs recruitment priorities.

Evaluation Method: CAHPS and QHP Survey Data
Alliant contracts with SPH Analytics to conduct its Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.0H Commercial Adult Member Satisfaction Survey and its Qualified Health Plan (QHP) Enrollee Experience Survey. Both surveys specifically seek member feedback on getting needed care and getting care quickly. The results from 2023 are shown in the table below.

CAHPS Survey Results	Results Reported in 2023	Quality Compass Report	Goal Met?
In the last 12 months, how often did you get an appointment for regular or routine health care as soon as you wanted?	89.8%	85.1%	Yes
In the last 12 months, when you needed care right away for an illness or injury, how often did you get care as soon as you wanted?	92.2%	89.9%	Yes
In the last 12 months, how often did you get an appointment to see a specialist as soon as you needed?	84.9%	87.0%	No
In the last 12 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan?	87.7%	90.4%	No

QHP Survey Results	Results Reported in 2023	SPH BoB Scaled Mean Results	Goal Met?
In the last 12 months, how often did you get an appointment for regular or routine health care as soon as you wanted?	84.6%	74.3%	Yes
In the last 12 months, when you needed care right away for an illness or injury, how often did you get care as soon as you wanted?	81.8%	72.6%	Yes
In the last 12 months, how often did you get an appointment to see a specialist as soon as you needed?	75.6%	67.2%	Yes
In the last 12 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan?	81.7%	77.3%	Yes

*SPH BoB = SPH Analytics Book of Business

The survey results are shared with Client Services, Provider Relations, Contracting and Marketing in order to better inform our efforts in improving network access and member education.

Response to Evaluation Results

As a result of our ongoing network evaluations, HOA/AHP have also taken additional measures to ensure members have access to mental health providers.

MDLive: We implemented MDLive, a vendor who provides telemedicine services in a multitude of areas. We are implementing behavioral health and urgent care services to serve our member population and to improve overall access to both Psychiatrists and licensed Therapists.

Quest Analytics: We have implemented the Quest Analytics QES Tool. This tool will help to identify practicing providers within our service area that can service our members, helping to prioritize and focus our recruiting efforts. The service also performs provider data verifications, which helps maintain accurate directory information so members can easily access available providers. This contract is in response to identified gaps in recruitment data sets.

Conclusion

Alliant Health Plans meets all geographic distribution and member-to-provider ratio goals as outlined in the 2023 Network Access Plan, and there are no member complaints regarding access to behavioral health services. Alliant Health Plans will continue to monitor the geographic region for additional contracting opportunities and evaluate all requests for out-of-network behavioral healthcare services for appropriateness.