

Titles and Qualifications Who Performed/Participated in NQTL Analysis

Title	Qualifications
Staff Vice President, Network Development & Contracting	Oversees functions related to networking development and contracting
Director, Network Reimbursement & Performance	Oversees functions related to reimbursement and performance
Manager, Reimbursement	Oversees functions related to reimbursement
Senior Manager, Data Analytics & Reporting	Oversees analytics and reporting related to network access
Senior Manager, Credentialing	Oversees functions related to credentialing
Senior Director, Contracting & Network Development	Oversees functions related to network contracting
Vice President, Implementation & Integration	Oversees functions related to implementation and integration

NQTL Type: Standards for provider admission to participate in a network, including reimbursement rates
Classification(s): Inpatient (In-network)
<b>Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification</b> <ul style="list-style-type: none"><li>Provide a clear description of the specific NQTL, plan terms, and policies at issue</li><li>Identify which M/S and MH/SUD benefits are subject to the NQTL</li></ul>
<b>Step 1(a): Provide a clear description of the specific NQTL, plan terms, and policies at issue:</b> <p><b>Access:</b></p> <p>Ambetter from Peach State Health Plan (“Ambetter”) defines the Standards for Provider Admission to Participate in a Network, including Reimbursement Rates NQTL to mean the performance of initial and ongoing assessments of its organizational providers in compliance with applicable local, state, and federal accreditation requirements, including the collection, verification, and evaluation of information on organizational providers to achieve a decision to approve or deny network participation in Ambetter’s contracted networks of qualified organizational health care providers, and home and community-based service providers pursuant to a negotiated and agreed-upon reimbursement methodology. Network access and monitoring, provider credentialing, and reimbursement rate-setting methodologies are three key components of the plan’s integrated strategy for Standards for Provider Admission to Participate in a Network, including Reimbursement Rates, and are described separately in each step of this comparative analysis for convenience, but ultimately function as integrated components of a comprehensive strategy for this NQTL.</p> <p>Ambetter ensures that its network has sufficient numbers and types of practitioners who provide primary care, behavioral health care and specialty care to meet the needs and preferences of its membership and adapts its network access, provider reimbursement, and credentialing strategies as needed to meet these needs and preferences. Reimbursement refers to the process of compensating providers for health care services rendered to beneficiaries. Credentialing is the process of obtaining and reviewing documentation to make a threshold determination of whether a provider may be accepted to participate in Ambetter’s network for facilities, suppliers, individual practitioners, and other providers (“providers”). The credentialing process requires providers to submit documentation including, but not limited to, the provider’s education, training, clinical privileges, experience, licensure, accreditation, certifications, professional liability insurance, malpractice history and professional competence. Generally, the terms credentialing and recredentialing include the review</p>

of the information and documentation collected, as well as verification that the information is accurate and complete. The Director of Contracting & Network Development provides guidance for and oversight of provider network admission and monitoring standards as described in Evaluation of Practitioner Availability Policy (CC.PRVR.47, pg. 1-6) and Network Adequacy and Accessibility Requirements, Reporting, and Monitoring Policy (HIM.NTWK.02, pg. 1-4).	
*Note: As used in this document the term “Plan” refers to Ambetter from Peach State Health Plan	
<b>Step 1(b): Identify the M/S benefits/services for which the NQTL is required:</b>  All benefits and services are available from the provider network, which is developed through the Network Access strategy.  Practitioners who practice exclusively within an inpatient setting or freestanding facilities and who provide care for Plan members only as a result of members being directed to the hospital, inpatient setting, or free-standing facility do not require credentialing.	<b>Step 1(b): Identify the MH/SUD benefits/services for which the NQTL is required:</b>  Same as M/S
<b>Step 2 – Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits</b>	
<b><u>Medical/Surgical:</u></b>  <i>Note: although this prompt asks for the “factors used to determine that the NQTL will apply,” because this NQTL applies to 100% of benefits in all classifications, this response reflects the factors used in the design of how this NQTL applies to providers of M/S services as compares to providers of MH/SUD services. This is a more meaningful framing for a comparability and stringency analysis for this NQTL type.</i>  <b>Access:</b>  Ambetter considers the following factors in developing the provider network admission and/or recruitment standards for M/S Providers: <ol style="list-style-type: none"> <li>Product License Network Adequacy Requirements</li> <li>Provider/Practitioner Licensing</li> <li>Geographic Distribution of Providers</li> <li>Cultural Needs and Preferences</li> <li>Availability of High-Volume/High Impact Specialty Providers</li> </ol>	<b><u>MH/SUD:</u></b>  <i>Note: although this prompt asks for the “factors used to determine that the NQTL will apply,” because this NQTL applies to 100% of benefits in all classifications, this response reflects the factors used in the design of how this NQTL applies to providers of M/S services as compares to providers of MH/SUD services. This is a more meaningful framing for a comparability and stringency analysis for this NQTL type.</i>  <b>Access:</b>  Same as M/S

<p><b>Credentialing:</b></p> <p><b>N/A</b> - Practitioners who practice exclusively within an inpatient setting or freestanding facilities and who provide care for Plan members only as a result of members being directed to the hospital, inpatient setting, or free-standing facility do not require credentialing.</p>	<p><b>Credentialing:</b></p> <p>Same as M/S</p>
<p><b>Reimbursement:</b></p> <p>The Plan considers the following factors when setting reimbursement for inpatient services, and determining that the reimbursement rate is appropriate:</p> <p><b>a. <u>Standard Pricing:</u></b></p> <p>i. The Plan establishes Standard Pricing based on the methodologies used by CMS for Medicare population based on the following factors:</p> <ol style="list-style-type: none"> <li>1. The CMS methodologies are the industry standard for inpatient M/S services</li> <li>2. The CMS methodologies are well documented and supported by objective standards and data accessible to all stakeholders</li> </ol> <p><b>b. <u>Provider negotiation factors:</u></b> No one factor is systematically given greater weight and the underlying data is provider and circumstance specific.</p> <p>i. Provider necessary to meet federal and state regulatory requirements for network adequacy with locations and/or the required number of practitioners available to meet the population needs within member drive time and distance requirements:</p> <p>ii. Provider's certified service offerings providing essential or unique services or supplies:</p>	<p><b>Reimbursement:</b></p> <p>Same as M/S</p>

<div><div>iii. Practitioners or facilities rendering care at locations affiliated with in network Providers</div><div>iv. Demonstrated quality performance</div><div>v. Member out of network utilization trend (e.g. reputation, location, quality, services)</div><div>vi. Member requested provider including requests by Broker/Sales Departments</div><div>vii. Member specific single case agreements</div></div>																																		
<div>Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.</div> <div><div><div>Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.</div><div>To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.</div></div></div>																																		
<div>Medical/Surgical:</div>	<div>MH/SUD:</div>																																	
<div>Access:</div> <div><div>1. Product License Network Adequacy Requirement:</div><div><div>a. Evidentiary standard:</div><div><div>i. Plans ensure that 90% of members have access to care for prescribed specialties as determined by CMS’s time and distance standards, which are listed below.</div><table><tr><td></td><td></td><td>Large Metro</td><td>Metro</td><td>Micro</td><td>Rural</td><td>CEAC</td></tr><tr><td rowspan="2">General hospital</td><td>Mileage</td><td>10</td><td>30</td><td>60</td><td>60</td><td>100</td></tr><tr><td>Minutes</td><td>20</td><td>45</td><td>80</td><td>75</td><td>110</td></tr><tr><td rowspan="2">Primary Care</td><td>Mileage</td><td>5</td><td>10</td><td>20</td><td>30</td><td>60</td></tr><tr><td>Minutes</td><td>10</td><td>15</td><td>30</td><td>40</td><td>70</td></tr></table></div></div></div>			Large Metro	Metro	Micro	Rural	CEAC	General hospital	Mileage	10	30	60	60	100	Minutes	20	45	80	75	110	Primary Care	Mileage	5	10	20	30	60	Minutes	10	15	30	40	70	<div>Access:</div> <div><div>1. Product License Network Adequacy Requirement:</div><div><div>Same as M/S</div></div></div>
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	Minutes	10	15	30	40	70																												

OB-GYN	Mileage	15	40	75	90	130
	Minutes	30	60	100	110	145
Dental	Mileage	15	30	60	75	110
	Minutes	30	45	80	90	125
Medical/Surgical Oncology	Mileage	10	30	45	60	100
	Minutes	20	45	60	75	110
Mental Health	Mileage	10	30	45	60	100
	Minutes	20	45	60	75	110
Outpatient Dialysis	Mileage	15	30	60	75	110
	Minutes	30	45	80	90	125
Pharmacy	Mileage	15	40	75	90	130
	Minutes	30	60	100	110	145
All Other Specialists included in QHP Filings	Mileage	15	40	75	90	130
	Minutes	30	60	100	110	145

- a. Sources: Network Adequacy Requirements, Reporting, and Monitoring Policy HIM.NTWK.02 (pg. 3), 45 C.F.R. 156.230(a)(2), CMS 2023 Final Letter to Issuers in the Federally-facilitated Exchanges at pg. 14, <https://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/final-2023-letter-to-issuers.pdf>; CMS Qualified Health Plan Issuer Application Instructions

2. **Provider / Practitioner Licensing:**

- a. *Evidentiary standard:* All network providers must demonstrate Professional Competence. For health care practitioners, verification of applicable education and training upon initial credentialing and maintenance of valid professional licensure for practitioner’s field of practice upon recredentialing, which includes requirements for Continuing Medical Education, are accepted as evidence of maintenance of knowledge and ability in practice area(s) for health care practitioner.
- b. *Source:* Practitioner Credentialing & Recredentialing Policy CC.CRED.01\_Practitioner\_Cred\_and\_Recred (pg. 5).

3. **Geographic Distribution of Primary Care Providers:**
- a. *Evidentiary standard:* Primary Care Providers deliver both M/S and MH/SUD services. The geographic requirements for Primary Care Providers are described above.
  - b. *Source:* Network Adequacy and Accessibility Requirements, Reporting and Monitoring HIM.NTWK.02 (pg. 3), C.F.R. 156.230(a)(2), CMS Qualified Health Plan Issuer Application Instructions

4. **Cultural Needs and Preferences:**
- a. *Evidentiary standard:*
    - i. The Plan assesses the cultural, ethnic, racial, and linguistic needs of its members at enrollment by capturing information on primary language and any other special needs. The Plan maintains the provided information in its system, which tracks enrollment, language, utilization, claims, referrals and pharmacy information. The availability of practitioners is adjusted within the network (if necessary) based on this information. The Plan utilizes the Provider Directory to notify members of any specialized services, including linguistic capabilities and handicap access, offered by network providers.
  - b. *Source:* Cultural Competency and Linguistic Assistance Policy CC.QI.CLAS.29 (pg. 4).

5. **Population Ratios:**
- a. *Evidentiary standard:* The Plan developed the below population ratios based on guidance from CMS and the NCQA.

Specialty	Ratio
Primary Care	1:2,000
Pediatrics	1:2,000
Allergy/Immunology	1:15,000
Cardiology	1:3,700
Endocrinology	1:15,000
Hematology/Oncology	1:15,000
Infectious Disease	1:15,000
Neurology	1:15,000

2. **Provider / Practitioner Licensing:**

Same as M/S

3. **Geographic Distribution of Primary Care Providers:**

Same as M/S

4. **Cultural Needs and Preferences:**

Same as M/S

Psychiatry	1:15,000
Rheumatology	1:15,000
General Surgery	1:5,000
OB/GYN	1:2,000

a. *Source:* CMS, Medicare Advantage Network Adequacy Criteria Guidance (pg. 8); NCQA, Network Management, Network Adequacy (pg. 186); and Accessibility Requirements, Reporting and Monitoring HIM.NTWK.02 (pg. 3).

**6. Availability of High Volume/High Impact Specialty Providers:**

- a. *Evidentiary standard:*
- i. The Plan identifies obstetricians/gynecologists as high volume/high impact specialty care practitioners pursuant to NCQA definitions.
    - 1. Obstetricians/Gynecologists- Members will have access to at least one obstetrician/gynecologist (OB/GYN) as described above.
    - 2. Oncologists - Members will have access to at least one oncologist as described above.
- b. *Source:* Evaluation of Practitioner Availability HIM.NTWK.02 (pg. 3).

**5. Population Ratios:**

Same as M/S

**6. Availability of High Volume/High Impact Specialty Providers:**

Same as M/S

**Credentialing:**

**N/A** - Practitioners who practice exclusively within an inpatient setting or freestanding facilities and who provide care for Plan members only as a result of members being directed to the hospital, inpatient setting, or free-standing facility do not require credentialing.

**Credentialing:**

Same as M/S

<p><b>Reimbursement:</b></p> <p><b>1. <u>Standard Pricing Methodology</u></b></p> <p>a. The Plan establishes Standard Pricing based on the methodologies used by CMS for Medicare population based on the following factors: The CMS methodologies are the industry standard for inpatient M/S services. Industry Standard methodology is applying the pricing components that describes the resources consumed by a rendered services (DRG Weights, RVU's, and Base Units) and establishing a standard rate that should be agreeable to most providers for the pricing component that converts the rendered service into a payment rate. The CMS methodologies are well documented and supported by objective standards and data accessible to all stakeholders.</p> <p><b>2. <u>Provider Negotiations</u></b></p> <p>For all providers for whom a Standard Pricing model exists, the targeted pricing level begins with the Standard Pricing described above. The Plan responds to provider-initiated requests to increase this standard pricing where the provider meets one or more of the following factors, and roughly proportionate to the cumulative weight of these factors:</p> <p>a. Provider necessary to meet network adequacy with locations and/or the required number of practitioners available to meet the population needs within member drive time and distance requirements:</p> <p>i. Definition, evidentiary standard, and sources: When there is a need identified in the network of participating providers for inpatient services, recruitment is initiated to execute provider agreements to fill network requirements.</p> <p>b. Provider's certified service offerings providing essential or unique services or supplies:</p>	<p><b>Reimbursement:</b></p> <p>Same as M/S</p>
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- i. Definition, evidentiary standard, and sources: Services not generally found offered by providers in the same specialty type, in the judgement and expertise of the reviewer, including propriety care delivery models, service techniques, complexity of cases treated, sole manufacturing of devices or trademarks, and for which member care needs may not be met in the plan region(s) served.
- c. Practitioners or facilities rendering care at locations affiliated with in network Providers
  - i. Definition, evidentiary standard, and sources: Non-participating practitioners or facilities rendering care in a participating provider location whether independently owned or under common ownership with the participating provider may allow for negotiation if care cannot reasonably be re-directed to in-network providers.
- d. Demonstrated quality performance
  - i. Definition, evidentiary standard, and sources: High Performing Providers are identified through the partnership with a third party agency, gathering information from CMS on the providers relative to our market and disclosing the information in a manner to allow the plan to target those deemed as “high performing”.
- e. Member out of network utilization trend (e.g. reputation, location, quality, services)
  - i. Definition, evidentiary standard, and sources: Claims experience demonstrating repeating utilization, typically within the preceding twelve month period, due to circumstances such as anticipated word of mouth or marketing campaign activity causing member steerage.
- f. Member requested provider including requests by Broker/Sales Departments

<p>i. Definition, evidentiary standard, and sources: Incoming requests from either internal or external Sales Agents/Brokers interacting with members or prospective membership and receiving requests to add named Providers to the network of participating providers. Requests directly from members to other plan internal departments such as Customer Service.</p> <p>g. Member specific single case agreements</p> <p>i. Definition, evidentiary standard, and sources: Negotiation with an out of network Provider for a single member’s specific case where circumstances drive the required use of the OON provider for the necessary services, devices, supplies. Case may represent unique member conditions, treatment plan, or the continuation of care delivery by out of network providers until transition to a participating provider can reasonably occur.</p>	
<p><b>Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.</b></p> <ul style="list-style-type: none"> <li><i>The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.</i></li> <li><i>If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).</i></li> <li><i>If the plan’s or issuer’s analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert’s qualifications and the extent to which the plan or issuer ultimately relied upon each expert’s evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.</i></li> </ul>	
<p><b>Medical/Surgical:</b></p> <p><b>Access:</b> Ambetter ensures that its network has sufficient numbers and types of practitioners who provide primary care, behavioral health care and specialty care to meet the needs and preferences of its membership. The Director of Contracting &amp; Network Development provides guidance and oversight over monitoring provider network admission standards as described in Evaluation of Practitioner Availability Policy (CC.PRVR.47, pg. 1-6) and Network Adequacy and Accessibility Requirements, Reporting, and Monitoring Policy (HIM.NTWK.02, pg. 1-2).</p>	<p><b>MH/SUD:</b></p> <p><b>Access:</b> Same as M/S</p>

Network adequacy must also be demonstrated to licensing agencies when applying for an insurance plan license to sell a product in a prescribed market area. Ambetter follows CMS Medicare standards plus a select list of additional specialties identified by the plan to enhance market support. Outcomes are monitored using a specific software application, Quest®.

In cases where the Georgia OCI, or other state agency, has additional requirements or different access standards, Ambetter will adhere to the broadest and most stringent standards.

When no regulation or direction exists from a government entity, Ambetter will apply a set of standards developed by Network Development. Annually, Network Development in conjunction with Regulatory Operations will review CMS guidance on current year requirements and update the adequacy and accessibility standards accordingly.

A county must meet the minimum network adequacy requirement, or have a mutually (Centene Commercial Solutions, Ambetter, and Network Development) agreed upon development plan in place, to be included in the service area for QHP filing.

Primary Care Providers (PCPs) adequacy and accessibility will be assessed based on the CMS definition (for instance: Family Medicine, Internal Medicine, General Practice for PCP and Family Medicine, Internal Medicine, and General Practice, Physician Assistant, and Nurse Practitioner for PCP Extended).

Network adequacy and accessibility will be monitored on an ongoing basis which will be no less than quarterly.

Requests to Join Network

Providers may request to join a network of participating providers or Ambetter may solicit their participation based on data or information from varying sources such as:

- Non-Participating Provider report of Authorizations Issued and Claims
- Providing Incoming Requests
- Sales and/or Broker Requests or any other internal requests

<ul style="list-style-type: none"> <li>▪ Single Case Agreement Requests from Ambetter Utilization Management Department.</li> <li>▪ Gaps Identified by the Quest® software solution</li> </ul> <p>Ambetter maintains a streamlined process to respond to written inquiries from providers seeking inclusion in any of Ambetter Health’s participating provider networks, across all benefit classifications. Similar processes exist for outgoing recruitment efforts and can be found in the internal intake process. The incoming process is as follows:</p> <p><b>Step 1:</b> Request to become a participating provider is received by Network Management via online web forms.</p> <p><b>Step 2:</b> The Network Management Team evaluates whether an existing agreement is in place, or if one is needed. If one is needed, the appropriate Network Management team member will be assigned to outreach.</p> <p><b>Step 3:</b> The negotiator will be assigned the and contracting activity based on specialty, region, and/or health system affiliation.</p> <p><b>Step 4:</b> The negotiator will research the provider) and determine whether or not a contract will be offered based on network, specialty, and/or geography.</p> <ol style="list-style-type: none"> <li>If yes, the negotiator will reach out to the prospect within 2 (two) weeks of receipt of request to gather any additional information needed to create a provider agreement.</li> <li>If a request for participation will not be extended, the negotiator will respond to the requestor to provide the rationale for rejecting participation in any or all networks.</li> </ol>	
<p><b>Credentialing:</b> N/A - Credentialing is performed by the hospital or freestanding facility; credentialing is not required by the Health Plan.</p>	<p><b>Credentialing:</b> Same as M/S</p>
<p><b>Provider Reimbursement</b></p> <p>The standard approach for M/S In-Patient In-Network reimbursement can be distinguished by the major facility/provider types:</p> <ol style="list-style-type: none"> <li>Short Term Acute Care Facilities:</li> </ol>	<p><b>Provider Reimbursement</b></p> <p>The standard approach for MH/SUD In-Patient In-Network reimbursement can be distinguished by the major facility/provider types:</p> <ol style="list-style-type: none"> <li>Short Term Acute Care:</li> </ol>

<div><div><div>a. Reimbursed based upon MSDRGs. This methodology is a predictable and known form of reimbursement that controls cost for both payors and providers. While this methodology is appropriate for a Medicare population, it has limitation to that of a Marketplace population (non-exhaustive examples include but not limited to: obstetrics, NICU, MH/SUD, and deliveries). All reimbursement term are finalized in mutually agreed upon negotiated rates between the Plan and providers of these services.</div><div>b. Per Diem reimbursement. This methodology is utilized for inpatient in-network services at a daily rate to reimburse services delivered for various member levels of care. Plan follows industry standards to leverage available CMS guidelines regarding the types of services contracted at per diem rates as well as the rates themselves.</div><div>c. Case Rate reimbursement. This methodology is utilized for inpatient in-network services when it is agreed upon with providers to bundle related services together at a single mutually acceptable comprehensive rate for treatment.</div></div><div><div>2. Critical Access Hospitals:</div><div><div>a. Reimbursement is based upon industry standard interim per diem rates established by CMS. This methodology is a predictable and known form of reimbursement that controls costs for both the payor and the provider of this type. While this methodology is appropriate for a Medicare population, it has limitations to that of a Marketplace population.</div></div></div><div><div>3. Skilled Nursing Facilities:</div><div><div>a. Reimbursement is based upon industry standard patient driven payment model (LTCDRG). This methodology leverages CMS assigned case mix classification criteria that determines the daily reimbursement rate.</div></div></div></div>	<div>Same as for M/S. This category includes Psychiatric Facilities.</div> <div><div>2. Critical Access Hospitals:</div><div>Same as for M/S</div></div> <div><div>3. Skilled Nursing Facilities:</div><div>Same as for M/S</div></div>
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b. Per Diem reimbursement. This methodology is utilized for inpatient in-network services at a daily rate to reimburse services delivered for various member levels of care. Plan follows industry standards to leverage available CMS guidelines regarding the types of services contracted at per diem rates as well as the rates themselves.

4. Long Term Acute Care Hospitals:

a. Reimbursed based upon LTCDRGs. This methodology is a predictable and known form of reimbursement that controls cost for both payors and providers. While this methodology is appropriate for a Medicare population, it has limitation to that of a Marketplace population where the members ability to recuperate is heightened thus potentially reducing the admission LOS. All reimbursement term are finalized in mutually agreed upon negotiated rates between the Plan and providers of these services.

b. Per Diem reimbursement. This methodology is utilized for inpatient in-network services at a daily rate to reimburse services delivered for various member levels of care. Plan follows industry standards to leverage available CMS guidelines regarding the types of services contracted at per diem rates as well as the rates themselves.

5. Hospitals and Facilities that are excluded from CMS IPPS reimbursement:

a. Reimbursement is excluded from the CMS IPPS reimbursement model for Children's and Cancer Hospitals. Services are negotiated by either CMS reported cost to charge ratio terms multiplied by billed charges up to a capitation per diem rate or mutually agreed upon per diem rates.

b. Per Diem reimbursement. This methodology is utilized for inpatient in-network services at a daily rate to reimburse services delivered for various member levels of care. Plan follows industry standards to leverage available CMS

4. Long Term Acute Care Hospitals:

N/A for MH/SUD

5. Hospitals and Facilities that are excluded from CMS IPPS reimbursement:

Same as for M/S. Includes Psychiatric Hospitals and Residential Treatment Centers

guidelines regarding the types of services contracted at per diem rates as well as the rates themselves.

- c. Case Rate reimbursement. This methodology is utilized for inpatient in-network services when it is agreed upon with providers to bundle related services together at a single mutually acceptable comprehensive rate for treatment.

**Across these facility/provider types, PLAN utilizes two primary pricing methodologies:**

- 1. DRG/Case Rate: A per-admission reimbursement grouping methodology, with weights based on severity, for inpatient hospital services. Ambetter uses the payment rates and methodologies published for each hospital facility as the Standard Pricing.
  - a. Inpatient facility classification: Reimbursement for Inpatient Benefit would be dependent on the hospitals classification with Medicare (i.e. Acute Care, Specialty, Critical Access).
    - i. General Acute Care Hospitals.
    - ii. Critical Access Hospitals: Located in rural area and furnish 24 hour emergency services, 7 days a week, and do not exceed 25 IP beds.
    - iii. Children's Hospitals: Predominately servicing age 21 or younger.
    - iv. Cancer Hospital: PPS exempt are designated by National Cancer Institute, organized primarily for treating/researching cancer, and 50% total discharges have principal diagnosis of cancer.
- 2. Per Diem: a per-day payment negotiated and mutually agreed to

**Across these facility/provider types, PLAN utilizes two primary pricing methodologies:**

Same as M/S

- a. Hospital classification: Reimbursement for Inpatient Benefit would be dependent on the hospital’s classification with Medicare (i.e. Acute Care, Specialty, Critical Access).
- b. Inpatient Exempt Unit services unit (Medical Rehab) are reimbursed on a per diem basis. The Exempt unit per diem rate is derived by Medicare and adjusted per hospital facility depending on their individual cost reporting.
  - i. Critical Access Hospitals: In accordance to the Medicare methodology, the Plan prices Inpatient Services at Critical Access Hospitals at a per diem basis. The per diem rate is derived by Medicare and adjusted per hospital facility depending on their individual cost reporting.
  - ii. Specialty Hospitals: In accordance to the Medicare methodology, the Plan prices Inpatient Services at Specialty Hospitals at a per diem basis. The per diem rate is derived by Medicare and adjusted per hospital facility depending on their individual cost reporting.

**In writing comparability and stringency analysis:**

**Access:** Step 1: As noted in the response to Step 1, Ambetter uses the same defined terms and process for the Provider Network Access NQTL as applied to M/S conditions as it does for MH/SUD conditions. As noted in the response to Step 1, Ambetter utilizes an integrated process of monitoring network adequacy to drive both assertive outbound provider recruitment and fielding/prioritizing requests from OON providers seeking to join the network. This process is identical for providers of M/S services and MH/SUD services. As such, this NQTL is comparable and no more stringent at Step 1 as applied to MH/SUD services as compared to providers of M/S services.

Step 2/3: As noted in the response to Steps 2 and 3, all factors are the same for MH/SUD and M/S providers. In Step 3, differences arise from the need to apply population ratios and time and distance standard to the different provider types that deliver MH/SUD vs. M/S services. Internists, general practitioner/family practitioners, and pediatricians treat both M/S and MH/SUD conditions, and therefore the population ratios for these providers are applicable to both MH/SUD and M/S benefits. Ambetter also applies population ratio and time and distance requirements to high volume/impact providers. These include OB-GYN and Oncology providers for M/S benefits and Prescribers (psychiatrists and nurse practitioners with a psychiatric specialty) and non-prescribers (psychologists, licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, etc.) for MH/SUD benefits. The population ratio and time and distance requirements are the same for all of these high volume/impact providers, creating effective equivalence of stringency in the application of this NQTL to MH/SUD and M/S providers.

Step 4: The processes and strategies outlined in Step 4 are the same for MH/SUD and M/S providers.



Taken together, the facts presented in Steps 1-3 and the facts and analysis presented here in Step 4 support the conclusion that, as written, Ambetter implements the Provider Network Access processes, strategies, evidentiary standards, and other factors to MH/SUD benefits in the classification in a manner that is comparable to and no more stringent than the application of these processes, strategies, evidentiary standards, and other factors to M/S benefits in the classification.

**Credentialing: N/A** - For both MH/SUD and M/S services, Credentialing is performed by the hospital or freestanding facility, credentialing is not required by the Health Plan. Therefore, the provider credentialing processes, strategies, evidentiary standards, and other factors, as written, for mental health/substance use disorder providers, are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and other factors used in the credentialing procedures for medical surgical providers.

**Reimbursement:** The reimbursement methodology for the inpatient in-network classification is the same for MH/SUD and M/S services at both the standard pricing methodology and negotiation phases of the process. Although there are M/S and MH/SUD provider-specific payment approaches, as described in Step 4, these methodologies are the same for comparable provider types. In particular, the inpatient M/S and MH/SUD levels of care use all use DRGs, per diems, and/or case rates based on the setting in a comparable manner across each provider setting. In addition, as noted in the responses to Steps 2 and 3, the factors considered in the development of the standard pricing (i.e. the initial offer price) and the factors considered in the negotiation from that standard price, are the same for MH/SUD and M/S inpatient services. As such, we conclude that the provider reimbursement methodology is comparable and no more stringent in its application to MH/SUD inpatient services compared to the application to M/S inpatient services in writing.

**In operation:**

**Access (see Appendix for full set of operations data):**

*Findings from the Provider Network Adequacy Report:*

- Performance Assessment for Necessary Network Providers
  - These standards include practices for practitioner credentialing and ongoing monitoring of the participating providers that meet the qualifications of applicable state and federal government regulations, applicable standards of accrediting bodies, including the National Committee for Quality Assurance (NCQA), and Plan requirements. Annual reports are created to include the cultural, linguistic, PCP/High Volume/High Impact adequacy, provider adequacy levels and provider to member ratios. A Quality Management Committee meeting is held to review the findings and solutions planned for any negative results to ensure a path for improvement is planned to meet targets.
  - A reporting tool is maintained to track progress in all contracting efforts. Reasons for the contracting engagement along with other key drivers such as specialty and outcomes are captured in this SharePoint tool and easily reportable for constant monitoring by contributing staff negotiators and management.
  - *Because the majority of these measures are focused on professional provider types, these findings are discussed in much greater detail in the Outpatient classification analysis below. See Appendix for a detailed snapshot of the Provider Contracting Tool Summary*

- Compliance with Network Adequacy Standards

- Ambetter ensures that its members are satisfied with its primary care network by conducting an annual performance assessment and measuring its performance against the standards at least annually. The methodology used to review the number and geographic distribution of primary care physicians, specialists and facility providers is included in the Quest® geographic access tool, which allows for direct measurement of performance. Reports are generated, distributed, and reviewed on a weekly basis. Any gaps in adequacy are actions initiated prior to the next weekly reporting period.
- *Because the majority of these measures are focused on professional provider types, these findings are discussed in much greater detail in the Outpatient classification analysis below. Sample report is attached*
- An analysis of the proportion of counties with network gaps for MH/SUD providers relative to M/S providers found the following:

Peach State	Average Network Adequacy (across all counties)
Inpatient Med/Surg	98.85%
Inpatient MH/SUD	99.18%

For complete data set please see attached.

*Conclusions:* Ambetter experiences generally low levels of grievance and appeals across all classifications of benefits. Filed grievances are lower for behavioral health services (1 grievance related to access to care) than for medical/surgical services (82 grievances related to access to care). This data supports a conclusion that the network adequacy process is implemented in a comparable and no more stringent manner between MH/SUD and M/S services.

Based on the Quest® geographic access tool report, the Ambetter network meets the network access requirements in almost all counties. Gaps are defined to mean that there are specific provider types that do not meet 100% of the access requirements. As noted above, Ambetter has a higher percentage for average network adequacy coverage for BH/SUD specialty types than M/S specialty types, nor are the gaps specific to practitioner geographic distribution or types of practitioners or providers. In addition, both M/S providers and BH/SUD providers satisfy the 90% threshold for adequate coverage across all counties. As such, we conclude that this NQTL type is being implemented, in operation, in a comparable and no more stringent manner for MH/SUD services compared to M/S services.

**Reimbursement:** To assess the “in operation” comparability and stringency analysis of the provider reimbursement methodology, the plan monitors multiple metrics to identify whether the practices in establishing the standard pricing and negotiating with individual providers (as described and analyzed above) are inadvertently resulting in discriminatory treatment of MH/SUD providers. The plan monitors the ratio of paid to charge-rates as well as availability data for a wide variety of practitioners to ensure that the reimbursement methodology results in equitable access for patients of MH/SUD services compared to M/S services. The table below includes the paid to charge rate data for the most recent period available and these data are updated at regular intervals. This analysis is also updated when the data are updated.

a. Paid to charge ratios

	<u>M/S</u>	<u>M/S</u>	<u>M/S</u>	<u>MH/SUD</u>	<u>MH/SUD</u>	<u>MH/SUD</u>
<u>Classification - IP</u>	<u>Billed Charges</u>	<u>Payment</u>	<u>Charge Ratio</u>	<u>Billed Charges</u>	<u>Payment</u>	<u>Charge Ratio</u>
2023	\$ 836,285,387	\$ 331,929,290	40%	\$ 31,482,816	\$ 10,202,171	32%

This data demonstrates that participating inpatient MH/SUD providers have been paid a comparable percentage of their billed charges (32%) relative to participating M/S providers (40%) in 2023. Network adequacy for inpatient providers is comparable between M/S providers (98.85%) and MH/SUD providers (91.18%), and all factors, sources, and evidentiary standards for contracting and reimbursing IP providers are the same for M/S and MH/SUD providers. The data is therefore consistent with a conclusion that Ambetter’s application of the Standards for Admission to a Provider Network, Including Reimbursement NQTL, is applied comparably and no more stringently to MH/SUD providers relative to M/S providers.

**Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section**

- This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA*

As stated in Step 1 above, all plan document terms that set forth Standards for provider admission to participate in a network, including reimbursement rates are the same for MH/SUD and M/S benefits and providers. Similarly, as stated in steps 2-4 above, all factors, sources, evidentiary standards, and processes that are used to develop Standards for provider admission to participate in a network, including reimbursement rates, as written and in operation, are the same or comparable for all MH/SUD and M/S benefits and providers.

As discussed in Step 4, the Plan analyzes the ratio of paid rates to charged rates to monitor the outcome of the participating provider reimbursement methodologies, and has determined that the outcomes of this methodology are at least comparable and are generally favorable for MH/SUD providers relative to M/S providers.

Based on the foregoing facts and analyses, the Plan concludes that, under the terms of the plan, as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the identified classifications 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 classifications.

**NQTL Type: Standards for provider admission to participate in a network, including reimbursement rates**

<b>Classification(s): Outpatient (In-Network)</b>	
<b>Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification</b> <ul style="list-style-type: none"> <li>• Provide a clear description of the specific NQTL, plan terms, and policies at issue</li> <li>• Identify which M/S and MH/SUD benefits are subject to the NQTL</li> </ul>	
<b>Step 1(a): Provide a clear description of the specific NQTL, plan terms, and policies at issue:</b>	
All definitions are the same as stated above in the Inpatient In-Network NQTL	
<b>Step 1(b): Identify the M/S benefits/services for which the NQTL is required:</b>  <b>Access:</b> All benefits and services	<b>Step 1(b): Identify the MH/SUD benefits/services for which the NQTL is required:</b>  <b>Access:</b> Same as M/S
<b>Credentialing:</b> All in-network providers must be credentialed.	<b>Credentialing:</b> Same as M/S
<b>Reimbursement:</b> All benefits and services	<b>Reimbursement:</b> Same as M/S
<b>Step 2 – Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits</b>	
<b>Medical/Surgical:</b>	<b>MH/SUD:</b>
<b>Access:</b> Same as Inpatient In-Network NQTL above	<b>Access:</b> Same as Inpatient In-Network NQTL above
<b>Credentialing:</b>  Credentialing requirements are based on the following factors and evidentiary standards: <ol style="list-style-type: none"> <li>1. State and federal laws and guidelines (including 42 CFR 438.214 and 42 CFR Part 422.204)</li> <li>2. Accreditation guidelines (NCQA, CMS)</li> </ol>	<b>Credentialing:</b> Same as M/S
<b>Reimbursement:</b> Same as Inpatient In-Network NQTL above	<b>Reimbursement:</b> Same as Inpatient In-Network NQTL above

**Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.**

- Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.*
- To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.*

<b>Medical/Surgical:</b>	<b>MH/SUD:</b>
<b>Access:</b> Same as Inpatient In-Network NQTL above	<b>Access:</b> Same as Inpatient In-Network NQTL above
<b>Credentialing:</b>  1. <b>State and federal laws and guidelines:</b> State and federal policies, regulations, and laws that are used to determine provider credentialing requirements include, (but are not limited to) provisions contained throughout Georgia insurance laws, and guidance related to healthcare or mental health parity, and federal laws or regulations (including 42 CFR 438.214 and 42 CFR Part 422.204). <i>Additionally, Ambetter from Peach State Health Plan adheres to Medicaid managed care state regulations further extending behavioral health credentialing permissions to a range of state licensed behavioral health facilities.</i>  2. <b>Accreditation Guidelines:</b> <i>Ambetter from Peach State Health Plan applies its credentialing standards in accordance with National Committee for Quality Assurance (NCQA) – CR-1 and Net 5. In addition, State regulatory agencies and the Centers for Medicare (CMS) and Medicaid Services standards are used to ensure that members get access to quality care.</i>	<b>Credentialing:</b> Same as M/S
<b>Reimbursement:</b> Same as Inpatient In-Network NQTL above	<b>Reimbursement:</b> Same as Inpatient In-Network NQTL above

**Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.**

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

<b>Medical/Surgical:</b>	<b>MH/SUD:</b>
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<b><u>Access:</u></b> Same as Inpatient In-Network analysis above	<b><u>Access:</u></b> Same as Inpatient In-Network analysis above
<b><u>Credentialing:</u></b>  <b>Application Process</b> Ambetter has credentialing policy and procedures for the initial application process and the recredentialing process, which includes the contents and scope of the application, type and scope of practitioners who qualify for membership, and the initial processing steps and recredentialing processing steps in the credentialing procedure. Ambetter adheres to managed care standards 42 CFR Part 438.214 and 42 CFR Part 422.204, National Committee of Quality Assurance (NCQA) and Centers for Medicare and Medicaid Services (CMS).  All new applicants for appointment, who are contracted to deliver professional services within the service areas defined by Ambetter and whose professional services meet the defined business needs will be given upon request, an application to participate with Ambetter. Credentialing begins with a Completed Application (“Complete Application”). Ambetter uses the CAQH application which must include basic demographic information including name, NPI, license number, servicing address(s), phone, office hours, accepting new patients, age range, education and training information, work history, affirmation questions and attestation to the correctness of the application.  Practitioners who practice exclusively within a State Licensed facility and who provide care only as a result of members being directed to the hospital or another inpatient setting, do not need to be individually credentialed by Ambetter.  <b>Timeline</b> Ambetter completes review of the health care professional’s application to participate in the Ambetter Network and shall, within 30 days of receiving a Completed Application to participate in the Ambetter Network, notify the health care professional as to whether s/he is credentialed; or whether additional time is necessary to make a determination because of a failure of a third party to provide necessary documentation, or if additional information is necessary, the notice to the health care professional must identify all additional information needed by the plan to make its determination. In such instances where additional time is necessary because of a lack of necessary documentation, Ambetter Health makes every effort to obtain such information as soon as possible and makes a final determination within 60 days of receiving the necessary documentation.  <b>Sanctions List</b> Ambetter monitors sanction/exclusions of the OIG, SAM/EPLS, state Exclusion List, and SSDMF monthly.	<b><u>Credentialing:</u></b> Same as M/S, as applicable

**Forms & Requirements:**

Ambetter performs primary source verification of all NCQA required data elements. Below is a list of all acceptable verification sources and the required verification time limit. Please note that where a 180 - day time limit is indicated this means that the verification must be conducted within 180 days prior to Credentials Committee approval date.

The following primary source (unless otherwise noted) verifications will be obtained and documented in the application/reapplication:

ITEM	PRIMARY SOURCE
Valid, Current License	<u>All Practitioners:</u>  Internet verification through the appropriate State Licensing Agency or website  Verification of licensure is required in all States where the practitioner provides care to members.
Valid, Current DEA Certificate	Copy of current Drug Enforcement Administration (DEA) Certificate or internet confirmation with the United States Department of Justice Drug Enforcement Administration Office of Diversion Control website.  DEA or DEA Coverage Plan (applicable only to those specialties eligible to prescribe controlled substances)
Education and Training: Completion of residency training *Initial Credentialing Only	<u>Physician:</u> If not board certified, written/verbal verification of the highest level of education is verified directly from the residency program (s) designated by the

<p>Graduation from Medical School/ Professional School *Initial Credentialing Only</p>	<p>applicant on the application or confirmation from AMA Physician Master File or the AOA Physician Master File/AOA Official Osteopathic Physician Profile.</p>		
	<p><u>Podiatry:</u> If not board certified, written/verbal confirmation of residency training completion directly from the residency program (s) designated by the applicant on the application.</p>		
	<p><u>Non Physician Professionals:</u> Not Applicable (residency training is N/A)</p>		
	<p><u>Physician:</u>  If not Board Certified and did not complete a residency program, written confirmation from Medical School, confirmation from AMA Physician Master File, the AOA Physician Master File/AOA Official Osteopathic Physician Profile designated by the applicant on the application or confirmation from the Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986. May be verified by state licensure if licensing board validates that they primary source verify training at this level.</p>		
	<p><u>Podiatry:</u> Written/verbal confirmation of completion of Podiatry Medical School designated by the applicant on the application. May be verified by state licensure if licensing board validates that they primary source verify training at this level.</p>		



	<p><u>Chiropractor:</u> Written/verbal confirmation of completion of Chiropractic College designated by the applicant on the application. May be verified by state licensure if licensing board validates that they primary source verify training at this level.</p> <p><u>Non Physician Professionals:</u> Written/verbal confirmation of professional/graduate school completion or confirmation from the National Student Clearing House designated by the applicant on the application. May be verified by state licensure if licensing board validates that they primary source verify training at this level.</p>		
Board Certification	<p><u>Physician:</u>  Internet query ABMS Board Certification Credentials Profile; AOA Official Osteopathic Physician Profile Report/AOA Physician Master File or AMA Physician Master File with Internet or written confirmation.</p> <p><u>Podiatry:</u> Written confirmation or Internet query of the American Board of Podiatric Surgery OR the American Board of Foot and Ankle Surgery (formerly American Board of Podiatric Orthopedics).</p> <p><u>Chiropractor:</u> Not Applicable</p>		

	<p><u>Non Physician Professionals:</u> Not Applicable</p>		
<p>Work History (5 years) *Initial Credentialing Only</p>	<p><u>All Practitioners:</u> Review CV/resume provided and/or completed Ambetter Provider Application or CAQH Application. Continuity of dates is required.</p> <p>At a minimum, five (5) years of work history is reviewed. If the practitioner has fewer than five (5) years of work history, the time frame starts from the initial licensure date.</p> <p>Each gap in employment exceeding six (6) months is clarified either verbally or in writing. A written explanation is required for employment gaps greater than one (1) year.</p>		
<p>Professional Liability Claims History</p>	<p><u>All Practitioners:</u> NPDB electronic query. Obtain written confirmation of the last five (5) years of malpractice settlements or judgments paid on behalf of the practitioner. Residency years are included in this five-year period.</p>		
<p>Malpractice Insurance Coverage</p>	<p><u>All Practitioners:</u> Current copy of professional liability insurance, or Attestation within credentialing application with amount of coverage, and effective and end dates is also acceptable.</p>		
<p>Hospital Affiliations</p>	<p><u>If applicable:</u> Affirmation of Professional Status confirmation.</p>		

National Practitioner Data Bank	<u>All Practitioners:</u>  NPDB electronic query.		
Professional Regulations/Sanction Information	<u>Physician &amp; Physician Assistant:</u>  Any pending or completed actions by the State License Board.  <u>Podiatry:</u> Any pending or completed actions by the State License Board  <u>Chiropractor:</u> Any pending or completed actions by the State License Board  <u>Non Physician Behavioral Health Care Professionals:</u> Any pending or completed actions by the State License Board  <u>Non Physician Practitioners:</u> Any pending or completed actions by the State License Board  Verification of State sanctions, restrictions or limitations on scope of practice through the appropriate State Agency is required in all States where the practitioner provides care to members.		
Sanction Activity by Medicare and Medicaid	<u>All Practitioners:</u>  1. NPDB electronic query 2. The US Department of Health & Human Services Office of Inspector General (OIG): List		

	<p>of Excluded Individuals/Entities (LEIE)_(OIG); <a href="http://exclusions.oig.hhs.gov/">http://exclusions.oig.hhs.gov/</a></p> <ol style="list-style-type: none"> <li>3. The Georgia state Exclusions List</li> <li>4. System for Award Management (SAM) (EPLS); <a href="https://www.sam.gov/content/home">https://www.sam.gov/content/home</a>.</li> <li>5. The Centers for Medicare &amp; Medicaid Services (CMS) - CMS Preclusion List.</li> <li>6. Social Security Administration Death Master File</li> </ol>		
National Provider Identifier (NPI)	<p><u>All Practitioners:</u></p> <p>National Plan Provider Enumeration System (NPES); <a href="https://npiregistry.cms.hhs.gov">https://npiregistry.cms.hhs.gov</a>.</p>		
Application/Reapplication	<p><u>All Practitioners:</u></p> <p>Indicate on application/reapplication:</p> <ol style="list-style-type: none"> <li>1. Reasons for inability to perform the essential functions of the position,</li> <li>2. Lack of present illegal drug use,</li> <li>3. History of loss of license and felony convictions,</li> <li>4. History of loss or limitation of privileges or disciplinary actions,</li> <li>5. Current malpractice insurance coverage,</li> <li>6. Current and signed attestation confirming the correctness and completeness of the application.</li> </ol>		

Approved practitioner sites and their staff are scheduled for the Practitioner orientation at which time they receive their Provider Manual.

Verification documentation in the file can be either written or verbal and will include copies of the credentialing information. A dated checklist indicating for each verification the source used, the date of the verification and the computer-generated identification of the person who verified the information.

The information/verifications collected and completed must be valid and current and shall not be more than 180 days old at the time of Committee review unless otherwise noted.

**Reimbursement:**

As part of the generalized standard approach of provider reimbursement, the standard approach for Out-Patient In-Network reimbursement can be described by the major facility/provider types and is applicable when mutually agreed upon:

1. Short Term Acute Care Facilities:
- a. Ambulatory Payment Classification (APC). APC is an industry standard methodology established by CMS that group services into a single reimbursement rate.

b. Per Diem reimbursement. This methodology is utilized for outpatient in-network services at a daily rate to reimburse services delivered for various member levels of care. Plan follows industry standards to leverage available CMS guidelines regarding the types of services contracted at per diem rates as well as the rates themselves.

c. Case Rate reimbursement. This methodology is utilized for outpatient in-network services when it is agreed upon with providers to bundle related services together at a single mutually acceptable comprehensive rate for treatment.

**Reimbursement:**

Same as M/S, as applicable

<p><b>d.</b> Reimbursed based upon Fee For Service (FFS). FFS methodology is an industry standard methodology with CMS guidelines that outline specific services, rates based upon time intervals of services for applicable provider types.</p>	
<p><b>2.</b> Critical Access Hospitals:</p> <p><b>a.</b> Reimbursement is based upon industry standard Medicare in effect on date of service Cost to Charge Ratio. While this methodology is appropriate for a Medicare population, it has limitations to that of a Marketplace population.</p> <p><b>b.</b> Per Diem reimbursement. This methodology is utilized for outpatient in-network services at a daily rate to reimburse services delivered for various member levels of care. Plan follows industry standards to leverage available CMS guidelines regarding the types of services contracted at per diem rates as well as the rates themselves.</p> <p><b>c.</b> Case Rate reimbursement. This methodology is utilized for outpatient in-network services when it is agreed upon with providers to bundle related services together at a single mutually acceptable comprehensive rate for treatment.</p> <p><b>d.</b> Reimbursed based upon Fee For Service (FFS). FFS methodology is an industry standard methodology with CMS guidelines that outline specific services, rates based upon time intervals of services for applicable provider types.</p>	
<p><b>3.</b> Skilled Nursing Facilities:</p> <p><b>a.</b> Medicare does not cover services delivered in an outpatient setting for Skilled Nursing facilities. This provider type has delivered outpatient therapy (PT/OT/ST) services for their respective communities.</p> <p><b>b.</b> Reimbursed based upon Fee For Service (FFS). FFS methodology is an industry standard methodology with CMS guidelines that outline specific services, rates based upon time intervals of services for applicable provider types.</p>	
<p><b>4.</b> Practitioner Services (PCP/Specialist)</p>	

a. Reimbursed based upon Fee For Service (FFS). FFS methodology is an industry standard methodology with CMS guidelines that outline specific services, rates based upon time intervals of services for applicable provider types.

5. Ancillary Services

- a. DMEPOS, LAB, Pharmacy, Radiology. Reimbursed based upon Fee For Service (FFS). FFS methodology is an industry standard methodology with CMS guidelines that outline specific services, rates based upon time intervals of services for applicable provider types.
- b. Ambulance. Reimbursed based on CMS Ambulance Fee Schedule with CMS Guidelines that outline the reimbursement, geographic area adjustments and requirements.
- c. Home Health. Reimbursed based on CMS Patient Driven Grouping Model. PDGM have 30 days periods and are categorized into 432 case mix periods for adjusting the payment. Per Diem reimbursement. This methodology is utilized for in-network services at a daily rate to reimburse services delivered for various member levels of care. Plan follows industry standards to leverage available CMS guidelines regarding the types of services contracted at per diem rates as well as the rates themselves
- d. Hospice. Reimbursed based on the Hospice Prospective Payment System where each day of hospice benefit is assigned to a Base Payment Rate and adjusted for geographic factors. Per Diem reimbursement. This methodology is utilized for in-network services at a daily rate to reimburse services delivered for various member levels of care. Plan follows industry standards to leverage available CMS guidelines regarding the types of services contracted at per diem rates as well as the rates themselves
- e. Home Infusion. CMS pays only 6 home infusion therapy HCPCS G Codes and are adjusted by the Geographically Adjustment that mostly cover for professional services. Per Diem reimbursement. This methodology is utilized for in-network services at a daily rate to reimburse services delivered for various member levels of care. Plan follows industry standards to leverage available CMS guidelines regarding the types of services contracted at per diem rates as well as the rates themselves.

6.

Children’s & Cancer Hospitals:
- a.

Ambulatory Payment Classification (APC). APC is an industry standard methodology established by CMS that group services into a single reimbursement rate.
- b.

Case Rate reimbursement. This methodology is utilized for outpatient in-network services when it is agreed upon with providers to bundle related services together at a single mutually acceptable comprehensive rate for treatment.
- c.

Reimbursed based upon Fee For Service (FFS). FFS methodology is an industry standard methodology with CMS guidelines that outline specific services, rates based upon time intervals of services for applicable provider types.
7.

Ambulatory Surgical Center CMS pays ASC based on assigned relative weights to APC’s in the ASC Medicare Fee Schedule and adjusted based on their Geographical Area.

**Across these facility/provider types, PLAN utilizes two primary pricing methodologies:**

1.

Standard Pricing
- a.

CPT FFS: Ambulatory Payment Classification Group (APC)
- b.

Payment benchmarks (Medicare): Medicare RBRVS published fee schedule or other applicable Medicare published fee schedules.
2.

Per Diem/Case Rate: a per-day, negotiated and mutually agreed to all-inclusive payment that encompasses all services rendered per daily occurrence of treatment
- a.

Hospital classification: Reimbursement for outpatient in-network benefits would be dependent on the hospitals classification with Medicare (i.e. Acute Care, Specialty, Critical Access, ambulatory surgery center, Urgent Care facility) which determines the scope of services inclusive to the per diem payment and subsequent rate setting.



**In writing comparability and stringency analysis:**

**Access:** Same as Inpatient In-Network Analysis above, except the following table:

<b><u>Network Adequacy</u></b>	
<b>Peach State</b>	<b>Average Adequacy</b>
Outpatient MH/SUD	98.5%
Outpatient M/S	99.7%

For complete data set please see attached.

Please also see Provider Availability Analysis below.

**Credentialing:**

The provider credentialing processes and strategies, as written, for mental health/substance use disorder providers, are comparable to and applied no more stringently than the processes and strategies used in the credentialing procedures for medical surgical providers. For both MH/SUD and M/S services, the credentialing process begins with a completed application. The application requirements are comparable for MH/SUD and M/S services and differ only in that the credentials are customized to the needs and specialty of the provider. Overall, the process followed is the same for both MH/SUD and M/S services. The Plan strives to complete the credentialing process within 60 days of a complete application from the provider.

The Plan relies upon (1) State and federal laws and guidelines and (2) accreditation guidelines in creating its provider credentialing processes in writing. The Plan considers Georgia state laws and guidance related to parity, and federal laws or regulations (including 42 CFR 438.214 and 42 CFR Part 422.204). The Plan’s credentialing guidelines are based on CMS standards and NCQA guidelines. These factors and evidentiary standards are identical for MH/SUD and M/S services, and are therefore, comparable, and no more stringent.

**Reimbursement:** The reimbursement methodology for the outpatient in-network classification is the same for MH/SUD and M/S services at both the standard pricing methodology and negotiation phases of the process. Although there are M/S and MH/SUD provider-specific payment approaches for outpatient services in a manner similar to the inpatient classification, as described in Step 4, these methodologies are not discriminatory in their differences. In particular, the inpatient M/S and MH/SUD levels of care use all use FFS codes for professional and ancillary services and a mix of APCs, per diems, and case rates for facility-based outpatient services in a comparable manner across each provider setting. In addition, as noted in the responses to Steps 2 and 3, the factors considered in the development of the standard pricing (i.e. the initial offer price) and the factors considered in the negotiation

from that standard price, are the same for MH/SUD and M/S outpatient services. As such, we conclude that the provider reimbursement methodology is comparable and no-more stringent in its application to MH/SUD inpatient services compared to the application to M/S outpatient services in writing.

**In operation:**

- Credentialing:** Review of credentialed providers demonstrated that Ambetter met the following timelines:
- 1. **M/S:** On average, all M/S providers were credentialed by Ambetter within 3.75 days of a complete application
  - 2. **MH/SUD:** On average all MH/SUD providers were credentialed by Ambetter within 3.75 days of a complete application

Ongoing Monitoring: Ambetter monitors sanction/exclusions of the OIG, SAM/EPLS, state Exclusion List, SSDMF on a monthly basis for behavioral health practitioners and medical/surgical providers.

Quality Audits: Ambetter has a quality audit team in the Credentialing Department that reviews a subset of behavioral health, medical/surgical provider credentialing files to ensure credentialing standards are met.

**Reimbursement:**

To assess the “in operation” comparability and stringency analysis of the provider reimbursement methodology, the plan monitors multiple metrics to identify whether the practices in establishing the standard pricing and negotiating with individual providers (as described and analyzed above) are inadvertently resulting in outcomes that may signal a need to re-evaluate the underlying factors, sources, evidentiary standards, or processes to ensure parity compliance.

**Paid to charge ratios**

	M/S	M/S	M/S	MH/SUD	MH/SUD	MH/SUD
Classification	Billed Charges	Payment	Charge Ratio	Billed Charges	Payment	Charge Ratio
Prof 2023	\$624,873,817	\$230,880,997	37%	\$26,516,531	\$13,004,303	49%

The current paid-to-charge ratios indicate that payments for professional MH/SUD providers relative to billed charges (49%) is higher than payments to professional M/S providers (37%) and is evidence that mental health parity is met.

**d. Provider availability analysis**

**Introduction**

Managed care health plans often require enrollees to utilize a designated practitioner network. The organization must ensure there are adequate numbers and geographic distribution of primary care, behavioral health, and specialty care practitioners to meet enrollee needs. Ambetter monitors practitioner availability annually against established standards, and initiates actions, as needed, to improve practitioner availability. This report describes the monitoring methodology, results, analysis, and actions for the period of January 1, 2023, through October 31, 2023.

**Availability of Primary Care, Specialty Care and Behavioral Health Care Practitioners**

Practitioner availability monitoring is completed for primary care practitioners (PCPs), high-volume and high-impact specialty care practitioners (SCPs), and high-volume behavioral health (BH) practitioner types. The health plan defines the mechanism utilized to monitor the type, number and geographic distribution of primary care, high-volume and high-impact specialty care, and high-volume behavioral healthcare practitioners as applicable to monitor the adequacy of the network and how effectively this network meets the needs, preferences, and diversity of the health plan’s enrollment.

**Standards and Methodology**

To evaluate the availability of practitioners who provide primary care, high-volume and high-impact specialty care and high-volume behavioral healthcare services, the health plan annually monitors the following:

- Ratio of number of each type of practitioners to number of enrollees
- Geographic distribution of each type of practitioner (distance and/or driving time to practitioner’s office)

**Findings of the Ambetter Network Adequacy Report**

**Section I: Primary Care**

Ambetter defines primary care practitioners as family practitioners, general practitioners, pediatricians, internists, nurse practitioners, physician assistance and other PCP Extenders. Primary care providers are those that fully accept the duties of a PCP and can be designated as an enrollee’s assigned PCP.

Table 2 lists the primary care practitioner standards, results, and determines if the goal was met for each PCP type for whom availability is monitored. The health plan conducts an analysis to identify potential opportunities to improve practitioner availability.

**Section II: Specialty Care**

Ambetter identifies high-volume specialty care practitioners as those who treat a significant portion of the health plan’s enrollees, as identified through analysis of the number of visits, based on claim and encounter data. At a minimum, high-volume specialists were identified as Obstetrics & Gynecology (OB/GYN).

Evaluation to identify high-impact practitioners utilizes an assessment of conditions with serious consequences for the enrollee, requiring significant health system resources, including high-cost medications and therapy options (i.e., chemotherapy and radiation) and increased inpatient and outpatient medical claims. Oncology was selected as high impact specialists since the care of cancer patients from diagnosis through primary treatment is complex, involving several diagnostic and treatment steps. These steps generally include staging, general medical assessments, definitive therapy (surgery or radiation depending on tumor type and stage) to control local disease, and often adjuvant therapy (i.e., radiation therapy, chemotherapy, hormonal therapy, or immunotherapy) to reduce the risk of recurrence. According to the Journal of the National Cancer Institute, oncologists face challenges of providing comprehensive care to cancer patients across the continuum including significant comorbid conditions or psychosocial issues.

***Practitioner Numeric and Geographic Standards and Results***

The tables below list the availability standards and results for the indicated practitioner type, and determines if the goal was met for each practitioner type for whom availability is monitored. The health plan conducts an analysis to identify potential opportunities to improve practitioner availability.

**Section III: Behavioral Healthcare**

Ambetter identifies high-volume behavioral healthcare practitioners through analysis of the number of visits, based on claim and encounter data. High-volume behavioral health specialties based on volume of healthcare visits were: Prescribing Psychiatrists and Non-prescribing Clinical Psychologists and Licensed Mental Health Practitioner (LMHP) including Clinical Social Workers, Professional Counselors, Marriage & Family Therapists, etc.

Table 4 lists the BH practitioner standards, results, and determines if the goal was met for each high-volume behavioral healthcare practitioner type for whom availability is monitored. The health plan conducts an analysis to identify potential opportunities to improve practitioner availability.

***Practitioner Numeric and Geographic Standards and Results***

The tables below list the availability standards and results for the indicated practitioner type, and determines if the goal was met for each practitioner type for whom availability is monitored. The health plan conducts an analysis to identify potential opportunities to improve practitioner availability.

Table 2: Primary Care Practitioner Numeric and Geographic Standards and Results

Practitioner Type Primary Care	Standards – Goal 90%	2023 Results	Goal Met?
Primary Care Practitioners: All	Enrollees have at least 2 PCP within 10 miles or 30 minutes of the enrollee’s home in Large Metro areas.	99.4%	Yes
	Enrollees have at least 2 PCP within 10 miles or 30 minutes of the enrollee’s home in Metro areas.	98.3%	Yes
	At least 1 PCP per 2,000 enrollees	1:7	Yes
Primary Care Practitioners: Family/ General Practitioners (FP/GP)	Enrollees have at least 1 FP/ GP within 10 miles or 30 minutes of the enrollee’s home in Large Metro areas.	99%	Yes
	Enrollees have at least 1 FP/ GP within 10 miles or 30 minutes of the enrollee’s home in Metro areas.	97.1%	Yes
	At least 1 FP/ GP per 2,000 enrollees	1:291	Yes
Primary Care Practitioners: Internal Medicine (IM) Practitioners	Enrollees have at least 1 IM Practitioner within 10 miles or 30 minutes of the enrollee’s home in Large Metro areas.	97.2%	Yes
	Enrollees have at least 1 IM Practitioner within 10 miles or 30 minutes of the enrollee’s home in Metro areas.	94.5%	Yes
	At least 1 IM Practitioner per 2,000 enrollees	1:353	Yes
Primary Care Practitioners: Pediatrics (PEDS)	Enrollees have at least 1 Pediatrics Practitioner within 10 miles or 30 minutes of the enrollee’s home in Large Metro areas.	95%	Yes
	Enrollees have at least 1 Pediatrics Practitioner within 10 miles or 30 minutes of the enrollee’s home in Metro areas.	93.5%	Yes

Table 4: BH Practitioner Geographic and Numeric Standards and Results

Practitioner Type Behavioral Healthcare	Standards- Goal 90%	2023 Results	Goal Met?
Psychiatrists	Enrollees have at least 1 Psychiatrists within 45 miles or 60 minutes of the enrollee’s home in Large Metro areas.	98%	Yes
	Enrollees have at least 1 Psychiatrists within 45 miles or 60 minutes of the enrollee’s home in Metro areas.	100%	Yes
	At least 1 Psychiatrist per 15,000 enrollees	1:1144	Yes
Clinical Psychologists	Enrollees have at least 1 Psychologists within 20 miles or 30 minutes of the enrollee’s home in Large Metro areas.	99.4%	Yes
	Enrollees have at least 1 Psychologists within 20 miles or 30 minutes of the enrollee’s home in Metro areas.	97.7%	Yes
Licensed Mental Health Professionals (LMHP)	Enrollees have at least 1 LMHP within 20 miles or 30 minutes of the enrollee’s home in Large Metro areas.	99.9%	Yes
	Enrollees have at least 1 LMHP within 20 miles or 30 minutes of the enrollee’s home in Metro areas.	100%	Yes
Ambetter Service Area consists of only Large Metro and Metro counties			

	At least 1 Pediatrics Practitioner per 2,000 enrollees	1:556	Yes
Ambetter Service Area consists of only Large Metro and Metro counties			

**A. Results and Analysis of the Availability of High-volume & High-impact Specialty Care Practitioners**

Table 3: Specialty Care Practitioner Numeric and Geographic Standards and Results

Practitioner Type Specialty Care	Standards – Goal 90%	2020 Results	Goal Met?
High-volume Specialty Care Practitioners: Obstetrics & Gynecology (OB/GYN)	Enrollees have at least 1 OB/GYN within 45 miles or 60 minutes of the enrollee’s home in Large Metro areas.	100%	Yes
	Enrollees have at least 1 OB/GYN within 45 miles or 60 minutes of the enrollee’s home in Metro areas.	100%	Yes
	At least 1 OB/GYN per 2,000 enrollees	1:452	Yes
High-impact Specialty Care Practitioners: Oncologists	Enrollees have at least 1 Oncologist within 30 miles or 20 minutes of the enrollee’s home in Large Metro areas.	99.6%	Yes
	Enrollees have at least 1 Oncologist within 30 miles or 45 minutes of the enrollee’s home in Metro areas.	99.8%	Yes
Ambetter Service Area consists of only Large Metro and Metro counties			

The data above demonstrate that Ambetter’s network adequacy for MH/SUD providers exceeded the network adequacy for Primary Care and High Volume/High Impact Specialty Care Medical/Surgical providers.

Specifically, for this analysis period, the health plan met the goal for the ratio standards for all practitioner types assessed. Goals for each geographic area reviewed in this analysis were also met for all prescribing and non-prescribing BH practitioner types observed. Although the goals were met for BH providers, the health plan continues to recruit, contract, and credential all available non-par BH practitioners as new practices enter the service area. The health plan also continues to monitor practitioner availability and address any gaps in BH practitioner availability.

***These data support a conclusion that Ambetter’s application of the Standards for Admission to a Provider Network, Including Reimbursement NQTL is applied comparably and no more stringently to MH/SUD providers relative to M/S providers.***

**Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section**

- This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA*

As stated in Step 1 above, all plan document terms that set forth Standards for provider admission to participate in a network, including reimbursement rates are the same for MH/SUD and M/S benefits and providers. Similarly, as stated in steps 2-4 above, all factors, sources, evidentiary standards, and processes that are used to develop Standards for provider admission to participate in a network, including reimbursement rates, as written and in operation, are the same or comparable for all MH/SUD and M/S benefits and providers.

As discussed in Step 4, Ambetter analyzes a wide range of operations measures to monitor the outcome of the methodologies for Standards for provider admission to participate in a network, including reimbursement rates, and has determined that the outcomes of these methodologies are at least comparable and are generally favorable for MH/SUD providers relative to M/S providers.

Based on the foregoing facts and analyses, Ambetter concludes that, under the terms of the plan, as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the identified classifications 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

**NQTL Type: Standards for provider admission to participate in a network, including reimbursement rates**

**Classification(s): Emergency**

**Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification**

- Provide a clear description of the specific NQTL, plan terms, and policies at issue**
- Identify which M/S and MH/SUD benefits are subject to the NQTL**

**Step 1(a): Provide a clear description of the specific NQTL, plan terms, and policies at issue:**

N/A – all Emergency providers are contracted to deliver services to treat both MH/SUD and M/S conditions so it is not possible to distinguish between Emergency M/S and Emergency MH/SUD providers.

**Step 2 – Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits**

<b>Medical/Surgical:</b> N/A	<b>MH/SUD:</b> N/A
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<b>Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.</b> <ul style="list-style-type: none"> <li><i>Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.</i></li> <li><i>To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.</i></li> </ul>	
Medical/Surgical: N/A	MH/SUD: N/A
<b>Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.</b> <ul style="list-style-type: none"> <li><i>The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.</i></li> <li><i>If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).</i></li> <li><i>If the plan’s or issuer’s analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert’s qualifications and the extent to which the plan or issuer ultimately relied upon each expert’s evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.</i></li> </ul>	
Medical/Surgical: N/A	MH/SUD: N/A
<b>Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section</b> <ul style="list-style-type: none"> <li><i>This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA</i></li> </ul>	
N/A	
<b>NQTL Type: Standards for provider admission to participate in a network, including reimbursement rates</b>	
<b>Classification(s): Prescription Drug – N/A</b>	
<b>Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification</b> <ul style="list-style-type: none"> <li>Provide a clear description of the specific NQTL, plan terms, and policies at issue</li> <li>Identify which M/S and MH/SUD benefits are subject to the NQTL</li> </ul>	



Step 1(a): Provide a clear description of the specific NQTL, plan terms, and policies at issue:	
All definitions are the same as state in the Inpatient and Outpatient analyses above	
<b>Step 1(b): Identify the M/S benefits/services for which the NQTL is required:</b>	<b>Step 1(b): Identify the MH/SUD benefits/services for which the NQTL is required:</b>
<b>Access:</b> N/A – all pharmacies dispense both MH/SUD and M/S drugs. Thus it is not possible to distinguish between M/S pharmacy providers and MH/SUD pharmacy providers.	<b>Access:</b> Same as M/S
<b>Credentialing:</b> N/A – The plan does not apply credentialing requirements separately to prescription drug providers. The plan utilizes CVS Caremark as its pharmacy benefit manager. CVS Caremark's credentialing practices were developed without regard to whether a pharmacy specializes in mental health, substance abuse, medical and or surgical fields.	<b>Credentialing:</b> Same as M/S
<b>Reimbursement:</b> N/A – Prescription Drug payment methodologies are not implemented on the basis of diagnosis and formulary design is addressed in separate NQTL analyses	<b>Reimbursement:</b> Same as M/S
<b>Step 2 – Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits</b>	
<b>Medical/Surgical:</b>	<b>MH/SUD:</b>
N/A	N/A
<b>Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.</b>	
<ul style="list-style-type: none"> <li><i>Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.</i></li> <li><i>To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.</i></li> </ul>	
<b>Medical/Surgical:</b>	<b>MH/SUD:</b>
N/A	N/A

<b>Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.</b> <ul style="list-style-type: none"> <li><i>The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.</i></li> <li><i>If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).</i></li> <li><i>If the plan’s or issuer’s analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert’s qualifications and the extent to which the plan or issuer ultimately relied upon each expert’s evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.</i></li> </ul>	
<b>Medical/Surgical:</b>	<b>MH/SUD:</b>
N/A	N/A
<b>Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section</b> <ul style="list-style-type: none"> <li><i>This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA</i></li> </ul>	
N/A	

Appendix

2023 Network Adequacy Report

Practitioner Availability and Accessibility of Services

Network Development and Contracting is responsible for the development and maintenance of Ambetter’s system of providers. The Department works closely with providers to ensure Members have access to providers. It is responsible for the initial build of the provider network and maintenance of existing providers once networks are established. The status of Network Adequacy (for time period 01/01/2023-10/31/2023), across all counties and specialty types (both M/S and Behavioral Health) is attached below.



GA\_NQTL - 2023.xlsx

#### Titles and Qualifications Who Performed/Participated in NQTL Analysis

Title	Qualifications
Director, Pharmacy	Oversees functions related to pharmacy
Vice President, Clinical Pharmacy Solutions	Oversees functions related to pharmacy
Pharmacy Provider Liaison II	Oversees functions related to pharmacy

## NQTL: Prescription Drug Formulary Tiering

**Classification:** Prescription drugs

**Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification**

Definition:

Formulary Tiering is defined as the process that the plan uses to develop the approved list of drugs covered under the pharmacy benefit plan and to assign such drugs to formulary tiers. Drugs that are not on the formulary may be covered on an exception basis if they are not excluded and if medical necessity can be established based on plan-approved prior authorization criteria or applicable regulations.

Ambetter from Peach State Health Plan uses the following formulary tiers

- **Tier 0** - No copayment for those drugs that are used for prevention and are mandated by the Affordable Care Act. Select oral contraceptives, vitamin D, folic acid for women of child bearing age, over-the-counter (OTC) aspirin, and smoking cessation products may be covered under this tier. Certain age limits may apply.
- **Tier 1A** - Lowest copayment for select drugs that offer the greatest value compared to other drugs used to treat similar conditions. Select over-the-counter (OTC) drugs may be covered under this tier.
- **Tier 1B** - Low copayment for those drugs that offer great value compared to other drugs used to treat similar conditions. Select over-the-counter (OTC) drugs may be covered under this tier.
- **Tier 2** - Medium copayment covers brand name drugs that are generally more affordable, or may be preferred compared to other drugs to treat the same conditions.
- **Tier 3** - High copayment covers higher cost brand name and non-preferred generic drugs. This tier may also cover non-specialty drugs that are not on the Prescription Drug List but approval has been granted for coverage.

- **Tier 4** - Highest copayment is for “specialty” drugs used to treat complex, chronic conditions that may require special handling, storage or clinical management. Prescription drugs covered under the specialty tier require fulfillment at a pharmacy that participates in Ambetter's "specialty" or "hemophilia" networks. For additional information on which pharmacies are within our "specialty" or "hemophilia" networks, please consult Ambetter website's pharmacy information section.

The 2023 formulary is available online at <https://ambetter.pshpgeorgia.com/resources/pharmacy-resources.html>

## **Step 2 – Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits**

All drugs (medical, mental health and substance use disorder) are treated equally and follow the same process as outlined.

Determinations of tiering status start with a clinical determination of efficacy by the P&T Committee, followed by an economic evaluation by the Strategy Development Committee (SDC).

The P&T Committee provides clinical determination of efficacy for formulary placement based on the following factors<sup>1,2</sup>:

1. Clinical efficacy
2. Quality of studies
3. Safety
4. Comparable long-term outcomes
5. Comparable populations
6. Ease of use/ease of compliance

Where the P&T Committee determines that two or more drugs are expected to achieve clinically equivalent therapeutic outcomes, SDC assigns drugs to higher or lower tiers based on its evaluation of comparative net cost.

<sup>1</sup> Clinical Pharmacy Advisory Committee Desktop Procedure 04: Clinical Pharmacy Advisory Committee Scoring System

<sup>2</sup> IFP.PHAR.03 Pharmacy and Therapeutics policy

**Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.**

The evidentiary standards applied by the P&T Committee for the factors outlined in Step 2 are as follows<sup>3</sup>:

**1. Clinical Efficacy (50 points)**

- i. Based on the available peer-reviewed, published literature and clinical judgment, clinical efficacy is determined by examining the efficacy of the primary and secondary outcomes of the pivotal clinical trials, and the number of non-responders and the number of patients who withdrew from the trial due to a lack of efficacy. Based on this evaluation, the drug is designated as one of the following with points awarded as follows: “Clearly superior” (41-50 points), “Slightly superior” (31-40 points), “Equal to” (21-30), “Slightly inferior” (11-20) or “Clearly inferior” (0-10).

**2. Quality of Studies (10 points)**

- i. Quality of studies supporting clinical efficacy. The following factors are considered and points are awarded as follows:
  - 1) The number of peer-reviewed pivotal studies (0 trials-0 points, 1 trial-1 point, 2 or more trials-2 points)
  - 2) Consistency of study results
  - 3) Presence of active comparator(s)
  - 4) Method of randomization
  - 5) Trial design (e.g. double-blind, placebo-controlled, multi-center)
  - 6) Description of withdrawals and dropouts
  - 7) Determination of study design as optimal
  - 8) Measurement of clinically meaningful endpoints
  - 9) Reporting of clinically meaningful endpoints
- ii. For 1 to 9, one point is awarded if more than 66% of the studies meet the criteria, or 0 points otherwise.

**3. Safety (24 points)**

- i. The drug is deemed “Superior,” “Equal,” or “Inferior” based on the absolute number and frequency (0-8 points) and severity (0-8 points) of adverse reactions, contraindications and black box warnings compared to the comparator drug and the drug, with a higher score representing more safety than the comparator drugs.
- ii. The drug is deemed “Superior,” “Equal,” or “Inferior” based on the absolute number (0-4 points) and severity (0-4 points) of drug-drug interactions compared to the comparator drug and the drug, with a higher score representing more safety than the comparator drugs.

<sup>3</sup> Clinical Pharmacy Advisory Committee Desktop Procedure 04: Clinical Pharmacy Advisory Committee Scoring System

#### 4. Other considerations (16 points)

- i. The drug is deemed “Superior,” “Equal,” or “Inferior” based on the comparability of long-term outcomes (i.e. availability of long-term outcome data of the drug versus the comparator) with a score awarded between 0 and 6 points, with 6 representing greater availability of such data.
- ii. The drug is deemed “Superior,” “Equal,” or “Inferior” based on comparability of populations (i.e. FDA approved indications or well supported off-label indications, age, race, disease sub-state(s), co-morbid condition(s), functional status, medications tried and failed, hepatic or renal insufficiency). The drug is awarded a score of 0 to 6, with 6 representing a larger applicable patient population for the same indication for the drug against the comparator.
- iii. The drug is deemed “Superior,” “Equal,” or “Inferior” based on ease of use/ease of compliance (i.e. dosing frequency, route of administration or lab work associated with the drug). The drug is awarded a score of 0 to 4, with 4 representing more convenient use of the drug leading to possibly better compliance compared to the comparator.

The scoring system yields a range of scores as follows:

- 78-100, which means that the drug presents significant advantages over current therapies
- 65-77, which means that the drug presents modest benefits over current therapies
- 46-64, which means that use of the drug anticipates equal therapeutic outcomes
- 29-45, which means that the drug may be used under unique circumstances
- 0-28, which means that use of the drug anticipates inferior therapeutic outcomes

Sources: Prescribing information, Phase II or III published trial results, national professional membership society treatment guidelines

Where the P&T Committee determines that two or more drugs are expected to achieve clinically equivalent therapeutic outcomes, SDC evaluates whether net cost savings can be achieved through differential assignment to preferred and non-preferred formulary tiers. Net cost analyses are not absolute values, but are relative cost comparisons between therapeutic alternatives. SDC applies the following factors to recommend preferred status among clinically equivalent drugs based on comparative net cost<sup>4</sup>:

- Net cost definition: net cost is calculated as the average wholesale price (AWP) minus the negotiated pharmacy network rate/discount and any applicable rebate. Net costs are compared among drugs determined by the P&T Committee to achieve clinically equivalent therapeutic outcomes.

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<sup>4</sup> Strategy Development Committee, CC.Pharm.125

- Comparative net cost evidentiary standards:
  - Preferred status is assigned if the drug has significant clinical advantages over current therapies, as determined by the P&T Committee.
  - Preferred status would be assigned if equal therapeutic outcomes are expected compared to other drugs in the class and all of the following scenarios are true:
    - A negotiated manufacturer rebate would make the drug the lowest net cost drug in the class AND
    - The class net cost would be lower AND
    - There are no pipeline events to consider (e.g. near term generic, biosimilar, or additional new molecular entity launch within a particular drug class).
  - Preferred status *would not* be considered if any of the following are true with respect to new FDA approved products that do not present any significant clinical advantages:
    - There are already lower cost generics or brands available with similar safety and efficacy.
    - The two individual drugs within a combination product are generically available
    - Dosage forms where there is a lower cost generic available, e.g., 1) New brand capsule or brand orally disintegrating tablet when there is a generic tablet, 2) New gel formulation when there is a generic alternative topical available.
    - New dose amounts when there are generic strengths available to achieve the same dose.
    - New extended-release formulations when there is a generic immediate-release.
    - New salt ester when another salt form is generically available.
    - New technology when lower cost options are available (e.g. improved ergonomic design for an injectable or better adhesive for a patch)
- Net cost sources: proprietary manufacturer rebate negotiation, Ambetter claims data, MediSpan cost data

**Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to medical or surgical benefits in the benefits classification**

The Plan's processes for formulary development are comparable and no more stringent for MH/SUD services as written. The Plan uses the same formulary tiering decision making process for M/S and MH/SUD drugs. The Clinical Pharmacy Advisory Committee (CPAC) reviews all newly approved drugs and newly-approved indications and dosage forms for formulary status, and scores the drugs based on the factors and evidentiary sources outlined in Steps 2 and 3. This information is then shared with the Pharmacy & Therapeutics (P&T) Committee.

The P&T Committee consists of internal and external actively practicing physicians and pharmacists. For formulary decisions on drugs used to treat mental health or substance use disorders, the P&T Committee incorporates input from appropriate specialists



(e.g., psychiatrists, addiction specialists) who have knowledge and/or experience in treating patients with the specific disease state. The P&T Committee then takes that recommendation and makes a clinical determination of efficacy.

Where the P&T Committee determines that two or more drugs are expected to achieve clinically equivalent therapeutic outcomes, the Strategy Development Committee (SDC) performs an economic evaluation, as outlined in Step 3, to make a final determination for formulary placement.

The Plan's processes regarding formulary development are also comparable and no more stringent for MH/SUD drugs in operation. While outcomes are not demonstrative of parity compliance, we evaluate stringency in operation by analyzing the distribution of M/S and MH/SUD drugs across formulary tiers to ensure that tiering placements are not disproportionately favorable to M/S drugs.

Formulary distribution for M/S drugs (2023):

Tier 1a - 2%  
Tier 1b - 55%  
Tier 2 - 7%  
Tier 3 - 10%  
Tier 4 - 20%  
Tier 0 - 6%

Formulary distribution for MH/SUD drugs (2023):

Tier 1a - 4%  
Tier 1b - 80%  
Tier 2 - 4%  
Tier 3 - 8%  
Tier 4 - 1%  
Tier 0 - 5%

**Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section**

Plan uses the same formulary tiering decision making process for M/S and MH/SUD drugs. On a quarterly basis, drug formulary reviews go through multiple levels of clinical review from CPAC's initial evaluation and tiering recommendation to the Corporate P&T committee's final decision. The process is heavily clinically driven using clinical efficacy, quality of studies, safety, comparable long-term outcomes, comparable populations, and ease of use/ease of compliance as the determining clinical factors for formulary decisions. Each factor is scored using an objective weighted scoring system, which cumulatively determines the formulary tiering recommendation. The sources used for the scoring process include prescribing information, clinical trials, peer-reviewed literature, treatment guidelines and clinical judgment, and these sources are the same regardless of the drug's category. For tiering decisions, financial factors, which are limited to the value of rebate contracts, net cost, market share and the impact on plan revenue, are only considered where two clinically equivalent drugs exist, and these financial factors are applied equally to both MH/SUD and M/S drugs.

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

In operation, in 2023, a significantly higher percentage of MH/SUD drugs compared to M/S drugs were available in Tier 1 (generic), a significantly lower percentage of MH/SUD drugs were placed in Tier 4 (high cost specialty drugs), and a comparable percentage of MH/SUD and M/S drugs were covered in Tier 3 (non-preferred brand). Similarly, in 2023, a higher proportion of MH/SUD drugs were covered in the lowest copayment tiers (1a and 1b – greatest value drugs) relative to M/S drugs, a much lower proportion of MH/SUD drugs were covered in the highest copayment tier (4 – specialty drugs) relative to M/S drugs, and comparable proportions of MH/SUD drugs and M/S drugs were covered in the higher copayment tier (3 – higher cost brand name and non-preferred generic drugs). Thus, for all analyzed plan years, in each tier, in operation, the distribution of drugs is either comparable or more favorable to MH/SUD drugs.

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

## **NQTL: Medical Necessity**

### **Classification: Prescription Drugs**

**Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification**

**Medically necessary** or medical necessity shall mean health care services that a provider (including physicians, nurse practitioners, physician assistants, and other licensed providers), exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease; and
3. Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

Medically necessary health care services may not include experimental and/or investigational technologies

**Step 2 – Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits**

Medical necessity criteria are developed for all drugs.

**Step 3 – Identify any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical or surgical benefits.**

Plan develops all medical necessity criteria and clinical policies for M/S and MH/SUD prescription drugs.

**Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are**

comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification

***Step 4(a)(i): Identify and define the processes and strategies used to select Medical Necessity standards, definitions, or guidelines***

Plan develops all medical necessity criteria and clinical policies for all M/S and MH/SUD prescription drugs.

***Step 4(a)(ii): Identify and define the processes and strategies used to develop internal Medical Necessity guidelines or modifications to external guidelines that are created by the Plan***

Process for creating medical necessity criteria/PA policy:

The need to create or revise a prior authorization policy is identified as part of the clinical evaluation process when a new drug is approved by the FDA, a new indication is given to a new dosage form of a drug, a new indication is given for a drug without a new dosage, clinically significant changes are needed due to updates to evidence-based national treatment guidelines or the publication of new study information, and/or there are updates to FDA-approved labeling.

When a new drug product or new indication is approved by the FDA, two clinical pharmacists are assigned to review the drug. A clinical pharmacist will be assigned as the author to complete the new drug review is responsible for creating a PA policy. The other pharmacist will serve as the primary reviewer to the author. The author will create a draft policy, which will be sent to at least two external physician specialists representing the applicable area of specialty and preferably certified by a Board of various American medical specialties (i.e. American Board of Medical Specialties [ABMS], American Board of Physician Specialties (ABPS), and American Osteopathic Association Bureau of Osteopathic Specialists [AOABOS]) for review and feedback. The author will revise the PA policy, if necessary, based on input from specialists. The two clinical pharmacists must agree on the recommendation, or else the Chair of the Clinical Pharmacy Advisory Committee (CPAC), a subcommittee of the Envolv Pharmacy Solutions Pharmacy and Therapeutics (P&T) Committee, will need to further review the recommendation.

The author will present the PA policy to CPAC and makes revisions based on input from CPAC. CPAC members include practitioners with professional knowledge or clinical expertise who have knowledge of the development, review, and the criteria used to adopt all drug related clinical policies. When CPAC approves the PA policy, the status will be changed from a draft PA policy to an interim PA policy. After CPAC approval, the recommendation is presented at a quarterly P&T Committee meeting, which ultimately approves the recommendation after any further feedback or changes to the recommendation.

***Step 4(b): Identify and describe the evidentiary standards relied upon for Medical Necessity guidelines, or modifications to external guidelines that are created by the Plan***

Sources:

- The American Hospital Formulary Service (AHFS) Drug Information
- Truven Health Analytics Micromedex DrugDex
- National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
- Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines
- Clinical Pharmacology
- Lexi-Comp
- The most recent manufacturer's Prescribing Information document and formulary dossier
- Peer reviewed medical literature
- Other reviews and monographs (e.g., The Formulary Monograph Service Inc.)
- Evidence-based medicine resources (e.g., HAYES, EBMS)
- Evidence-based clinical practice guidelines
- Peer-reviewed medical literature appearing in the regular editions for off-label use of drugs and biologicals in an anti-cancer chemotherapeutic regimen

***Step 4(c): Identify and define the factors and processes that are used to monitor and evaluate the efficacy and validity of Medical Necessity guidelines***

The Utilization Management Committee and the Quality Improvement committee meet on a quarterly basis wherein denial rates, appeal rates, are reviewed.

These committees are comprised of appropriate behavioral health practitioners, practicing psychiatrists, Medical Directors, appropriate medical professionals and utilization management program staff.

Updates and revisions to policies and criteria are reviewed annually. During this time, appropriate behavioral health practitioners, including but not limited to psychiatrists, psychologists, and social workers with professional knowledge or clinical expertise in the area being reviewed have an opportunity to give advice or comment on adoption of UM criteria and on instructions for applying the criteria.

Our training and policies ensure appropriate utilization of medical necessity criteria and clinical policies for prescription drugs with annual Inter-rater reliability testing. All Utilization Managers applying MNC must pass this annual test. Coverage criteria are evidence-based, standards for medical necessity reviews. We review denial rates, appeal overturn rates and ensure the inter-rater reliability annually.

**Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section**

For each step, the relevant information is the same for M/S and MH/SUD benefits. Therefore, we conclude that, as written and in operation, the processes, strategies, evidentiary standards, and factors used to develop MN criteria for MH/SUD drugs are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to develop MN criteria for medical/surgical drugs.

## NQTL: Experimental and Investigational

### Classification: Prescription Drugs

#### Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification

Prescription drugs determined to be experimental or investigational are excluded from the Plan's definition for medically necessary treatments and services and are excluded from coverage.

***Experimental or investigational treatment*** means medical, surgical, diagnostic, or other health care services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that, after consultation with a medical professional, we determine to be:

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("USFDA") regulation, regardless of whether the trial is subject to USFDA oversight.
2. An *unproven service*.
3. Subject to USFDA approval, and:
  - a. It does not have USFDA approval;
  - b. It has USFDA approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
  - c. It has USFDA approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a USFDA-approved drug is a use that is determined by *us* to be:
    - i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
    - ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
    - iii. Not an *unproven service*; or
  - d. It has USFDA approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the USFDA or has not been determined through peer reviewed medical literature to treat the medical condition of the *member*.
4. *Experimental or investigational* according to the *provider's* research protocols.

#### Step 2 – Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits

N/A – E/I treatments are not covered benefits

**Step 3 – Identify any source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.**

Determinations of whether a prescription drug is experimental or investigational are based on the sources and evidentiary standards set forth in the definition below.

***Experimental or investigational treatment*** means medical, surgical, diagnostic, or other health care services, treatments, procedures, technologies, supplies, devices, drug therapies, or medications that, after consultation with a medical professional, we determine to be:

1. Under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration ("USFDA") regulation, regardless of whether the trial is subject to USFDA oversight.
2. An *unproven service*.
3. Subject to USFDA approval, and:
  - a. It does not have USFDA approval;
  - b. It has USFDA approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
  - c. It has USFDA approval, but is being used for an indication or at a dosage that is not an accepted off-label use. An accepted off-label use of a USFDA-approved drug is a use that is determined by *us* to be:
    - i. Included in authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
    - ii. Safe and effective for the proposed use based on supportive clinical evidence in peer-reviewed medical publications; or
    - iii. Not an *unproven service*; or
  - d. It has USFDA approval, but is being used for a use, or to treat a condition, that is not listed on the Premarket Approval issued by the USFDA or has not been determined through peer reviewed medical literature to treat the medical condition of the *member*.
4. *Experimental or investigational* according to the *provider's* research protocols.

**Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to medical or surgical benefits in the benefits classification**



**Step 4(a)(i): Identify the conditions or factors, if any, under which E/I treatments or services are covered**

N/A – prescriptions determined to be E/I are not covered

**Step 4(b): Briefly describe the processes by which coverage determinations or exceptions are made for E/I Treatments**

Coverage or exception determinations are made according to the same processes as applied to Prior Authorization.

**Step 4(c): Identify and define the factors and processes that are used to monitor and evaluate the application of E/I Treatment policies**

The volume of E/I determinations, coverage denials for E/I services, and appeals is too low to permit meaningful quantitative comparisons between M/S and MH/SUD. However, the same in operation processes and strategies are used to determine whether identified services are E/I, regardless of whether the treated condition is a M/S or MH/SUD condition.

**Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section**

For each step, the relevant information is the same for M/S and MH/SUD benefits. Therefore, we conclude that, as written and in operation, the processes, strategies, evidentiary standards, and factors used to design and apply E/I determinations for MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to design and apply E/I determinations for medical/surgical benefits in each classification of benefits.

## NQTL: Prior Authorization

### Classification: Prescription Drugs

**Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification**

Definition:

Prior authorization is applied to identified formulary drugs, formulary exceptions, and exceptions to step therapy and other utilization management policies to ensure that the prescription is medically necessary—i.e. reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care.

Prior authorization is applied to coverage determinations for which manual review is appropriate (i.e. where auto-adjudication is not appropriate). Prior authorization criteria may require information retrievable from both the pharmacy claims adjudication system and the member's medical charts.

Drugs subject to PA: please see 2023 formulary at <https://ambetter.pshpgeorgia.com/resources/pharmacy-resources.html>

*CC.PHARM.55: Prior Authorization Policy Development*

**Step 2 – Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits**

Factors used to determine that prior authorization will apply to a drug are<sup>5</sup>:

- a) The abuse potential of the drug:
- b) Whether a new to market molecular entity has been evaluated by the P&T Committee
- c) The possibility for off-label use of the drug

<sup>5</sup> CC.PHARM.55: Prior Authorization Policy Development

- d) Any safety or efficacy concerns
- e) The place in therapy of the drug with respect to standard of care

Next, if at least one of these factors is met, and if there is an opportunity to manage cost, then SDC evaluates whether utilization management goals can be met through formulary tiering and/or a ST policy. PA is generally the preferred strategy when the concerns identified according to the factors above are significant and/or where clinical review is likely to be necessary (as opposed to automated processes pursuant to FT or ST).

**Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.**

- a) The abuse potential of the drug:
  - *Evidentiary standard:* abuse potential is determined by the CPAC based on euphoric potential identified in clinical trial results, or based on DEA designation as a controlled substance
  - *Sources:* DEA scheduling, Phase III clinical trial results, package insert or manufacturer dossier
- b) Whether a new to market molecular entity has been evaluated by the P&T Committee
  - *Evidentiary standard:* all new molecular entities are non-formulary until reviewed by the P&T Committee. The Pipeline team tracks all drugs submitted to FDA for approval process and ensures that drugs in Part D protected classes are reviewed within 90 days, and that all other drugs are reviewed within 180 days.
  - *Sources:* P&T Committee review status
- c) The drug is commonly used off-label
  - *Evidentiary standard:* common off-label use is identified when there are on-going clinical trials for other indications, when external specialists providing input to the P&T Committee express high-likelihood of off-label use of the drug due to unavailability of effective therapies for related indications, when a drug is newly approved in a class that is commonly used for various other indications
  - *Sources:* treatment guidelines, specialist opinion, availability of peer-reviewed studies for other clinical indications for the drug, currently on-going clinical trials for other indications
- d) Significant safety or efficacy concerns
  - *Evidentiary standard:* as identified in the P&T scoring sheet review, prescribing information, Phase III clinical trial results
  - *Sources:* see P&T scoring sheet
- e) The drug is not a first-line agent under the prevailing standard of care
  - *Evidentiary standard:* is the drug not a first-line agent
  - *Sources:* treatment guidelines, specialist opinion, study design

Sources:

- The American Hospital Formulary Service (AHFS) Drug Information
- Truven Health Analytics Micromedex DrugDex
- National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
- Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines
- Clinical Pharmacology
- Lexi-Comp
- The most recent manufacturer's Prescribing Information document and formulary dossier
- Peer reviewed medical literature
- Other reviews and monographs (e.g., The Formulary Monograph Service Inc.)
- Evidence-based medicine resources (e.g., HAYES, EBMS)
- Evidence-based clinical practice guidelines
- Peer-reviewed medical literature appearing in the regular editions for off-label use of drugs and biologicals in an anti-cancer chemotherapeutic regimen

**Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification**

1. In order for a PA request to be covered, the prescriber must submit information consistent with the developed criteria to obtain approval for the medication. A form for submission of a PA request is posted on Plan web sites. Use of this form is not required to obtain approval, but the form is provided as guidance on the information that may be necessary to assure prompt review of a PA request.
2. Initial PA requests are reviewed by a Pharmacy Technician (PT) or a licensed Clinical Pharmacist at Envolve Pharmacy Solutions. For requests that meet initial screening criteria, an authorization for approval is entered in the Envolve Pharmacy Solutions PBM application and the prescriber notified that approval has been granted.
  - a. If the request does not contain sufficient information to make an informed decision, the Envolve Pharmacy Solutions reviewer notifies the prescriber and documents the request for additional information. The additional information notification outlines clinical information that is required for approval.
  - b. If the additional information is not received within the timeframes established by NCQA or the state, whichever requires the faster response time, a denial notification is processed in accordance with the process described above.

3. Standard and urgent PA requests are responded to within the applicable timeframe established by NCQA or the state, whichever requires the faster response time.
  - a. For formulary exception requests, verbal notification of the determination for the exception request will be provided no later than 72 hours after the request is received or within 24 hours for urgent requests or when the enrollee is suffering from a serious health condition. A written response will be provided within 48 hours of the verbal notification.
4. When a request does not meet criteria, the request is forwarded to a licensed Envolve Pharmacy Solutions Clinical Pharmacist for a final determination. Clinical Pharmacists review all denials unless state law requires a physician or other practitioner's review.
5. In the event of a PA denial, the prescriber is faxed notification of the adverse determination, including the reason for the denial, along with a request for use of formulary alternatives (when appropriate). Envolve Pharmacy Solutions provides the Ambetter health plans, on a daily basis, a completed member denial letter for each denial processed.
6. The member denial letter is mailed to the member by Envolve Pharmacy Solutions within three (3) calendar days of making the final determination, not to exceed the timeframes established by NCQA or the state. Both the prescriber notification and the member denial letters include the reason for the denial and language notifying them of their rights to appeal the decision, including contact information at both the Plan and any applicable state agencies, if required.
7. The prescriber or the member may request reconsideration of any denial made by Envolve Pharmacy Solutions or the Plan health plan Medical Director.

***Step 4(c): Identify and define the factors and processes that are used to monitor and evaluate the application of Prior Authorization***

Quantity/Proportion of M/S drugs subject to PA:

Percentage of M/S formulary drugs that currently require prior authorization is 30%

PA denial rates for M/S:

From 1/1/23 to 11/30/23, 38% of M/S PAs were denied.

PA appeal rates for M/S:

From 1/1/23 to 11/30/23, 3% of MH/SUD PA decisions were appealed.

***Step 4(c) : Identify and define the factors and processes that are used to monitor and evaluate the application of Prior Authorization***

Quantity/Proportion of MH/SUD drugs subject to PA:

Percentage of MH/SUD formulary drugs that currently require prior authorization is 11%

PA denial rates for MH/SUD:

From 1/1/23 to 11/30/23, 30% of MH/SUD PAs were denied.

PA appeal rates for MH/SUD:

From 1/1/23 to 11/30/23, 2% of MH/SUD PA decisions were appealed.

**Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section**

The process for creating a prior authorization policy for a drug is the same for both M/S and MH/SUD drugs. When defined triggers for prior authorization policy development are met, two clinical pharmacists develop the initial prior authorization policy recommendation with input from applicable physician specialists for the drug at issue, which is then reviewed by CPAC and ultimately subject to approval by the P&T Committee on a quarterly basis.

The two clinical pharmacists determine whether to recommend a prior authorization policy for a drug based on the drug's abuse potential, whether the drug is new to the market, possible off-label use of the drug, safety/efficacy concerns and the drug's place in therapy with respect to the standard of care. Whether each factor is met is based upon defined evidentiary standards, which are based upon clinical or regulatory sources, such as drug compendiums, prescribing information and peer-reviewed medical literature. The factors, standards and sources for those standards are the same regardless of whether a drug is a M/S or MH/SUD drug.

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

In operation, a request for prior authorization is subject to the same review process for both M/S and MH/SUD drugs, and the same reviewers are used for M/S and MH/SUD drug authorization reviews. A patient's prescriber requests the prior authorization, which is either approved or denied by a pharmacy technician or licensed clinical pharmacist, with a final determination made by a clinical pharmacist. Request approval timelines for all drug categories adhere to NCQA and state standards. Prescribers or patients may request reconsideration of any denial.

In operation, the percentage of MH/SUD drugs requiring prior authorization is much lower than the percentage of M/S drugs requiring prior authorization. The denial rate for MH/SUD drug requests (30%) is lower than the denial rate for M/S drug requests (38%) and the very low rate of appeals for MH/SUD drugs (2%) indicates that benefit determinations and denials for MH/SUD drugs are in fact performed in a manner that is no more stringent than determinations and denials for M/S drugs.

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

## NQTL: Step Therapy

### Classification: Prescription Drugs

#### **Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification**

Definition: Step Therapy (ST) is the practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug and progressing to other more costly or risky therapy, only if necessary (i.e., members must try drug "A" before they can get drug "B").

Step therapy includes coverage determinations that can be made appropriately through auto-adjudication and determinations that require manual authorizations pursuant to clinical review. ST criteria require information that are retrievable by the pharmacy claims adjudication system. Such information typically include: drug use history and age.

#### **Step 2 – Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits**

Step therapy is required for a drug where:

- (1) Equal clinical therapeutic outcomes are anticipated between the requested product and the redirected product, and
- (2) Treatment guidelines support the redirected product as the first-line treatment option.

Drugs subject to ST: please see 2023 formulary at <https://ambetter.pshpgeorgia.com/resources/pharmacy-resources.html>

#### **Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.**

**(1) Equivalence of clinical therapeutic outcomes**

(a) *Evidentiary standard:* drugs determined to yield equal or superior therapeutic outcomes under the CPAC scoring system\* are determined to provide equivalent clinical therapeutic outcomes

(b) *Sources:* CPAC scoring sheet

*\*see full description of the factors, sources, and evidentiary standards for the CPAC scoring system in the Formulary Tiering NQTL analysis*

**(2) Treatment guidelines support the redirected product as the first-line treatment option**

(a) *Evidentiary standard:* a treatment guideline exists to indicate a first-line treatment alternative to the drug under consideration that is clinically acceptable for the indication. If there are multiple choices for a first line agent and some agents are not covered by the plan formulary, the first-line agent will be selected from the agents that are preferred on the formulary.

(b) *Sources:* national treatment guidelines

**Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to medical or surgical benefits in the benefits classification**

Medical/Surgical:

Triggers for determining whether to create a ST policy:

Same as for PA

Process for creating a ST policy:

Same as for PA

Quantity/proportion of M/S drugs currently subject to ST:

**2%** of M/S Drugs are subject to ST

Data regarding denials, appeals, and appeal overturns include both ST and PA. Any claim that gets rejected at point of service

MH/SUD

Triggers for determining whether to create a ST policy:

Same as for M/S

Process for creating a ST policy:

Same as for M/S

Quantity/proportion of MH/SUD drugs currently subject to ST:

**2%** of MH/SUD drugs are subject to ST

Data regarding denials, appeals, and appeal overturns include both ST and PA. Any claim that gets rejected at point of service pursuant to a ST requirement would turn into a PA and be processed as such.



<p>pursuant to a ST requirement would turn into a PA and be processed as such.</p> <p><u>Denial rates for failure to complete the required steps</u> Same as PA</p> <p><u>Internal and/or external appeal rates</u> Same as PA</p> <p><u>Appeal overturn rates</u> Same as PA</p>	<p><u>Denial rates for failure to complete the required steps</u> Same as PA</p> <p><u>Internal and/or external appeal rates</u> Same as PA</p> <p><u>Appeal overturn rates</u> Same as PA</p>
<p><b>Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section</b></p>	
<p>The process for creating a step therapy policy for a drug is the same for both M/S and MH/SUD drugs. When defined triggers for step therapy policy development are met, two clinical pharmacists develop the initial prior authorization policy recommendation with input from applicable physician specialists for the drug at issue, which is then reviewed by CPAC and ultimately subject to approval by the P&amp;T Committee on a quarterly basis.</p> <p>The two clinical pharmacists determine whether to recommend a step therapy policy for a drug based on two factors: 1) Whether there are two drugs with equivalent therapeutic outcomes and 2) Whether treatment guidelines support the redirected drug as the first-line treatment option. The determination as to the former is based on an objective weighted scoring system and the latter is sourced from national treatment guidelines. These factors, standards and sources are the same regardless of whether a drug is a M/S or MH/SUD drug.</p> <p>Thus we conclude that the processes, strategies, evidentiary standards, and other factors used to apply Step Therapy to MH/SUD drugs, as <i>written</i>, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply Step Therapy to M/S drugs.</p> <p>In operation, for both M/S and MH/SUD drugs, authorization approval timelines adhere to NCQA and state standards. Finally, the percentage of MH/SUD drugs subject to Step Therapy is comparable to the percentage of M/S drugs subject to Step Therapy, noting that overall, very few drugs in general require Step Therapy (4/197 MH/SUD and 28/1853 M/S drugs require Step Therapy).</p>	

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

Titles and Qualifications Who Performed/Participated in NQTL Analysis

Title	Qualifications
Staff Vice President, Network Development & Contracting	Oversees functions related to networking development and contracting
Director, Network Reimbursement & Performance	Oversees functions related to reimbursement and performance
Manager, Reimbursement	Oversees functions related to reimbursement
Senior Manager, Data Analytics & Reporting	Oversees analytics and reporting related to network access
Senior Manager, Credentialing	Oversees functions related to credentialing
Senior Director, Contracting & Network Development	Oversees functions related to network contracting
Vice President, Implementation & Integration	Oversees functions related to implementation and integration

NQTL Type: Standards for provider admission to participate in a network, including reimbursement rates
Classification(s): Inpatient (In-network)
<b>Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification</b> <ul style="list-style-type: none"><li>• <i>Provide a clear description of the specific NQTL, plan terms, and policies at issue</i></li><li>• <i>Identify which M/S and MH/SUD benefits are subject to the NQTL</i></li></ul>
<b>Step 1(a): Provide a clear description of the specific NQTL, plan terms, and policies at issue:</b> <p><b>Access:</b></p> <p>Ambetter from Peach State Health Plan (“Ambetter”) defines the Standards for Provider Admission to Participate in a Network, including Reimbursement Rates NQTL to mean the performance of initial and ongoing assessments of its organizational providers in compliance with applicable local, state, and federal accreditation requirements, including the collection, verification, and evaluation of information on organizational providers to achieve a decision to approve or deny network participation in Ambetter’s contracted networks of qualified organizational health care providers, and home and community-based service providers pursuant to a negotiated and agreed-upon reimbursement methodology. Network access and monitoring, provider credentialing, and reimbursement rate-setting methodologies are three key components of the plan’s integrated strategy for Standards for Provider Admission to Participate in a Network, including Reimbursement Rates, and are described separately in each step of this comparative analysis for convenience, but ultimately function as integrated components of a comprehensive strategy for this NQTL.</p> <p>Ambetter ensures that its network has sufficient numbers and types of practitioners who provide primary care, behavioral health care and specialty care to meet the needs and preferences of its membership and adapts its network access, provider reimbursement, and credentialing strategies as needed to meet these needs and preferences. Reimbursement refers to the process of compensating providers for health care services rendered to beneficiaries. Credentialing is the process of obtaining and reviewing documentation to make a threshold determination of whether a provider may be accepted to participate in Ambetter’s network for facilities, suppliers, individual practitioners, and other providers (“providers”). The credentialing process requires providers to submit documentation including, but not limited to, the provider’s education, training, clinical privileges, experience, licensure, accreditation, certifications, professional liability insurance, malpractice history and professional competence. Generally, the terms credentialing and recredentialing include the review</p>

of the information and documentation collected, as well as verification that the information is accurate and complete. The Director of Contracting & Network Development provides guidance for and oversight of provider network admission and monitoring standards as described in Evaluation of Practitioner Availability Policy (CC.PRVR.47, pg. 1-6) and Network Adequacy and Accessibility Requirements, Reporting, and Monitoring Policy (HIM.NTWK.02, pg. 1-4).	
*Note: As used in this document the term “Plan” refers to Ambetter from Peach State Health Plan	
<b>Step 1(b): Identify the M/S benefits/services for which the NQTL is required:</b>  All benefits and services are available from the provider network, which is developed through the Network Access strategy.  Practitioners who practice exclusively within an inpatient setting or freestanding facilities and who provide care for Plan members only as a result of members being directed to the hospital, inpatient setting, or free-standing facility do not require credentialing.	<b>Step 1(b): Identify the MH/SUD benefits/services for which the NQTL is required:</b>  Same as M/S
<b>Step 2 – Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits</b>	
<b><u>Medical/Surgical:</u></b>  <i>Note: although this prompt asks for the “factors used to determine that the NQTL will apply,” because this NQTL applies to 100% of benefits in all classifications, this response reflects the factors used in the design of how this NQTL applies to providers of M/S services as compares to providers of MH/SUD services. This is a more meaningful framing for a comparability and stringency analysis for this NQTL type.</i>  <b>Access:</b>  Ambetter considers the following factors in developing the provider network admission and/or recruitment standards for M/S Providers: <ol style="list-style-type: none"> <li>Product License Network Adequacy Requirements</li> <li>Provider/Practitioner Licensing</li> <li>Geographic Distribution of Providers</li> <li>Cultural Needs and Preferences</li> <li>Availability of High-Volume/High Impact Specialty Providers</li> </ol>	<b><u>MH/SUD:</u></b>  <i>Note: although this prompt asks for the “factors used to determine that the NQTL will apply,” because this NQTL applies to 100% of benefits in all classifications, this response reflects the factors used in the design of how this NQTL applies to providers of M/S services as compares to providers of MH/SUD services. This is a more meaningful framing for a comparability and stringency analysis for this NQTL type.</i>  <b>Access:</b>  Same as M/S

<p><b>Credentialing:</b></p> <p><b>N/A</b> - Practitioners who practice exclusively within an inpatient setting or freestanding facilities and who provide care for Plan members only as a result of members being directed to the hospital, inpatient setting, or free-standing facility do not require credentialing.</p>	<p><b>Credentialing:</b></p> <p>Same as M/S</p>
<p><b>Reimbursement:</b></p> <p>The Plan considers the following factors when setting reimbursement for inpatient services, and determining that the reimbursement rate is appropriate:</p> <p><b>a. <u>Standard Pricing:</u></b></p> <ul style="list-style-type: none"> <li>i. The Plan establishes Standard Pricing based on the methodologies used by CMS for Medicare population based on the following factors: <ul style="list-style-type: none"> <li>1. The CMS methodologies are the industry standard for inpatient M/S services</li> <li>2. The CMS methodologies are well documented and supported by objective standards and data accessible to all stakeholders</li> </ul> </li> </ul> <p><b>b. <u>Provider negotiation factors:</u></b> No one factor is systematically given greater weight and the underlying data is provider and circumstance specific.</p> <ul style="list-style-type: none"> <li>i. Provider necessary to meet federal and state regulatory requirements for network adequacy with locations and/or the required number of practitioners available to meet the population needs within member drive time and distance requirements:</li> <li>ii. Provider's certified service offerings providing essential or unique services or supplies:</li> </ul>	<p><b>Reimbursement:</b></p> <p>Same as M/S</p>

<div> <div>iii. Practitioners or facilities rendering care at locations affiliated with in network Providers</div> <div>iv. Demonstrated quality performance</div> <div>v. Member out of network utilization trend (e.g. reputation, location, quality, services)</div> <div>vi. Member requested provider including requests by Broker/Sales Departments</div> <div>vii. Member specific single case agreements</div> </div>	
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**Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.**

- Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.*
- To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.*

<b><u>Medical/Surgical:</u></b>	<b><u>MH/SUD:</u></b>
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<b>Access:</b>						
<div> <div>1. Product License Network Adequacy Requirement:</div> <div> <div>a. Evidentiary standard:</div> <div>i. Plans ensure that 90% of members have access to care for prescribed specialties as determined by CMS’s time and distance standards, which are listed below.</div> </div> </div>						
		<b>Large Metro</b>	<b>Metro</b>	<b>Micro</b>	<b>Rural</b>	<b>CEAC</b>
<b>General hospital</b>	<b>Mileage</b>	10	30	60	60	100
	<b>Minutes</b>	20	45	80	75	110
<b>Primary Care</b>	<b>Mileage</b>	5	10	20	30	60
	<b>Minutes</b>	10	15	30	40	70

<b>Access:</b>						
<div> <div>1. Product License Network Adequacy Requirement:</div> <div> <div>Same as M/S</div> </div> </div>						

OB-GYN	Mileage	15	40	75	90	130
	Minutes	30	60	100	110	145
Dental	Mileage	15	30	60	75	110
	Minutes	30	45	80	90	125
Medical/Surgical Oncology	Mileage	10	30	45	60	100
	Minutes	20	45	60	75	110
Mental Health	Mileage	10	30	45	60	100
	Minutes	20	45	60	75	110
Outpatient Dialysis	Mileage	15	30	60	75	110
	Minutes	30	45	80	90	125
Pharmacy	Mileage	15	40	75	90	130
	Minutes	30	60	100	110	145
All Other Specialists included in QHP Filings	Mileage	15	40	75	90	130
	Minutes	30	60	100	110	145

- a. Sources: Network Adequacy Requirements, Reporting, and Monitoring Policy HIM.NTWK.02 (pg. 3), 45 C.F.R. 156.230(a)(2), CMS 2023 Final Letter to Issuers in the Federally-facilitated Exchanges at pg. 14, <https://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/final-2023-letter-to-issuers.pdf>; CMS Qualified Health Plan Issuer Application Instructions

2. **Provider / Practitioner Licensing:**

- a. *Evidentiary standard:* All network providers must demonstrate Professional Competence. For health care practitioners, verification of applicable education and training upon initial credentialing and maintenance of valid professional licensure for practitioner’s field of practice upon recredentialing, which includes requirements for Continuing Medical Education, are accepted as evidence of maintenance of knowledge and ability in practice area(s) for health care practitioner.
- b. *Source:* Practitioner Credentialing & Recredentialing Policy CC.CRED.01\_Practitioner\_Cred\_and\_Recred (pg. 5).

3. **Geographic Distribution of Primary Care Providers:**
- a. *Evidentiary standard:* Primary Care Providers deliver both M/S and MH/SUD services. The geographic requirements for Primary Care Providers are described above.
  - b. *Source:* Network Adequacy and Accessibility Requirements, Reporting and Monitoring HIM.NTWK.02 (pg. 3), C.F.R. 156.230(a)(2), CMS Qualified Health Plan Issuer Application Instructions

4. **Cultural Needs and Preferences:**
- a. *Evidentiary standard:*
    - i. The Plan assesses the cultural, ethnic, racial, and linguistic needs of its members at enrollment by capturing information on primary language and any other special needs. The Plan maintains the provided information in its system, which tracks enrollment, language, utilization, claims, referrals and pharmacy information. The availability of practitioners is adjusted within the network (if necessary) based on this information. The Plan utilizes the Provider Directory to notify members of any specialized services, including linguistic capabilities and handicap access, offered by network providers.
  - b. *Source:* Cultural Competency and Linguistic Assistance Policy CC.QI.CLAS.29 (pg. 4).

5. **Population Ratios:**
- a. *Evidentiary standard:* The Plan developed the below population ratios based on guidance from CMS and the NCQA.

Specialty	Ratio
Primary Care	1:2,000
Pediatrics	1:2,000
Allergy/Immunology	1:15,000
Cardiology	1:3,700
Endocrinology	1:15,000
Hematology/Oncology	1:15,000
Infectious Disease	1:15,000
Neurology	1:15,000

2. **Provider / Practitioner Licensing:**

Same as M/S

3. **Geographic Distribution of Primary Care Providers:**

Same as M/S

4. **Cultural Needs and Preferences:**

Same as M/S



Psychiatry	1:15,000
Rheumatology	1:15,000
General Surgery	1:5,000
OB/GYN	1:2,000

a. *Source:* CMS, Medicare Advantage Network Adequacy Criteria Guidance (pg. 8); NCQA, Network Management, Network Adequacy (pg. 186); and Accessibility Requirements, Reporting and Monitoring HIM.NTWK.02 (pg. 3).

**6. Availability of High Volume/High Impact Specialty Providers:**

- a. *Evidentiary standard:*
- i. The Plan identifies obstetricians/gynecologists as high volume/high impact specialty care practitioners pursuant to NCQA definitions.
    - 1. Obstetricians/Gynecologists- Members will have access to at least one obstetrician/gynecologist (OB/GYN) as described above.
    - 2. Oncologists - Members will have access to at least one oncologist as described above.
- b. *Source:* Evaluation of Practitioner Availability HIM.NTWK.02 (pg. 3).

**5. Population Ratios:**

Same as M/S

**6. Availability of High Volume/High Impact Specialty Providers:**

Same as M/S

**Credentialing:**

**N/A** - Practitioners who practice exclusively within an inpatient setting or freestanding facilities and who provide care for Plan members only as a result of members being directed to the hospital, inpatient setting, or free-standing facility do not require credentialing.

**Credentialing:**

Same as M/S

<p><b>Reimbursement:</b></p> <p><b>1. <u>Standard Pricing Methodology</u></b></p> <p>a. The Plan establishes Standard Pricing based on the methodologies used by CMS for Medicare population based on the following factors: The CMS methodologies are the industry standard for inpatient M/S services. Industry Standard methodology is applying the pricing components that describes the resources consumed by a rendered services (DRG Weights, RVU's, and Base Units) and establishing a standard rate that should be agreeable to most providers for the pricing component that converts the rendered service into a payment rate. The CMS methodologies are well documented and supported by objective standards and data accessible to all stakeholders.</p> <p><b>2. <u>Provider Negotiations</u></b></p> <p>For all providers for whom a Standard Pricing model exists, the targeted pricing level begins with the Standard Pricing described above. The Plan responds to provider-initiated requests to increase this standard pricing where the provider meets one or more of the following factors, and roughly proportionate to the cumulative weight of these factors:</p> <p>a. Provider necessary to meet network adequacy with locations and/or the required number of practitioners available to meet the population needs within member drive time and distance requirements:</p> <p>i. Definition, evidentiary standard, and sources: When there is a need identified in the network of participating providers for inpatient services, recruitment is initiated to execute provider agreements to fill network requirements.</p> <p>b. Provider's certified service offerings providing essential or unique services or supplies:</p>	<p><b>Reimbursement:</b></p> <p>Same as M/S</p>
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- i. Definition, evidentiary standard, and sources: Services not generally found offered by providers in the same specialty type, in the judgement and expertise of the reviewer, including propriety care delivery models, service techniques, complexity of cases treated, sole manufacturing of devices or trademarks, and for which member care needs may not be met in the plan region(s) served.
- c. Practitioners or facilities rendering care at locations affiliated with in network Providers
  - i. Definition, evidentiary standard, and sources: Non-participating practitioners or facilities rendering care in a participating provider location whether independently owned or under common ownership with the participating provider may allow for negotiation if care cannot reasonably be re-directed to in-network providers.
- d. Demonstrated quality performance
  - i. Definition, evidentiary standard, and sources: High Performing Providers are identified through the partnership with a third party agency, gathering information from CMS on the providers relative to our market and disclosing the information in a manner to allow the plan to target those deemed as “high performing”.
- e. Member out of network utilization trend (e.g. reputation, location, quality, services)
  - i. Definition, evidentiary standard, and sources: Claims experience demonstrating repeating utilization, typically within the preceding twelve month period, due to circumstances such as anticipated word of mouth or marketing campaign activity causing member steerage.
- f. Member requested provider including requests by Broker/Sales Departments

<p>i. Definition, evidentiary standard, and sources: Incoming requests from either internal or external Sales Agents/Brokers interacting with members or prospective membership and receiving requests to add named Providers to the network of participating providers. Requests directly from members to other plan internal departments such as Customer Service.</p> <p>g. Member specific single case agreements</p> <p>i. Definition, evidentiary standard, and sources: Negotiation with an out of network Provider for a single member’s specific case where circumstances drive the required use of the OON provider for the necessary services, devices, supplies. Case may represent unique member conditions, treatment plan, or the continuation of care delivery by out of network providers until transition to a participating provider can reasonably occur.</p>	
<p><b>Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.</b></p> <ul style="list-style-type: none"> <li><i>The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.</i></li> <li><i>If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).</i></li> <li><i>If the plan’s or issuer’s analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert’s qualifications and the extent to which the plan or issuer ultimately relied upon each expert’s evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.</i></li> </ul>	
<p><b>Medical/Surgical:</b></p> <p><b>Access:</b> Ambetter ensures that its network has sufficient numbers and types of practitioners who provide primary care, behavioral health care and specialty care to meet the needs and preferences of its membership. The Director of Contracting &amp; Network Development provides guidance and oversight over monitoring provider network admission standards as described in Evaluation of Practitioner Availability Policy (CC.PRVR.47, pg. 1-6) and Network Adequacy and Accessibility Requirements, Reporting, and Monitoring Policy (HIM.NTWK.02, pg. 1-2).</p>	<p><b>MH/SUD:</b></p> <p><b>Access:</b> Same as M/S</p>

Network adequacy must also be demonstrated to licensing agencies when applying for an insurance plan license to sell a product in a prescribed market area. Ambetter follows CMS Medicare standards plus a select list of additional specialties identified by the plan to enhance market support. Outcomes are monitored using a specific software application, Quest®.

In cases where the Georgia OCI, or other state agency, has additional requirements or different access standards, Ambetter will adhere to the broadest and most stringent standards.

When no regulation or direction exists from a government entity, Ambetter will apply a set of standards developed by Network Development. Annually, Network Development in conjunction with Regulatory Operations will review CMS guidance on current year requirements and update the adequacy and accessibility standards accordingly.

A county must meet the minimum network adequacy requirement, or have a mutually (Centene Commercial Solutions, Ambetter, and Network Development) agreed upon development plan in place, to be included in the service area for QHP filing.

Primary Care Providers (PCPs) adequacy and accessibility will be assessed based on the CMS definition (for instance: Family Medicine, Internal Medicine, General Practice for PCP and Family Medicine, Internal Medicine, and General Practice, Physician Assistant, and Nurse Practitioner for PCP Extended).

Network adequacy and accessibility will be monitored on an ongoing basis which will be no less than quarterly.

Requests to Join Network

Providers may request to join a network of participating providers or Ambetter may solicit their participation based on data or information from varying sources such as:

- Non-Participating Provider report of Authorizations Issued and Claims
- Providing Incoming Requests
- Sales and/or Broker Requests or any other internal requests

<ul style="list-style-type: none"> <li>▪ Single Case Agreement Requests from Ambetter Utilization Management Department.</li> <li>▪ Gaps Identified by the Quest® software solution</li> </ul> <p>Ambetter maintains a streamlined process to respond to written inquiries from providers seeking inclusion in any of Ambetter Health’s participating provider networks, across all benefit classifications. Similar processes exist for outgoing recruitment efforts and can be found in the internal intake process. The incoming process is as follows:</p> <p><b>Step 1:</b> Request to become a participating provider is received by Network Management via online web forms.</p> <p><b>Step 2:</b> The Network Management Team evaluates whether an existing agreement is in place, or if one is needed. If one is needed, the appropriate Network Management team member will be assigned to outreach.</p> <p><b>Step 3:</b> The negotiator will be assigned the and contracting activity based on specialty, region, and/or health system affiliation.</p> <p><b>Step 4:</b> The negotiator will research the provider) and determine whether or not a contract will be offered based on network, specialty, and/or geography.</p> <ol style="list-style-type: none"> <li>If yes, the negotiator will reach out to the prospect within 2 (two) weeks of receipt of request to gather any additional information needed to create a provider agreement.</li> <li>If a request for participation will not be extended, the negotiator will respond to the requestor to provide the rationale for rejecting participation in any or all networks.</li> </ol>	
<p><b>Credentialing:</b> N/A - Credentialing is performed by the hospital or freestanding facility; credentialing is not required by the Health Plan.</p>	<p><b>Credentialing:</b> Same as M/S</p>
<p><b>Provider Reimbursement</b></p> <p>The standard approach for M/S In-Patient In-Network reimbursement can be distinguished by the major facility/provider types:</p> <ol style="list-style-type: none"> <li>Short Term Acute Care Facilities:</li> </ol>	<p><b>Provider Reimbursement</b></p> <p>The standard approach for MH/SUD In-Patient In-Network reimbursement can be distinguished by the major facility/provider types:</p> <ol style="list-style-type: none"> <li>Short Term Acute Care:</li> </ol>

<div><div><div>a. Reimbursed based upon MSDRGs. This methodology is a predictable and known form of reimbursement that controls cost for both payors and providers. While this methodology is appropriate for a Medicare population, it has limitation to that of a Marketplace population (non-exhaustive examples include but not limited to: obstetrics, NICU, MH/SUD, and deliveries). All reimbursement term are finalized in mutually agreed upon negotiated rates between the Plan and providers of these services.</div><div>b. Per Diem reimbursement. This methodology is utilized for inpatient in-network services at a daily rate to reimburse services delivered for various member levels of care. Plan follows industry standards to leverage available CMS guidelines regarding the types of services contracted at per diem rates as well as the rates themselves.</div><div>c. Case Rate reimbursement. This methodology is utilized for inpatient in-network services when it is agreed upon with providers to bundle related services together at a single mutually acceptable comprehensive rate for treatment.</div></div><div><div>2. Critical Access Hospitals:</div><div><div>a. Reimbursement is based upon industry standard interim per diem rates established by CMS. This methodology is a predictable and known form of reimbursement that controls costs for both the payor and the provider of this type. While this methodology is appropriate for a Medicare population, it has limitations to that of a Marketplace population.</div></div></div><div><div>3. Skilled Nursing Facilities:</div><div><div>a. Reimbursement is based upon industry standard patient driven payment model (LTCDRG). This methodology leverages CMS assigned case mix classification criteria that determines the daily reimbursement rate.</div></div></div></div>	<div>Same as for M/S. This category includes Psychiatric Facilities.</div> <div><div>2. Critical Access Hospitals:</div><div>Same as for M/S</div></div> <div><div>3. Skilled Nursing Facilities:</div><div>Same as for M/S</div></div>
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b. Per Diem reimbursement. This methodology is utilized for inpatient in-network services at a daily rate to reimburse services delivered for various member levels of care. Plan follows industry standards to leverage available CMS guidelines regarding the types of services contracted at per diem rates as well as the rates themselves.

4. Long Term Acute Care Hospitals:

a. Reimbursed based upon LTCDRGs. This methodology is a predictable and known form of reimbursement that controls cost for both payors and providers. While this methodology is appropriate for a Medicare population, it has limitation to that of a Marketplace population where the members ability to recuperate is heightened thus potentially reducing the admission LOS. All reimbursement term are finalized in mutually agreed upon negotiated rates between the Plan and providers of these services.

b. Per Diem reimbursement. This methodology is utilized for inpatient in-network services at a daily rate to reimburse services delivered for various member levels of care. Plan follows industry standards to leverage available CMS guidelines regarding the types of services contracted at per diem rates as well as the rates themselves.

5. Hospitals and Facilities that are excluded from CMS IPPS reimbursement:

a. Reimbursement is excluded from the CMS IPPS reimbursement model for Children's and Cancer Hospitals. Services are negotiated by either CMS reported cost to charge ratio terms multiplied by billed charges up to a capitation per diem rate or mutually agreed upon per diem rates.

b. Per Diem reimbursement. This methodology is utilized for inpatient in-network services at a daily rate to reimburse services delivered for various member levels of care. Plan follows industry standards to leverage available CMS

4. Long Term Acute Care Hospitals:

N/A for MH/SUD

5. Hospitals and Facilities that are excluded from CMS IPPS reimbursement:

Same as for M/S. Includes Psychiatric Hospitals and Residential Treatment Centers



guidelines regarding the types of services contracted at per diem rates as well as the rates themselves.

- c. Case Rate reimbursement. This methodology is utilized for inpatient in-network services when it is agreed upon with providers to bundle related services together at a single mutually acceptable comprehensive rate for treatment.

**Across these facility/provider types, PLAN utilizes two primary pricing methodologies:**

- 1. DRG/Case Rate: A per-admission reimbursement grouping methodology, with weights based on severity, for inpatient hospital services. Ambetter uses the payment rates and methodologies published for each hospital facility as the Standard Pricing.
  - a. Inpatient facility classification: Reimbursement for Inpatient Benefit would be dependent on the hospitals classification with Medicare (i.e. Acute Care, Specialty, Critical Access).
    - i. General Acute Care Hospitals.
    - ii. Critical Access Hospitals: Located in rural area and furnish 24 hour emergency services, 7 days a week, and do not exceed 25 IP beds.
    - iii. Children's Hospitals: Predominately servicing age 21 or younger.
    - iv. Cancer Hospital: PPS exempt are designated by National Cancer Institute, organized primarily for treating/researching cancer, and 50% total discharges have principal diagnosis of cancer.
- 2. Per Diem: a per-day payment negotiated and mutually agreed to

**Across these facility/provider types, PLAN utilizes two primary pricing methodologies:**

Same as M/S

- a. Hospital classification: Reimbursement for Inpatient Benefit would be dependent on the hospital’s classification with Medicare (i.e. Acute Care, Specialty, Critical Access).
- b. Inpatient Exempt Unit services unit (Medical Rehab) are reimbursed on a per diem basis. The Exempt unit per diem rate is derived by Medicare and adjusted per hospital facility depending on their individual cost reporting.
  - i. Critical Access Hospitals: In accordance to the Medicare methodology, the Plan prices Inpatient Services at Critical Access Hospitals at a per diem basis. The per diem rate is derived by Medicare and adjusted per hospital facility depending on their individual cost reporting.
  - ii. Specialty Hospitals: In accordance to the Medicare methodology, the Plan prices Inpatient Services at Specialty Hospitals at a per diem basis. The per diem rate is derived by Medicare and adjusted per hospital facility depending on their individual cost reporting.

**In writing comparability and stringency analysis:**

**Access:** Step 1: As noted in the response to Step 1, Ambetter uses the same defined terms and process for the Provider Network Access NQTL as applied to M/S conditions as it does for MH/SUD conditions. As noted in the response to Step 1, Ambetter utilizes an integrated process of monitoring network adequacy to drive both assertive outbound provider recruitment and fielding/prioritizing requests from OON providers seeking to join the network. This process is identical for providers of M/S services and MH/SUD services. As such, this NQTL is comparable and no more stringent at Step 1 as applied to MH/SUD services as compared to providers of M/S services.

Step 2/3: As noted in the response to Steps 2 and 3, all factors are the same for MH/SUD and M/S providers. In Step 3, differences arise from the need to apply population ratios and time and distance standard to the different provider types that deliver MH/SUD vs. M/S services. Internists, general practitioner/family practitioners, and pediatricians treat both M/S and MH/SUD conditions, and therefore the population ratios for these providers are applicable to both MH/SUD and M/S benefits. Ambetter also applies population ratio and time and distance requirements to high volume/impact providers. These include OB-GYN and Oncology providers for M/S benefits and Prescribers (psychiatrists and nurse practitioners with a psychiatric specialty) and non-prescribers (psychologists, licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, etc.) for MH/SUD benefits. The population ratio and time and distance requirements are the same for all of these high volume/impact providers, creating effective equivalence of stringency in the application of this NQTL to MH/SUD and M/S providers.

Step 4: The processes and strategies outlined in Step 4 are the same for MH/SUD and M/S providers.

Taken together, the facts presented in Steps 1-3 and the facts and analysis presented here in Step 4 support the conclusion that, as written, Ambetter implements the Provider Network Access processes, strategies, evidentiary standards, and other factors to MH/SUD benefits in the classification in a manner that is comparable to and no more stringent than the application of these processes, strategies, evidentiary standards, and other factors to M/S benefits in the classification.

**Credentialing: N/A** - For both MH/SUD and M/S services, Credentialing is performed by the hospital or freestanding facility, credentialing is not required by the Health Plan. Therefore, the provider credentialing processes, strategies, evidentiary standards, and other factors, as written, for mental health/substance use disorder providers, are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and other factors used in the credentialing procedures for medical surgical providers.

**Reimbursement:** The reimbursement methodology for the inpatient in-network classification is the same for MH/SUD and M/S services at both the standard pricing methodology and negotiation phases of the process. Although there are M/S and MH/SUD provider-specific payment approaches, as described in Step 4, these methodologies are the same for comparable provider types. In particular, the inpatient M/S and MH/SUD levels of care use all use DRGs, per diems, and/or case rates based on the setting in a comparable manner across each provider setting. In addition, as noted in the responses to Steps 2 and 3, the factors considered in the development of the standard pricing (i.e. the initial offer price) and the factors considered in the negotiation from that standard price, are the same for MH/SUD and M/S inpatient services. As such, we conclude that the provider reimbursement methodology is comparable and no more stringent in its application to MH/SUD inpatient services compared to the application to M/S inpatient services in writing.

**In operation:**

**Access (see Appendix for full set of operations data):**

*Findings from the Provider Network Adequacy Report:*

- Performance Assessment for Necessary Network Providers
  - These standards include practices for practitioner credentialing and ongoing monitoring of the participating providers that meet the qualifications of applicable state and federal government regulations, applicable standards of accrediting bodies, including the National Committee for Quality Assurance (NCQA), and Plan requirements. Annual reports are created to include the cultural, linguistic, PCP/High Volume/High Impact adequacy, provider adequacy levels and provider to member ratios. A Quality Management Committee meeting is held to review the findings and solutions planned for any negative results to ensure a path for improvement is planned to meet targets.
  - A reporting tool is maintained to track progress in all contracting efforts. Reasons for the contracting engagement along with other key drivers such as specialty and outcomes are captured in this SharePoint tool and easily reportable for constant monitoring by contributing staff negotiators and management.
  - *Because the majority of these measures are focused on professional provider types, these findings are discussed in much greater detail in the Outpatient classification analysis below. See Appendix for a detailed snapshot of the Provider Contracting Tool Summary*

- Compliance with Network Adequacy Standards

- Ambetter ensures that its members are satisfied with its primary care network by conducting an annual performance assessment and measuring its performance against the standards at least annually. The methodology used to review the number and geographic distribution of primary care physicians, specialists and facility providers is included in the Quest® geographic access tool, which allows for direct measurement of performance. Reports are generated, distributed, and reviewed on a weekly basis. Any gaps in adequacy are actions initiated prior to the next weekly reporting period.
- *Because the majority of these measures are focused on professional provider types, these findings are discussed in much greater detail in the Outpatient classification analysis below. Sample report is attached*
- An analysis of the proportion of counties with network gaps for MH/SUD providers relative to M/S providers found the following:

Peach State	Average Network Adequacy (across all counties)
Inpatient Med/Surg	98.85%
Inpatient MH/SUD	99.18%

For complete data set please see attached.

*Conclusions:* Ambetter experiences generally low levels of grievance and appeals across all classifications of benefits. Filed grievances are lower for behavioral health services (1 grievance related to access to care) than for medical/surgical services (82 grievances related to access to care). This data supports a conclusion that the network adequacy process is implemented in a comparable and no more stringent manner between MH/SUD and M/S services.

Based on the Quest® geographic access tool report, the Ambetter network meets the network access requirements in almost all counties. Gaps are defined to mean that there are specific provider types that do not meet 100% of the access requirements. As noted above, Ambetter has a higher percentage for average network adequacy coverage for BH/SUD specialty types than M/S specialty types, nor are the gaps specific to practitioner geographic distribution or types of practitioners or providers. In addition, both M/S providers and BH/SUD providers satisfy the 90% threshold for adequate coverage across all counties. As such, we conclude that this NQTL type is being implemented, in operation, in a comparable and no more stringent manner for MH/SUD services compared to M/S services.

**Reimbursement:** To assess the “in operation” comparability and stringency analysis of the provider reimbursement methodology, the plan monitors multiple metrics to identify whether the practices in establishing the standard pricing and negotiating with individual providers (as described and analyzed above) are inadvertently resulting in discriminatory treatment of MH/SUD providers. The plan monitors the ratio of paid to charge-rates as well as availability data for a wide variety of practitioners to ensure that the reimbursement methodology results in equitable access for patients of MH/SUD services compared to M/S services. The table below includes the paid to charge rate data for the most recent period available and these data are updated at regular intervals. This analysis is also updated when the data are updated.

a. Paid to charge ratios

	<u>M/S</u>	<u>M/S</u>	<u>M/S</u>	<u>MH/SUD</u>	<u>MH/SUD</u>	<u>MH/SUD</u>
<u>Classification - IP</u>	<u>Billed Charges</u>	<u>Payment</u>	<u>Charge Ratio</u>	<u>Billed Charges</u>	<u>Payment</u>	<u>Charge Ratio</u>
2023	\$ 836,285,387	\$ 331,929,290	40%	\$ 31,482,816	\$ 10,202,171	32%

This data demonstrates that participating inpatient MH/SUD providers have been paid a comparable percentage of their billed charges (32%) relative to participating M/S providers (40%) in 2023. Network adequacy for inpatient providers is comparable between M/S providers (98.85%) and MH/SUD providers (91.18%), and all factors, sources, and evidentiary standards for contracting and reimbursing IP providers are the same for M/S and MH/SUD providers. The data is therefore consistent with a conclusion that Ambetter’s application of the Standards for Admission to a Provider Network, Including Reimbursement NQTL, is applied comparably and no more stringently to MH/SUD providers relative to M/S providers.

**Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section**

- This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA*

As stated in Step 1 above, all plan document terms that set forth Standards for provider admission to participate in a network, including reimbursement rates are the same for MH/SUD and M/S benefits and providers. Similarly, as stated in steps 2-4 above, all factors, sources, evidentiary standards, and processes that are used to develop Standards for provider admission to participate in a network, including reimbursement rates, as written and in operation, are the same or comparable for all MH/SUD and M/S benefits and providers.

As discussed in Step 4, the Plan analyzes the ratio of paid rates to charged rates to monitor the outcome of the participating provider reimbursement methodologies, and has determined that the outcomes of this methodology are at least comparable and are generally favorable for MH/SUD providers relative to M/S providers.

Based on the foregoing facts and analyses, the Plan concludes that, under the terms of the plan, as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the identified classifications 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 classifications.

**NQTL Type: Standards for provider admission to participate in a network, including reimbursement rates**

<b>Classification(s): Outpatient (In-Network)</b>	
<b>Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification</b> <ul style="list-style-type: none"> <li>• Provide a clear description of the specific NQTL, plan terms, and policies at issue</li> <li>• Identify which M/S and MH/SUD benefits are subject to the NQTL</li> </ul>	
<b>Step 1(a): Provide a clear description of the specific NQTL, plan terms, and policies at issue:</b>	
All definitions are the same as stated above in the Inpatient In-Network NQTL	
<b>Step 1(b): Identify the M/S benefits/services for which the NQTL is required:</b>  <b>Access:</b> All benefits and services	<b>Step 1(b): Identify the MH/SUD benefits/services for which the NQTL is required:</b>  <b>Access:</b> Same as M/S
<b>Credentialing:</b> All in-network providers must be credentialed.	<b>Credentialing:</b> Same as M/S
<b>Reimbursement:</b> All benefits and services	<b>Reimbursement:</b> Same as M/S
<b>Step 2 – Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits</b>	
<b>Medical/Surgical:</b>	<b>MH/SUD:</b>
<b>Access:</b> Same as Inpatient In-Network NQTL above	<b>Access:</b> Same as Inpatient In-Network NQTL above
<b>Credentialing:</b>  Credentialing requirements are based on the following factors and evidentiary standards: <ol style="list-style-type: none"> <li>1. State and federal laws and guidelines (including 42 CFR 438.214 and 42 CFR Part 422.204)</li> <li>2. Accreditation guidelines (NCQA, CMS)</li> </ol>	<b>Credentialing:</b> Same as M/S
<b>Reimbursement:</b> Same as Inpatient In-Network NQTL above	<b>Reimbursement:</b> Same as Inpatient In-Network NQTL above

**Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.**

- Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.*
- To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.*

<b>Medical/Surgical:</b>	<b>MH/SUD:</b>
<b>Access:</b> Same as Inpatient In-Network NQTL above	<b>Access:</b> Same as Inpatient In-Network NQTL above
<b>Credentialing:</b>  1. <b>State and federal laws and guidelines:</b> State and federal policies, regulations, and laws that are used to determine provider credentialing requirements include, (but are not limited to) provisions contained throughout Georgia insurance laws, and guidance related to healthcare or mental health parity, and federal laws or regulations (including 42 CFR 438.214 and 42 CFR Part 422.204). <i>Additionally, Ambetter from Peach State Health Plan adheres to Medicaid managed care state regulations further extending behavioral health credentialing permissions to a range of state licensed behavioral health facilities.</i>  2. <b>Accreditation Guidelines:</b> <i>Ambetter from Peach State Health Plan applies its credentialing standards in accordance with National Committee for Quality Assurance (NCQA) – CR-1 and Net 5. In addition, State regulatory agencies and the Centers for Medicare (CMS) and Medicaid Services standards are used to ensure that members get access to quality care.</i>	<b>Credentialing:</b> Same as M/S
<b>Reimbursement:</b> Same as Inpatient In-Network NQTL above	<b>Reimbursement:</b> Same as Inpatient In-Network NQTL above

**Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.**

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

<b>Medical/Surgical:</b>	<b>MH/SUD:</b>
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<b><u>Access:</u></b> Same as Inpatient In-Network analysis above	<b><u>Access:</u></b> Same as Inpatient In-Network analysis above
<b><u>Credentialing:</u></b>  <b>Application Process</b> Ambetter has credentialing policy and procedures for the initial application process and the recredentialing process, which includes the contents and scope of the application, type and scope of practitioners who qualify for membership, and the initial processing steps and recredentialing processing steps in the credentialing procedure. Ambetter adheres to managed care standards 42 CFR Part 438.214 and 42 CFR Part 422.204, National Committee of Quality Assurance (NCQA) and Centers for Medicare and Medicaid Services (CMS).  All new applicants for appointment, who are contracted to deliver professional services within the service areas defined by Ambetter and whose professional services meet the defined business needs will be given upon request, an application to participate with Ambetter. Credentialing begins with a Completed Application (“Complete Application”). Ambetter uses the CAQH application which must include basic demographic information including name, NPI, license number, servicing address(s), phone, office hours, accepting new patients, age range, education and training information, work history, affirmation questions and attestation to the correctness of the application.  Practitioners who practice exclusively within a State Licensed facility and who provide care only as a result of members being directed to the hospital or another inpatient setting, do not need to be individually credentialed by Ambetter.  <b>Timeline</b> Ambetter completes review of the health care professional’s application to participate in the Ambetter Network and shall, within 30 days of receiving a Completed Application to participate in the Ambetter Network, notify the health care professional as to whether s/he is credentialed; or whether additional time is necessary to make a determination because of a failure of a third party to provide necessary documentation, or if additional information is necessary, the notice to the health care professional must identify all additional information needed by the plan to make its determination. In such instances where additional time is necessary because of a lack of necessary documentation, Ambetter Health makes every effort to obtain such information as soon as possible and makes a final determination within 60 days of receiving the necessary documentation.  <b>Sanctions List</b> Ambetter monitors sanction/exclusions of the OIG, SAM/EPLS, state Exclusion List, and SSDMF monthly.	<b><u>Credentialing:</u></b> Same as M/S, as applicable



**Forms & Requirements:**

Ambetter performs primary source verification of all NCQA required data elements. Below is a list of all acceptable verification sources and the required verification time limit. Please note that where a 180 - day time limit is indicated this means that the verification must be conducted within 180 days prior to Credentials Committee approval date.

The following primary source (unless otherwise noted) verifications will be obtained and documented in the application/reapplication:

ITEM	PRIMARY SOURCE
Valid, Current License	<u>All Practitioners:</u>  Internet verification through the appropriate State Licensing Agency or website  Verification of licensure is required in all States where the practitioner provides care to members.
Valid, Current DEA Certificate	Copy of current Drug Enforcement Administration (DEA) Certificate or internet confirmation with the United States Department of Justice Drug Enforcement Administration Office of Diversion Control website.  DEA or DEA Coverage Plan (applicable only to those specialties eligible to prescribe controlled substances)
Education and Training: Completion of residency training *Initial Credentialing Only	<u>Physician:</u> If not board certified, written/verbal verification of the highest level of education is verified directly from the residency program (s) designated by the

<p>Graduation from Medical School/ Professional School *Initial Credentialing Only</p>	<p>applicant on the application or confirmation from AMA Physician Master File or the AOA Physician Master File/AOA Official Osteopathic Physician Profile.</p>		
	<p><u>Podiatry:</u> If not board certified, written/verbal confirmation of residency training completion directly from the residency program (s) designated by the applicant on the application.</p>		
	<p><u>Non Physician Professionals:</u> Not Applicable (residency training is N/A)</p>		
	<p><u>Physician:</u>  If not Board Certified and did not complete a residency program, written confirmation from Medical School, confirmation from AMA Physician Master File, the AOA Physician Master File/AOA Official Osteopathic Physician Profile designated by the applicant on the application or confirmation from the Educational Commission for Foreign Medical Graduates (ECFMG) for international medical graduates licensed after 1986. May be verified by state licensure if licensing board validates that they primary source verify training at this level.</p>		
	<p><u>Podiatry:</u> Written/verbal confirmation of completion of Podiatry Medical School designated by the applicant on the application. May be verified by state licensure if licensing board validates that they primary source verify training at this level.</p>		

	<p><u>Chiropractor:</u> Written/verbal confirmation of completion of Chiropractic College designated by the applicant on the application. May be verified by state licensure if licensing board validates that they primary source verify training at this level.</p> <p><u>Non Physician Professionals:</u> Written/verbal confirmation of professional/graduate school completion or confirmation from the National Student Clearing House designated by the applicant on the application. May be verified by state licensure if licensing board validates that they primary source verify training at this level.</p>		
Board Certification	<p><u>Physician:</u>  Internet query ABMS Board Certification Credentials Profile; AOA Official Osteopathic Physician Profile Report/AOA Physician Master File or AMA Physician Master File with Internet or written confirmation.</p> <p><u>Podiatry:</u> Written confirmation or Internet query of the American Board of Podiatric Surgery OR the American Board of Foot and Ankle Surgery (formerly American Board of Podiatric Orthopedics).</p> <p><u>Chiropractor:</u> Not Applicable</p>		

	<p><u>Non Physician Professionals:</u> Not Applicable</p>		
<p>Work History (5 years) *Initial Credentialing Only</p>	<p><u>All Practitioners:</u> Review CV/resume provided and/or completed Ambetter Provider Application or CAQH Application. Continuity of dates is required.</p> <p>At a minimum, five (5) years of work history is reviewed. If the practitioner has fewer than five (5) years of work history, the time frame starts from the initial licensure date.</p> <p>Each gap in employment exceeding six (6) months is clarified either verbally or in writing. A written explanation is required for employment gaps greater than one (1) year.</p>		
<p>Professional Liability Claims History</p>	<p><u>All Practitioners:</u> NPDB electronic query. Obtain written confirmation of the last five (5) years of malpractice settlements or judgments paid on behalf of the practitioner. Residency years are included in this five-year period.</p>		
<p>Malpractice Insurance Coverage</p>	<p><u>All Practitioners:</u> Current copy of professional liability insurance, or Attestation within credentialing application with amount of coverage, and effective and end dates is also acceptable.</p>		
<p>Hospital Affiliations</p>	<p><u>If applicable:</u> Affirmation of Professional Status confirmation.</p>		

National Practitioner Data Bank	<u>All Practitioners:</u>  NPDB electronic query.		
Professional Regulations/Sanction Information	<u>Physician &amp; Physician Assistant:</u>  Any pending or completed actions by the State License Board.  <u>Podiatry:</u> Any pending or completed actions by the State License Board  <u>Chiropractor:</u> Any pending or completed actions by the State License Board  <u>Non Physician Behavioral Health Care Professionals:</u> Any pending or completed actions by the State License Board  <u>Non Physician Practitioners:</u> Any pending or completed actions by the State License Board  Verification of State sanctions, restrictions or limitations on scope of practice through the appropriate State Agency is required in all States where the practitioner provides care to members.		
Sanction Activity by Medicare and Medicaid	<u>All Practitioners:</u>  1. NPDB electronic query 2. The US Department of Health & Human Services Office of Inspector General (OIG): List		

	<p>of Excluded Individuals/Entities (LEIE)_(OIG); <a href="http://exclusions.oig.hhs.gov/">http://exclusions.oig.hhs.gov/</a></p> <ol style="list-style-type: none"> <li>3. The Georgia state Exclusions List</li> <li>4. System for Award Management (SAM) (EPLS); <a href="https://www.sam.gov/content/home">https://www.sam.gov/content/home</a>.</li> <li>5. The Centers for Medicare &amp; Medicaid Services (CMS) - CMS Preclusion List.</li> <li>6. Social Security Administration Death Master File</li> </ol>		
National Provider Identifier (NPI)	<p><u>All Practitioners:</u></p> <p>National Plan Provider Enumeration System (NPPEs); <a href="https://npiregistry.cms.hhs.gov">https://npiregistry.cms.hhs.gov</a>.</p>		
Application/Reapplication	<p><u>All Practitioners:</u></p> <p>Indicate on application/reapplication:</p> <ol style="list-style-type: none"> <li>1. Reasons for inability to perform the essential functions of the position,</li> <li>2. Lack of present illegal drug use,</li> <li>3. History of loss of license and felony convictions,</li> <li>4. History of loss or limitation of privileges or disciplinary actions,</li> <li>5. Current malpractice insurance coverage,</li> <li>6. Current and signed attestation confirming the correctness and completeness of the application.</li> </ol>		

Approved practitioner sites and their staff are scheduled for the Practitioner orientation at which time they receive their Provider Manual.

Verification documentation in the file can be either written or verbal and will include copies of the credentialing information. A dated checklist indicating for each verification the source used, the date of the verification and the computer-generated identification of the person who verified the information.

The information/verifications collected and completed must be valid and current and shall not be more than 180 days old at the time of Committee review unless otherwise noted.

**Reimbursement:**

As part of the generalized standard approach of provider reimbursement, the standard approach for Out-Patient In-Network reimbursement can be described by the major facility/provider types and is applicable when mutually agreed upon:

1. Short Term Acute Care Facilities:
- a. Ambulatory Payment Classification (APC). APC is an industry standard methodology established by CMS that group services into a single reimbursement rate.

b. Per Diem reimbursement. This methodology is utilized for outpatient in-network services at a daily rate to reimburse services delivered for various member levels of care. Plan follows industry standards to leverage available CMS guidelines regarding the types of services contracted at per diem rates as well as the rates themselves.

c. Case Rate reimbursement. This methodology is utilized for outpatient in-network services when it is agreed upon with providers to bundle related services together at a single mutually acceptable comprehensive rate for treatment.

**Reimbursement:**

Same as M/S, as applicable

	<p><b>d.</b> Reimbursed based upon Fee For Service (FFS). FFS methodology is an industry standard methodology with CMS guidelines that outline specific services, rates based upon time intervals of services for applicable provider types.</p>	
<b>2.</b>	<p>Critical Access Hospitals:</p> <p><b>a.</b> Reimbursement is based upon industry standard Medicare in effect on date of service Cost to Charge Ratio. While this methodology is appropriate for a Medicare population, it has limitations to that of a Marketplace population.</p> <p><b>b.</b> Per Diem reimbursement. This methodology is utilized for outpatient in-network services at a daily rate to reimburse services delivered for various member levels of care. Plan follows industry standards to leverage available CMS guidelines regarding the types of services contracted at per diem rates as well as the rates themselves.</p> <p><b>c.</b> Case Rate reimbursement. This methodology is utilized for outpatient in-network services when it is agreed upon with providers to bundle related services together at a single mutually acceptable comprehensive rate for treatment.</p> <p><b>d.</b> Reimbursed based upon Fee For Service (FFS). FFS methodology is an industry standard methodology with CMS guidelines that outline specific services, rates based upon time intervals of services for applicable provider types.</p>	
<b>3.</b>	<p>Skilled Nursing Facilities:</p> <p><b>a.</b> Medicare does not cover services delivered in an outpatient setting for Skilled Nursing facilities. This provider type has delivered outpatient therapy (PT/OT/ST) services for their respective communities.</p> <p><b>b.</b> Reimbursed based upon Fee For Service (FFS). FFS methodology is an industry standard methodology with CMS guidelines that outline specific services, rates based upon time intervals of services for applicable provider types.</p>	
<b>4.</b>	<p>Practitioner Services (PCP/Specialist)</p>	



- a. Reimbursed based upon Fee For Service (FFS). FFS methodology is an industry standard methodology with CMS guidelines that outline specific services, rates based upon time intervals of services for applicable provider types.

5. Ancillary Services

- a. DMEPOS, LAB, Pharmacy, Radiology. Reimbursed based upon Fee For Service (FFS). FFS methodology is an industry standard methodology with CMS guidelines that outline specific services, rates based upon time intervals of services for applicable provider types.
- b. Ambulance. Reimbursed based on CMS Ambulance Fee Schedule with CMS Guidelines that outline the reimbursement, geographic area adjustments and requirements.
- c. Home Health. Reimbursed based on CMS Patient Driven Grouping Model. PDGM have 30 days periods and are categorized into 432 case mix periods for adjusting the payment. Per Diem reimbursement. This methodology is utilized for in-network services at a daily rate to reimburse services delivered for various member levels of care. Plan follows industry standards to leverage available CMS guidelines regarding the types of services contracted at per diem rates as well as the rates themselves
- d. Hospice. Reimbursed based on the Hospice Prospective Payment System where each day of hospice benefit is assigned to a Base Payment Rate and adjusted for geographic factors. Per Diem reimbursement. This methodology is utilized for in-network services at a daily rate to reimburse services delivered for various member levels of care. Plan follows industry standards to leverage available CMS guidelines regarding the types of services contracted at per diem rates as well as the rates themselves
- e. Home Infusion. CMS pays only 6 home infusion therapy HCPCS G Codes and are adjusted by the Geographically Adjustment that mostly cover for professional services. Per Diem reimbursement. This methodology is utilized for in-network services at a daily rate to reimburse services delivered for various member levels of care. Plan follows industry standards to leverage available CMS guidelines regarding the types of services contracted at per diem rates as well as the rates themselves.

6.

Children’s & Cancer Hospitals:
- a.

Ambulatory Payment Classification (APC). APC is an industry standard methodology established by CMS that group services into a single reimbursement rate.
- b.

Case Rate reimbursement. This methodology is utilized for outpatient in-network services when it is agreed upon with providers to bundle related services together at a single mutually acceptable comprehensive rate for treatment.
- c.

Reimbursed based upon Fee For Service (FFS). FFS methodology is an industry standard methodology with CMS guidelines that outline specific services, rates based upon time intervals of services for applicable provider types.
7.

Ambulatory Surgical Center CMS pays ASC based on assigned relative weights to APC’s in the ASC Medicare Fee Schedule and adjusted based on their Geographical Area.

**Across these facility/provider types, PLAN utilizes two primary pricing methodologies:**

1.

Standard Pricing
- a.

CPT FFS: Ambulatory Payment Classification Group (APC)
- b.

Payment benchmarks (Medicare): Medicare RBRVS published fee schedule or other applicable Medicare published fee schedules.
2.

Per Diem/Case Rate: a per-day, negotiated and mutually agreed to all-inclusive payment that encompasses all services rendered per daily occurrence of treatment
- a.

Hospital classification: Reimbursement for outpatient in-network benefits would be dependent on the hospitals classification with Medicare (i.e. Acute Care, Specialty, Critical Access, ambulatory surgery center, Urgent Care facility) which determines the scope of services inclusive to the per diem payment and subsequent rate setting.

**In writing comparability and stringency analysis:**

**Access:** Same as Inpatient In-Network Analysis above, except the following table:

<b><u>Network Adequacy</u></b>	
<b>Peach State</b>	<b>Average Adequacy</b>
Outpatient MH/SUD	98.5%
Outpatient M/S	99.7%

For complete data set please see attached.

Please also see Provider Availability Analysis below.

**Credentialing:**

The provider credentialing processes and strategies, as written, for mental health/substance use disorder providers, are comparable to and applied no more stringently than the processes and strategies used in the credentialing procedures for medical surgical providers. For both MH/SUD and M/S services, the credentialing process begins with a completed application. The application requirements are comparable for MH/SUD and M/S services and differ only in that the credentials are customized to the needs and specialty of the provider. Overall, the process followed is the same for both MH/SUD and M/S services. The Plan strives to complete the credentialing process within 60 days of a complete application from the provider.

The Plan relies upon (1) State and federal laws and guidelines and (2) accreditation guidelines in creating its provider credentialing processes in writing. The Plan considers Georgia state laws and guidance related to parity, and federal laws or regulations (including 42 CFR 438.214 and 42 CFR Part 422.204). The Plan’s credentialing guidelines are based on CMS standards and NCQA guidelines. These factors and evidentiary standards are identical for MH/SUD and M/S services, and are therefore, comparable, and no more stringent.

**Reimbursement:** The reimbursement methodology for the outpatient in-network classification is the same for MH/SUD and M/S services at both the standard pricing methodology and negotiation phases of the process. Although there are M/S and MH/SUD provider-specific payment approaches for outpatient services in a manner similar to the inpatient classification, as described in Step 4, these methodologies are not discriminatory in their differences. In particular, the inpatient M/S and MH/SUD levels of care use all use FFS codes for professional and ancillary services and a mix of APCs, per diems, and case rates for facility-based outpatient services in a comparable manner across each provider setting. In addition, as noted in the responses to Steps 2 and 3, the factors considered in the development of the standard pricing (i.e. the initial offer price) and the factors considered in the negotiation

from that standard price, are the same for MH/SUD and M/S outpatient services. As such, we conclude that the provider reimbursement methodology is comparable and no-more stringent in its application to MH/SUD inpatient services compared to the application to M/S outpatient services in writing.

**In operation:**

- Credentialing:** Review of credentialed providers demonstrated that Ambetter met the following timelines:
- 1. **M/S:** On average, all M/S providers were credentialed by Ambetter within 3.75 days of a complete application
  - 2. **MH/SUD:** On average all MH/SUD providers were credentialed by Ambetter within 3.75 days of a complete application

Ongoing Monitoring: Ambetter monitors sanction/exclusions of the OIG, SAM/EPLS, state Exclusion List, SSDMF on a monthly basis for behavioral health practitioners and medical/surgical providers.

Quality Audits: Ambetter has a quality audit team in the Credentialing Department that reviews a subset of behavioral health, medical/surgical provider credentialing files to ensure credentialing standards are met.

**Reimbursement:**

To assess the “in operation” comparability and stringency analysis of the provider reimbursement methodology, the plan monitors multiple metrics to identify whether the practices in establishing the standard pricing and negotiating with individual providers (as described and analyzed above) are inadvertently resulting in outcomes that may signal a need to re-evaluate the underlying factors, sources, evidentiary standards, or processes to ensure parity compliance.

**Paid to charge ratios**

	M/S	M/S	M/S	MH/SUD	MH/SUD	MH/SUD
Classification	Billed Charges	Payment	Charge Ratio	Billed Charges	Payment	Charge Ratio
Prof 2023	\$624,873,817	\$230,880,997	37%	\$26,516,531	\$13,004,303	49%

The current paid-to-charge ratios indicate that payments for professional MH/SUD providers relative to billed charges (49%) is higher than payments to professional M/S providers (37%) and is evidence that mental health parity is met.

**d. Provider availability analysis**

**Introduction**

Managed care health plans often require enrollees to utilize a designated practitioner network. The organization must ensure there are adequate numbers and geographic distribution of primary care, behavioral health, and specialty care practitioners to meet enrollee needs. Ambetter monitors practitioner availability annually against established standards, and initiates actions, as needed, to improve practitioner availability. This report describes the monitoring methodology, results, analysis, and actions for the period of January 1, 2023, through October 31, 2023.

**Availability of Primary Care, Specialty Care and Behavioral Health Care Practitioners**

Practitioner availability monitoring is completed for primary care practitioners (PCPs), high-volume and high-impact specialty care practitioners (SCPs), and high-volume behavioral health (BH) practitioner types. The health plan defines the mechanism utilized to monitor the type, number and geographic distribution of primary care, high-volume and high-impact specialty care, and high-volume behavioral healthcare practitioners as applicable to monitor the adequacy of the network and how effectively this network meets the needs, preferences, and diversity of the health plan’s enrollment.

**Standards and Methodology**

To evaluate the availability of practitioners who provide primary care, high-volume and high-impact specialty care and high-volume behavioral healthcare services, the health plan annually monitors the following:

- Ratio of number of each type of practitioners to number of enrollees
- Geographic distribution of each type of practitioner (distance and/or driving time to practitioner’s office)

**Findings of the Ambetter Network Adequacy Report**

**Section I: Primary Care**

Ambetter defines primary care practitioners as family practitioners, general practitioners, pediatricians, internists, nurse practitioners, physician assistance and other PCP Extenders. Primary care providers are those that fully accept the duties of a PCP and can be designated as an enrollee’s assigned PCP.

Table 2 lists the primary care practitioner standards, results, and determines if the goal was met for each PCP type for whom availability is monitored. The health plan conducts an analysis to identify potential opportunities to improve practitioner availability.

**Section II: Specialty Care**

Ambetter identifies high-volume specialty care practitioners as those who treat a significant portion of the health plan’s enrollees, as identified through analysis of the number of visits, based on claim and encounter data. At a minimum, high-volume specialists were identified as Obstetrics & Gynecology (OB/GYN).

Evaluation to identify high-impact practitioners utilizes an assessment of conditions with serious consequences for the enrollee, requiring significant health system resources, including high-cost medications and therapy options (i.e., chemotherapy and radiation) and increased inpatient and outpatient medical claims. Oncology was selected as high impact specialists since the care of cancer patients from diagnosis through primary treatment is complex, involving several diagnostic and treatment steps. These steps generally include staging, general medical assessments, definitive therapy (surgery or radiation depending on tumor type and stage) to control local disease, and often adjuvant therapy (i.e., radiation therapy, chemotherapy, hormonal therapy, or immunotherapy) to reduce the risk of recurrence. According to the Journal of the National Cancer Institute, oncologists face challenges of providing comprehensive care to cancer patients across the continuum including significant comorbid conditions or psychosocial issues.

***Practitioner Numeric and Geographic Standards and Results***

The tables below list the availability standards and results for the indicated practitioner type, and determines if the goal was met for each practitioner type for whom availability is monitored. The health plan conducts an analysis to identify potential opportunities to improve practitioner availability.

**Section III: Behavioral Healthcare**

Ambetter identifies high-volume behavioral healthcare practitioners through analysis of the number of visits, based on claim and encounter data. High-volume behavioral health specialties based on volume of healthcare visits were: Prescribing Psychiatrists and Non-prescribing Clinical Psychologists and Licensed Mental Health Practitioner (LMHP) including Clinical Social Workers, Professional Counselors, Marriage & Family Therapists, etc.

Table 4 lists the BH practitioner standards, results, and determines if the goal was met for each high-volume behavioral healthcare practitioner type for whom availability is monitored. The health plan conducts an analysis to identify potential opportunities to improve practitioner availability.

***Practitioner Numeric and Geographic Standards and Results***

The tables below list the availability standards and results for the indicated practitioner type, and determines if the goal was met for each practitioner type for whom availability is monitored. The health plan conducts an analysis to identify potential opportunities to improve practitioner availability.

Table 2: Primary Care Practitioner Numeric and Geographic Standards and Results

Practitioner Type Primary Care	Standards – Goal 90%	2023 Results	Goal Met?
Primary Care Practitioners: All	Enrollees have at least 2 PCP within 10 miles or 30 minutes of the enrollee’s home in Large Metro areas.	99.4%	Yes
	Enrollees have at least 2 PCP within 10 miles or 30 minutes of the enrollee’s home in Metro areas.	98.3%	Yes
	At least 1 PCP per 2,000 enrollees	1:7	Yes
Primary Care Practitioners: Family/ General Practitioners (FP/GP)	Enrollees have at least 1 FP/ GP within 10 miles or 30 minutes of the enrollee’s home in Large Metro areas.	99%	Yes
	Enrollees have at least 1 FP/ GP within 10 miles or 30 minutes of the enrollee’s home in Metro areas.	97.1%	Yes
	At least 1 FP/ GP per 2,000 enrollees	1:291	Yes
Primary Care Practitioners: Internal Medicine (IM) Practitioners	Enrollees have at least 1 IM Practitioner within 10 miles or 30 minutes of the enrollee’s home in Large Metro areas.	97.2%	Yes
	Enrollees have at least 1 IM Practitioner within 10 miles or 30 minutes of the enrollee’s home in Metro areas.	94.5%	Yes
	At least 1 IM Practitioner per 2,000 enrollees	1:353	Yes
Primary Care Practitioners: Pediatrics (PEDS)	Enrollees have at least 1 Pediatrics Practitioner within 10 miles or 30 minutes of the enrollee’s home in Large Metro areas.	95%	Yes
	Enrollees have at least 1 Pediatrics Practitioner within 10 miles or 30 minutes of the enrollee’s home in Metro areas.	93.5%	Yes

Table 4: BH Practitioner Geographic and Numeric Standards and Results

Practitioner Type Behavioral Healthcare	Standards- Goal 90%	2023 Results	Goal Met?
Psychiatrists	Enrollees have at least 1 Psychiatrists within 45 miles or 60 minutes of the enrollee’s home in Large Metro areas.	98%	Yes
	Enrollees have at least 1 Psychiatrists within 45 miles or 60 minutes of the enrollee’s home in Metro areas.	100%	Yes
	At least 1 Psychiatrist per 15,000 enrollees	1:1144	Yes
Clinical Psychologists	Enrollees have at least 1 Psychologists within 20 miles or 30 minutes of the enrollee’s home in Large Metro areas.	99.4%	Yes
	Enrollees have at least 1 Psychologists within 20 miles or 30 minutes of the enrollee’s home in Metro areas.	97.7%	Yes
Licensed Mental Health Professionals (LMHP)	Enrollees have at least 1 LMHP within 20 miles or 30 minutes of the enrollee’s home in Large Metro areas.	99.9%	Yes
	Enrollees have at least 1 LMHP within 20 miles or 30 minutes of the enrollee’s home in Metro areas.	100%	Yes
Ambetter Service Area consists of only Large Metro and Metro counties			

	At least 1 Pediatrics Practitioner per 2,000 enrollees	1:556	Yes
Ambetter Service Area consists of only Large Metro and Metro counties			

**A. Results and Analysis of the Availability of High-volume & High-impact Specialty Care Practitioners**

Table 3: Specialty Care Practitioner Numeric and Geographic Standards and Results

Practitioner Type Specialty Care	Standards – Goal 90%	2020 Results	Goal Met?
High-volume Specialty Care Practitioners: Obstetrics & Gynecology (OB/GYN)	Enrollees have at least 1 OB/GYN within 45 miles or 60 minutes of the enrollee’s home in Large Metro areas.	100%	Yes
	Enrollees have at least 1 OB/GYN within 45 miles or 60 minutes of the enrollee’s home in Metro areas.	100%	Yes
	At least 1 OB/GYN per 2,000 enrollees	1:452	Yes
High-impact Specialty Care Practitioners: Oncologists	Enrollees have at least 1 Oncologist within 30 miles or 20 minutes of the enrollee’s home in Large Metro areas.	99.6%	Yes
	Enrollees have at least 1 Oncologist within 30 miles or 45 minutes of the enrollee’s home in Metro areas.	99.8%	Yes
Ambetter Service Area consists of only Large Metro and Metro counties			

The data above demonstrate that Ambetter’s network adequacy for MH/SUD providers exceeded the network adequacy for Primary Care and High Volume/High Impact Specialty Care Medical/Surgical providers.

Specifically, for this analysis period, the health plan met the goal for the ratio standards for all practitioner types assessed. Goals for each geographic area reviewed in this analysis were also met for all prescribing and non-prescribing BH practitioner types observed. Although the goals were met for BH providers, the health plan continues to recruit, contract, and credential all available non-par BH practitioners as new practices enter the service area. The health plan also continues to monitor practitioner availability and address any gaps in BH practitioner availability.



***These data support a conclusion that Ambetter’s application of the Standards for Admission to a Provider Network, Including Reimbursement NQTL is applied comparably and no more stringently to MH/SUD providers relative to M/S providers.***

**Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section**

- This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA*

As stated in Step 1 above, all plan document terms that set forth Standards for provider admission to participate in a network, including reimbursement rates are the same for MH/SUD and M/S benefits and providers. Similarly, as stated in steps 2-4 above, all factors, sources, evidentiary standards, and processes that are used to develop Standards for provider admission to participate in a network, including reimbursement rates, as written and in operation, are the same or comparable for all MH/SUD and M/S benefits and providers.

As discussed in Step 4, Ambetter analyzes a wide range of operations measures to monitor the outcome of the methodologies for Standards for provider admission to participate in a network, including reimbursement rates, and has determined that the outcomes of these methodologies are at least comparable and are generally favorable for MH/SUD providers relative to M/S providers.

Based on the foregoing facts and analyses, Ambetter concludes that, under the terms of the plan, as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the identified classifications 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

**NQTL Type: Standards for provider admission to participate in a network, including reimbursement rates**

**Classification(s): Emergency**

**Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification**

- Provide a clear description of the specific NQTL, plan terms, and policies at issue**
- Identify which M/S and MH/SUD benefits are subject to the NQTL**

**Step 1(a): Provide a clear description of the specific NQTL, plan terms, and policies at issue:**

N/A – all Emergency providers are contracted to deliver services to treat both MH/SUD and M/S conditions so it is not possible to distinguish between Emergency M/S and Emergency MH/SUD providers.

**Step 2 – Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits**

<b>Medical/Surgical:</b> N/A	<b>MH/SUD:</b> N/A
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<b>Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.</b> <ul style="list-style-type: none"> <li><i>Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.</i></li> <li><i>To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.</i></li> </ul>	
Medical/Surgical: N/A	MH/SUD: N/A
<b>Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.</b> <ul style="list-style-type: none"> <li><i>The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.</i></li> <li><i>If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).</i></li> <li><i>If the plan’s or issuer’s analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert’s qualifications and the extent to which the plan or issuer ultimately relied upon each expert’s evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.</i></li> </ul>	
Medical/Surgical: N/A	MH/SUD: N/A
<b>Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section</b> <ul style="list-style-type: none"> <li><i>This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA</i></li> </ul>	
N/A	
<b>NQTL Type: Standards for provider admission to participate in a network, including reimbursement rates</b>	
<b>Classification(s): Prescription Drug – N/A</b>	
<b>Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification</b> <ul style="list-style-type: none"> <li>Provide a clear description of the specific NQTL, plan terms, and policies at issue</li> <li>Identify which M/S and MH/SUD benefits are subject to the NQTL</li> </ul>	

Step 1(a): Provide a clear description of the specific NQTL, plan terms, and policies at issue:	
All definitions are the same as state in the Inpatient and Outpatient analyses above	
<b>Step 1(b): Identify the M/S benefits/services for which the NQTL is required:</b>	<b>Step 1(b): Identify the MH/SUD benefits/services for which the NQTL is required:</b>
<b>Access:</b> N/A – all pharmacies dispense both MH/SUD and M/S drugs. Thus it is not possible to distinguish between M/S pharmacy providers and MH/SUD pharmacy providers.	<b>Access:</b> Same as M/S
<b>Credentialing:</b> N/A – The plan does not apply credentialing requirements separately to prescription drug providers. The plan utilizes CVS Caremark as its pharmacy benefit manager. CVS Caremark's credentialing practices were developed without regard to whether a pharmacy specializes in mental health, substance abuse, medical and or surgical fields.	<b>Credentialing:</b> Same as M/S
<b>Reimbursement:</b> N/A – Prescription Drug payment methodologies are not implemented on the basis of diagnosis and formulary design is addressed in separate NQTL analyses	<b>Reimbursement:</b> Same as M/S
<b>Step 2 – Identify the factors used to determine that the NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits</b>	
<b>Medical/Surgical:</b>	<b>MH/SUD:</b>
N/A	N/A
<b>Step 3 – Identify the evidentiary standards used for the factors identified in Step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.</b>	
<ul style="list-style-type: none"> <li><i>Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.</i></li> <li><i>To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.</i></li> </ul>	
<b>Medical/Surgical:</b>	<b>MH/SUD:</b>
N/A	N/A

<b>Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.</b> <ul style="list-style-type: none"> <li><i>The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.</i></li> <li><i>If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).</i></li> <li><i>If the plan’s or issuer’s analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert’s qualifications and the extent to which the plan or issuer ultimately relied upon each expert’s evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.</i></li> </ul>	
<b>Medical/Surgical:</b>	<b>MH/SUD:</b>
N/A	N/A
<b>Step 5 – Provide the specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results that indicate that the plan or coverage is or is not in compliance with this section</b> <ul style="list-style-type: none"> <li><i>This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA</i></li> </ul>	
N/A	

Appendix

2023 Network Adequacy Report

**Practitioner Availability and Accessibility of Services**

Network Development and Contracting is responsible for the development and maintenance of Ambetter’s system of providers. The Department works closely with providers to ensure Members have access to providers. It is responsible for the initial build of the provider network and maintenance of existing providers once networks are established. The status of Network Adequacy (for time period 01/01/2023-10/31/2023), across all counties and specialty types (both M/S and Behavioral Health) is attached below.



GA\_NQTL - 2023.xlsx