MHPAEA Summary Form

Under a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. must make sure that there is "parity" between mental health and substance use disorder benefits, and medical and surgical benefits. This generally means that financial requirements and treatment limitations applied to mental health or substance use disorder benefits cannot be more restrictive than the financial requirements and treatment limitations applied to medical and surgical benefits. The types of limits covered by parity protections include:

- Financial requirements—such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- Treatment limitations—such as limits on the number of days or visits covered, or other limits on the scope or duration of treatment (for example, being required to get prior authorization).

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. has performed an analysis of mental health parity as required by Maryland law and has submitted the required report to the State of Maryland. Below is a summary of that report.

The filing has been completed by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., ("Health Plan") with input from the Mid-Atlantic Permanente Medical Group, P.C., ("Medical Group"), referred to collectively as "Kaiser Permanente."

If you have any questions on this summary, please call (800) 777-7902.

If you have questions on your specific health plan, please call (800) 777-7902.

Overview:

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

1. Definition of Medical Necessity

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

The Health Plan applies relevant Utilization Management (UM) criteria to make medical necessity decisions in the following settings, i.e., In-Network Inpatient, Out of Network Inpatient, In-Network Outpatient-Office, Out of Network Outpatient- Office, In Network Outpatient-All Other, Out of Network Outpatient-All Other and the relevant UM criteria is applied to medical/surgical (M/S) and mental health/substance us disorders (MH/SUD) in the exact same manner. The Medical Necessity NQTL does not apply to the Emergency Services benefit because all emergency services are automatically covered for all plans. UM adopts and utilizes nationally developed clinical criteria and regionally developed medical coverage policies that are approved by the Regional Utilization Management Committee (RUMC) to evaluate the necessity of medical/surgical and behavioral health services requiring approval. The RUMC membership includes a cross section of health care professionals from across the organization, among them senior level physicians from both medical-surgical and behavioral health departments who play a key role in the approval of UM criteria.

The non-formulary exception process provides physicians and members access to a medically necessary drug under the drug benefit, even when that drug is not on the formulary. Non-formulary drugs are used if the member fails to respond to formulary drug therapy, or has special circumstances requiring the use of a non-formulary drug (e.g., allergy or contraindication). The prescriber makes the final decision regarding what drug is appropriate for the patient/member. If the appropriate drug is not on the formulary and is deemed medically necessary by the prescriber, he/she identifies the appropriate exception or indicates the reason for medical necessity on the prescription, electronic drug order or medication request form.

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

The factors that influence the application of medical necessity for medical/surgical and behavioral health services are:

- The severity or chronicity of an illness – Services that, in the professional judgment of the members of the Regional Utilization Management Committee and or the Regional Pharmacy and Therapeutics (P&T) Committee are specifically for the treatment of severe or chronic conditions. Examples are - Clinical indications and/or evidence, professional standards and protocols, comparative effectiveness studies and clinical trials.
- Clinical efficiency of treatment or service - Services which, in the professional judgment of members of the Regional Utilization Management Committee and or the Regional P&T Committee are based on evidence as defined by nationally accepted best practices. Examples are adherence to clinical standards - over-utilization of services or overprescribing could lead to quality/safety concerns for the

member. Efficacy demonstrated in rare conditions only - drugs that are approved for specific rare conditions and specific diagnostic testing is required

- Appropriate level of care - Services which, in the professional judgment of members of the Regional Utilization Management Committee and or the Regional P&T Committee are provided at the appropriate level of care for the member's condition. Examples are least restrictive appropriate level of care - lowest
  There were no factors that were considered but rejected.

The Kaiser Permanente formulary is a list of drugs approved by the Regional P&T Committee ("Committee" for general use. The members of the Committee come from various clinical specialties that adequately represent the needs of our enrollees. The majority members are practicing physicians and/or practicing clinical pharmacists. The Committee includes at least one practitioner with expertise in pediatrics, one practitioner with expertise in psychiatry, and at least one practicing physician and one practicing clinical pharmacist who are experts regarding care of elderly or disabled individuals. The Committee, with expert guidance from various medical specialties, evaluates, appraises, and selects from available medications those considered to be the most appropriate for patient care and general use within the region. The purpose of the formulary is to promote rational, safe, and cost-effective drug use. The formulary process provides an objective and balanced evaluation of medications based on sound clinical evidence that supports the safe, appropriate, and cost-effective use of the drug. A member or provider may request a non-formulary medication based on the non-formulary exception process. If the non-formulary exception reasons are met (1-4), the member will receive the medication at their pharmacy benefit. If the non-formulary exception is not met (5), the member has the option to receive the non-formulary medication at full price.

The following are the non-formulary (NF) exception reasons:

- NF Code 1: Allergy/Adverse Reaction to formulary drug(s)
- NF Code 2: Treatment failure to formulary drug(s)
- NF Code 3: The choices available in the Drug Formulary are not suited for the present patient care need and the drug selected is required for patient safety.
- NF Code 4: The use of a Formulary Drug Product may provoke an underlying medical condition, which would be detrimental to patient care.
- NF Code 5: Patient requests non-formulary drug, patient pays full price.

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

UM adopts and utilizes nationally developed clinical criteria and regionally developed medical coverage policies that are approved by the RUMC to evaluate the necessity of medical/surgical and behavioral health services requiring approval. The RUMC membership includes a cross section of

health care professionals from across the organization, among them senior level physicians from both medical-surgical and behavioral health who play a key role in the approval of UM criteria.

When reviewing medical/surgical and behavioral health referrals for medical necessity, Health Plan uses nationally recognized, written criteria, i.e., Milliman Care Guidelines (MCG™) or American Society of Addiction Medicine (ASAM), based on sound clinical evidence to make utilization decisions and specifies procedures for appropriately applying the criteria. Objective, evidence-based criteria are applied while taking individual circumstances into account when determining medical appropriateness of health care services. Utilization Management is a Health Plan accountability and Mid-Atlantic Permanente Medical Group (MAPMG) participates substantively in the process, recommending the UM decision on Health Plan's behalf.

The Kaiser Permanente formulary is a list of drugs approved by the Regional P&T Committee. The committee, with expert guidance from various medical specialties, evaluates, appraises, and selects from available medications those considered to be the most appropriate for patient care and general use within the region. The purpose of the formulary is to promote rational, safe, and cost-effective drug use. The formulary process provides an objective and balanced evaluation of medications based on sound clinical evidence that supports the safe, appropriate, and cost-effective use of the drug.

Applying evidence-based medicine, the Regional P&T Committee determine whether a medicine should be added to the drug formulary. Drugs included in the formulary are selected on the basis of sound clinical evidence that supports it's:

- First-line therapy, standard of care
- Alternative to first-line
- Safety and efficacy
- Bioequivalent to existing drugs, most cost-effective
- Frequency of use based on its place in therapy
- Stewardship

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

The scope of the Utilization Program includes RUMC oversight of the development, review, evaluation to consistently adopt criteria that are approved based on the active involvement of appropriate and actively credentialed practitioners. All Medical Coverage Polices (MCP) and UM criteria sets are reviewed and revised annually and updated as needed, then reviewed and approved by the RUMC as delegated by the Regional Quality Improvement Committee (RQIC). MCPs are reviewed against current clinical and medical evidence and are updated, when appropriate. Neither coverage policies nor criteria sets are designed to be the final determinate of the need for care but are used to provide guidance, along with

consideration for the needs and health status of the individual patient. Licensed, board-certified practitioners or clinical subject matter experts in their area of specialty are given the opportunity to advise or comment on development or adoption of UM criteria, and on instructions for applying criteria. This process occurs in the same manner and is no more stringent for MH/SUD than for M/S.
This process is a team effort that includes behavioral and non-behavioral health practitioners from across the region, led by the MAPMG UM Physician Director of Referrals in partnership with the UM physician reviewers, Assistant Physician-in-Chief (APIC), service chiefs, subject matter experts and the UM Compliance team.

Drugs reserved for non-formulary are due to limited data regarding its place in therapy, stemming from:

- Issue with safety or efficacy
- Lack of compelling evidence
- Low value
- Duplicate bioequivalent agents, not cost-effective
- Stewardship
- Volume of use

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

Annually, UM evaluates the consistency with which healthcare professionals involved in UM apply criteria for M/S and MH/SUD in decision-making, and act on opportunities to improve consistency. Monitoring and inter-rater reliability (IRR) assessment activities evaluate UM staff and physician reviewers to ensure consistency and appropriateness in the use of clinical criteria among our licensed health professionals conducting UM review for M/S and MH/SUD. Studies of consistency (e.g., inter-rater reliability), and actions to improve consistency are shared with UM physicians and staff and reported to Accreditation Readiness Team (ART), RUMC and RQIC through the quarterly work plan.

An inter-rater reliability assessment is used to measure the level of consistency among the staff and adherence to medical management criteria or standard. Its purpose is to:

- Minimize variation in the application of clinical guidelines and policies
- Evaluate staff ability to identify potential avoidable waste, fraud, and abuse
- Evaluate staff ability to identify quality of care issues
- Identify specific areas needing improvement including additional training needs

Non-formulary Exception Reasons are applicable to both MH/SUD and M/S and can be due to:

- Allergy/Adverse Reaction to formulary drug(s)
- Treatment failure to formulary drug(s)
- The choices available in the Drug Formulary are not suited for the present patient care need and the drug selected is required for patient safety.
- The use of a Formulary Drug Product may provoke an underlying medical condition, which would be detrimental to patient care.
- Patient requests non-formulary drug, and demand unnecessary by the prescriber, therefore patient pays full price.

Operationally, behavioral health and medical/surgical non-formulary medical necessity requests follow the same workflow requiring a prescribing physician furnishing the non-formulary exception reason. These non-formulary exception requests are processed by the UM pharmacy team and forwarded to a UM physician when the non-formulary exception criteria is not met for final review before a denial is issued. The UM physician is responsible for denying the request. Annually an interrater reliability and quality assurance processes takes place to ensure consistency of criteria applied by UM pharmacy team.

This NQTL, the medical necessity and the non-formulary exception process, is applicable to both MH/SUD and M/S.

2. Prior Authorization Review Process

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

Prior authorization is a pre-service request for authorization of payment for an item or service under the terms of a member's plan of benefits. Health Plan members are referred first for non-emergency inpatient services to an in-network provider within Kaiser Permanente's delivery system. If a member requires covered services not available from a network provider, he or she will be referred to an out-of-network provider inside or outside the Health Plan's service area with review and approval by our UM Department. Members are advised to call 911 (where available) or go to the nearest hospital emergency department if they believe they are experiencing a medical emergency. No prior authorization is required for emergency services. When a member receives treatment for an emergency medical condition, Health Plan covers emergency services received from network providers or out-of-network providers. Once the emergency condition has been stabilized, coverage of further services requires authorization from Health Plan.

The Kaiser Permanente Pharmacy and Therapeutic Committee establishes and approves the specific prior authorization criteria based on FDA approved indications, peer-reviewed scientific evidence, clinical practice guidelines, industry standard of care and quality and safety concerns.

Drugs requiring prior authorization have specific clinical criteria based on FDA approved indications, peer-reviewed scientific evidence, clinical practice guidelines and standard of practices treatment protocols including but not limited to diagnosis of specified condition, laboratory requirements or prescriber specialty, that must be met in order for the prescription to be eligible for coverage. Kaiser Permanente formulary posted on kp.org lists medications requiring prior authorization.

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

Factors used to determine the need for prior authorization for both M/S and MH/SUD include:

- The severity or chronicity of an illness – Services that, in the professional judgment of the members of the Regional Utilization Management Committee and or the Regional P&T Committee are specifically for the treatment of severe or chronic conditions. Examples are - Clinical indications and/or evidence, professional standards and protocols, comparative effectiveness studies and clinical trials.
- Clinical efficiency of treatment or service - Services which, in the professional judgment of members of the Regional Utilization Management Committee and or the Regional P&T Committee are based on evidence as defined by nationally accepted best practices. Examples are adherence to clinical standards - over-utilization of services of overprescribing could lead to quality/safety concerns for the

member. Efficacy demonstrated in rare conditions only - drugs that are approved for specific rare conditions and specific diagnostic testing is required

- Appropriate level of care - Services which, in the professional judgment of members of the Regional Utilization Management Committee and or the Regional P&T Committee are provided at the appropriate level of care for the member's condition. Examples are least restrictive appropriate level of care - lowest
  There were no factors that were considered but rejected.

Drugs requiring prior authorization have specific clinical criteria based on FDA approved indications, peer-reviewed scientific evidence, clinical practice guidelines and standard of practices treatment protocols including but not limited to diagnosis of specified condition, laboratory requirements or prescriber specialty, that must be met in order for the prescription to be eligible for coverage. These criteria are developed, reviewed and approved by Kaiser Permanente Pharmacy and Therapeutic Committee.

Prior authorizations are applied to outpatient prescription drugs:

- With multiple medical uses to ensure appropriate prescribing,
- Higher in cost,
- With significant safety concern
- At risk for waste, abuse and misuse.

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

UM adopts and utilizes nationally developed clinical criteria and regionally developed medical coverage policies that are approved by the RUMC to evaluate the necessity of medical/surgical and behavioral health services requiring approval. The RUMC membership includes a cross section of health care professionals from across the organization, among them senior level physicians from both medical-surgical and behavioral health who play a key role in the approval of UM criteria.

When reviewing medical/surgical and behavioral health referrals for prior authorization review, Health Plan uses nationally recognized, written criteria, i.e., MCG™ or ASAM, based on sound clinical evidence to make utilization decisions and specifies procedures for appropriately applying the criteria. Objective, evidence-based criteria are applied while taking individual circumstances into account when determining medical appropriateness of health care services. Utilization Management is a Health Plan accountability and MAPMG participates substantively in the process, recommending the UM decision on Health Plan's behalf.

The Pharmacy and Therapeutics Committee follow national guidelines, peer reviews, and evidentiary standards in the development of the prior authorization criteria. Members of the Pharmacy and Therapeutics Committee reviews the available information, including the prescribing information, independent studies, and other recognized authoritative compendia and creates criteria for review with assistance of Specialty Departments. The physician specialist provides input regarding the appropriate use of a specific drug. Criteria are reviewed annually or when changes are made. The Kaiser Permanente Pharmacy and Therapeutic Committee establishes and approves the specific criteria for these drugs based on FDA approved indications, peer-reviewed scientific evidence, clinical practice guidelines, industry standard of care and quality and safety concerns. The Committee members are made up of trained and licensed clinical pharmacists, physicians and other clinicians as appropriate. The process of adding prior authorization criteria for either behavioral health or medical/surgical drugs, follow the same evidentiary standards in the development of the criteria. The physician specialist provides input regarding the appropriate use of a specific drug. Criteria are reviewed annually or when changes are made. The prior authorization criteria are applied to medications with:

- Potential for significant safety concerns
- High potential for adverse effects
- High cost-to-benefit ratio in conjunction with other available therapies for the disease state
- High potential for abuse or misuse

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

The scope of the Utilization Program includes RUMC oversight of the development, review, evaluation to consistently adopt criteria that are approved based on the active involvement of appropriate and actively credentialed practitioners. All MCP and UM criteria sets are reviewed and revised annually and updated as needed, then reviewed and approved by the RUMC as delegated by the Regional Quality Improvement Committee, RQIC. MCPs are reviewed against current clinical and medical evidence and are updated, when appropriate. Neither coverage policies nor criteria sets are designed to be the final determinate of the need for care but are used to provide guidance, along with consideration for the needs and health status of the individual patient. Licensed, board-certified practitioners or clinical subject matter experts in their area of specialty are given the opportunity to advise or comment on development or adoption of UM criteria, and on instructions for applying criteria. This process occurs in the same manner and is no more stringent for MH/SUD than for M/S.

This process is a team effort that includes behavioral and non-behavioral health practitioners from across the region, led by the MAPMG UM Physician Director of Referrals in partnership with the UM physician reviewers, APIC, service chiefs, subject matter experts and the UM Compliance team.

Kaiser Permanente P&T approved prior authorization criteria development take into consideration:

- Potential for significant safety concerns
- High potential for adverse effects
- High cost-to-benefit ratio in conjunction with other clinical considerations (comparative cost of alternative equivalent therapy, availability of current formulary drugs to meet therapeutic need)
- High potential for abuse or misuse

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

Annually, UM evaluates the consistency with which healthcare professionals involved in UM apply criteria for M/S and MH/SUD in decision-making, and act on opportunities to improve consistency. Monitoring and IRR assessment activities evaluate UM staff and physician reviewers to ensure consistency and appropriateness in the use of clinical criteria among our licensed health professionals conducting UM review for M/S and MH/SUD. Studies of consistency (e.g., inter-rater reliability), and actions to improve consistency are shared with UM physicians and staff and reported to ART, RUMC and RQIC through the quarterly work plan.

An inter-rater reliability assessment is used to measure the level of consistency among the staff and adherence to medical management criteria or standard. Its purpose is to:

- Minimize variation in the application of clinical guidelines and policies
- Evaluate staff ability to identify potential avoidable waste, fraud, and abuse
- Evaluate staff ability to identify quality of care issues
- Identify specific areas needing improvement including additional training needs

Drugs requiring prior authorization have specific clinical criteria based on FDA approved indications, peer-reviewed scientific evidence, clinical practice guidelines and standard of practices treatment protocols including but not limited to diagnosis of specified condition, laboratory requirements or prescriber specialty, that must be met in order for the prescription to be eligible for coverage. These criteria are developed, reviewed and approved by Kaiser Permanente Pharmacy and Therapeutic Committee. All prior authorization criteria are subject to an annual review process.

Prior authorizations are applied to outpatient prescription drugs:

- With multiple medical uses to ensure appropriate prescribing,
- Higher in cost comparable to alternative therapies
- With significant safety concern
- At risk for waste, abuse and misuse.

Staff members conducting the UM prior authorization reviews undergo an annual interrater reliability assessment test.

3. Concurrent Review Process

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

When performing concurrent review for referrals classifications, Network Inpatient, Out of Network Inpatient, Network Outpatient-Office, Out of Network Outpatient- Office, In Network Outpatient-All Other, Out of Network Outpatient-All Other, all steps in the referral management process are documented and notified via the KP HealthConnect (KPHC) electronic medical record. The initial referral is reviewed by clinically licensed and qualified UM staff for availability of the benefits in their plan, adequacy of clinical information, and criteria. The member's benefit array, referral specific clinical information, history, and other medical records of care, are available to the UM reviewer directly within the same electronic platform. During this process, the clinical reviewer enters relevant member specific information directly into the referral notes. The applicable UM criteria is also entered in the referral for review.

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

The following information is taken into consideration when conducting concurrent review:

- If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the organization does not meet the definition of "urgent care," the request may be handled as a new request and decided within the time frame appropriate for the type of decision (i.e., preservice or post-service)
- If the course of care ends prior to requesting an extension, then the request becomes a standard pre-service claim
- When determining whether a concurrent request meets the definition of "urgent," Health Plan considers the content of the request and whether making the decision is in accordance with the non-urgent preservice time frame which could lead to adverse health consequences
- The staff determines whether it is reasonable to handle the request as urgent if application of a non-urgent time frame could involve an unnecessary interruption in the member's treatment that may jeopardize the member's health or ability to recover.

Examples of Factors for determining that concurrent review is appropriate:

- Severity or chronicity of an illness
- Lack of Clinical efficiency of treatment or service

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

After reviewing the evidentiary standards for both benefit areas, both Medical/Surgical and mental health/substance abuse disorder services follow a similar concurrent review process that applies the following evidentiary standards:

- Evidence Based Medicine: Routine evaluation by a trained reviewer similarly credentialed for both M/S and MH/SUD in the application of evidence-based medicine as defined within each practice.
- Medical Necessity and Level of Care: Assessment of medical necessity and level of care placement follows MCG for mental health. Recommended level of care evaluation for SUD also includes ASAM. CMS guidelines are applied to skilled nursing to ensure the length of stay is appropriate to the patient's needs, while providing proper clinical care coordination.

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

The scope of the Utilization Program includes RUMC oversight of the development, review, evaluation to consistently adopt criteria that are approved based on the active involvement of appropriate and actively credentialed practitioners. All MCP and UM criteria sets are reviewed and revised annually and updated as needed, then reviewed and approved by the RUMC as delegated by the Regional Quality Improvement Committee, RQIC. MCPs are reviewed against current clinical and medical evidence and are updated, when appropriate. Neither coverage policies nor criteria sets are designed to be the final determinate of the need for care but are used to provide guidance, along with consideration for the needs and health status of the individual patient. Licensed, board-certified practitioners or clinical subject matter experts on asks for in their area of specialty are given the opportunity to advise or comment on development or adoption of UM criteria, and on instructions for applying criteria. This process occurs in the same manner and is no more stringent for MH/SUD than for M/S.

This process is a team effort that includes behavioral and non-behavioral health practitioners from across the region, led by the MAPMG UM Physician Director of Referrals in partnership with the UM physician reviewers, APIC, service chiefs, subject matter experts and the UM Compliance team.

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

Annually, UM evaluates the consistency with which its UM reviewers apply criteria in decision making, and acts upon opportunities to improve consistency. Monitoring and IRR assessment activities evaluate UM staff and physician reviewers to ensure consistency and appropriateness in the use of clinical criteria among our licensed health professionals conducting UM review. Studies of consistency (e.g., inter-rater reliability), and actions to improve and ensure consistency are shared with UM physicians and staff and reported to ART, RUMC and the RQIC, through the

quarterly work plan.

The annual IRR assessment measures the level of consistency among the staff and their adherence to medical management criteria or standards. Its purpose is to:

- Minimize variation in the application of clinical guidelines and policies
- Evaluate staff's ability to identify potential avoidable waste, fraud, and abuse
- Evaluate staff's ability to identify quality of care issues
- Identify specific areas needing improvement including additional training needs

4. Retrospective Review Process

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

Health Plan UM conducts retrospective reviews in the same exact manner for both Med Surg and MH/SUD, and for all settings, i.e., Network Inpatient, Out of Network Inpatient, Network Outpatient-Office, Out of Network Outpatient- Office, In Network Outpatient-All Other , Out of Network Outpatient-All Other to determine benefit/coverage or medical necessity after a service has been provided, in cases where there was no notification to Health Plan or a request for Health Plan review prior to a member's receipt of the item or services. The retrospective review process follows the same steps as outlined for prior authorization, using applicable coverage and medical necessity UM criteria.

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

The factors that influence the application of retrospective review for medical/surgical and behavioral health services are:

- The severity or chronicity of an illness – Services that, in the professional judgment of the members of the Regional Utilization Management Committee and or the Regional P&T Committee are specifically for the treatment of severe or chronic conditions. Examples are - Clinical indications and/or evidence, professional standards and protocols, comparative effectiveness studies and clinical trials.
- Clinical efficiency of treatment or service - Services which, in the professional judgment of members of the Regional Utilization Management Committee and or the Regional P&T Committee are based on evidence as defined by nationally accepted best practices. Examples are adherence to clinical standards - over-utilization of services of overprescribing could lead to quality/safety concerns for the member. Efficacy demonstrated in rare conditions only - drugs that are approved for specific rare conditions and specific diagnostic testing is required.
- Appropriate level of care - Services which, in the professional judgment of members of the Regional Utilization Management Committee and or the Regional P&T Committee are provided at the appropriate level of care for the member's condition. Examples are least restrictive appropriate level of care - lowest
  There were no factors that were considered but rejected.

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

UM adopts and utilizes nationally developed clinical criteria and regionally developed medical coverage policies that are approved by the Regional Utilization Management Committee, RUMC, to evaluate the necessity of medical/surgical and behavioral health services requiring

approval. The RUMC membership includes a cross section of health care professionals from across the organization, among them senior level physicians from both medical-surgical and behavioral health who play a key role in the approval of UM criteria.

When reviewing medical/surgical and behavioral health referrals for retrospective review, Health Plan uses nationally recognized, written criteria, i.e., MCG™ or ASAM, based on sound clinical evidence to make utilization decisions and specifies procedures for appropriately applying the criteria. Objective, evidence-based criteria are applied while taking individual circumstances into account when determining medical appropriateness of health care services. Utilization Management is a Health Plan accountability and MAPMG participates substantively in the process, recommending the UM decision on Health Plan's behalf.

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

The scope of the Utilization Program includes RUMC oversight of the development, review, and evaluation of criteria to support adoption of criteria that are approved based on the active involvement of appropriate and actively credentialed practitioners. All MCP and UM criteria sets are reviewed and revised annually and updated as needed, then reviewed and approved by the RUMC as delegated by the Regional Quality Improvement Committee, RQIC. MCPs are reviewed against current clinical and medical evidence and are updated, when appropriate. Neither coverage policies nor criteria sets are designed to be the final determinant of the delivery of, but are used to provide guidance, along with consideration for the needs and health status of the individual patient. Licensed, board-certified practitioners or clinical subject matter experts in their area of specialty are given the opportunity to advise or comment on development or adoption of UM criteria, and on instructions for applying criteria. This process occurs in the same manner and is no more stringent for MH/SUD than for M/S.

This process is a team effort that includes behavioral and non-behavioral health practitioners from across the region, led by the MAPMG UM Physician Director of Referrals in partnership with the UM physician reviewers, APIC, service chiefs, subject matter experts and the UM Compliance team.

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

Annually, UMOC(?) evaluates the consistency with which healthcare professionals involved in UM apply criteria for M/S and MH/SUD in decision-making, and act on opportunities to improve consistency. Monitoring and IRR assessment activities evaluate UM staff and physician reviewers to ensure consistency and appropriateness in the use of clinical criteria among our licensed health professionals conducting UM review for M/S and MH/SUD. Studies of consistency (e.g., inter-rater reliability), and actions to improve consistency are shared with UM physicians and staff and reported to ART, RUMC and RQIC through the quarterly work plan.

An inter-rater reliability assessment is used to measure the level of consistency among the staff and adherence to medical management criteria or standard. Its purpose is to:

- Minimize variation in the application of clinical guidelines and policies
- Evaluate staff ability to identify potential avoidable waste, fraud, and abuse
- Evaluate staff ability to identify quality of care issues
- Identify specific areas needing improvement including additional training needs

5. Emergency Services

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

There are no NQTLs applied to emergency services, either for M/S or MH/SUD. There is no differentiation in emergency benefits between M/S and MH/SUD. There is only a single ER benefit and ambulance benefit.

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

There are no NQTLs applied to emergency services, either for M/S or MH/SUD. There is no differentiation in emergency benefits between M/S and MH/SUD. There is only a single ER benefit and ambulance benefit.

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

There are no NQTLs applied to emergency services, either for M/S or MH/SUD. There is no differentiation in emergency benefits between M/S and MH/SUD. There is only a single ER benefit and ambulance benefit.

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

There are no NQTLs applied to emergency services, either for M/S or MH/SUD. There is no differentiation in emergency benefits between M/S and MH/SUD. There is only a single ER benefit and ambulance benefit.

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

There are no NQTLs applied to emergency services, either for M/S or MH/SUD. There is no differentiation in emergency benefits between M/S and MH/SUD. There is only a single ER benefit and ambulance benefit.

6. Pharmacy Services

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

The comparative analysis of pharmacy services are addressed within the other requested NQTL categories.

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

The comparative analysis of pharmacy services are addressed within the other requested NQTL categories.

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

The comparative analysis of pharmacy services are addressed within the other requested NQTL categories.

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

The comparative analysis of pharmacy services are addressed within the other requested NQTL categories.

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

The comparative analysis of pharmacy services are addressed within the other requested NQTL categories.

7. <u>Prescription Drug Formulary Design</u>

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

NQTLs applied by the Pharmacy and Therapeutics Committee include Prior Authorization/Step Therapy and Quantity Limits (QLs) Restricted prescribing does not apply to MH/SUD medications.

Kaiser Permanente Commercial plans have a closed formulary unless otherwise specified (open formulary design). The Kaiser Permanente Pharmacy and Therapeutic Committee establishes and approves the formulary status and any applied quantity limits or prior authorizations for these drugs based on FDA approved indications, peer-reviewed scientific evidence, clinical practice guidelines, industry standard of care and quality and safety concerns.

Any FDA-approved drug may be evaluated, or re-evaluated, for formulary addition or deletion, or for modification of criteria or restrictions on its use. In addition, drug class reviews will be conducted periodically.

Any member, provider or pharmacist may request that a drug or dosage form be added to or deleted from the formulary.

For plans with an open formulary design, all medications are covered under the prescription benefit and no NQTLs are applied as they are out of scope. Prescriptions are not limited by quantity, step therapy, or prior authorization.

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

Factors Considered For All Drugs (including medical/surgical medications and MH/SUD medications):

- Safety and effectiveness as determined by:
  - Medical evidence (nationally published clinical guidelines, primary research and clinical research studies, manufacturer package insert
  - Expert opinion (nationally published consensus statements)
  - Relevant findings of appropriate external organizations (NCQA, AHRQ, AMA, NCCN, FDA, CDC)
- Additional information considered in making decisions include:
  - Availability of current formulary drugs to meet the therapeutic need

- Reliability and quality control of the drug manufacturer
- Current utilization of the drug by practitioners within the program
- Comparative cost of alternative equivalent therapy
- Utilization of the Non-formulary Exception Process
- Other unique attributes which may warrant inclusion of the drug.
- State and local mandates for benefit coverage and Medicare regulations

P&T ensures the formulary drug list covers a range of drugs across a broad distribution of therapeutic categories, classes, and recommended drug treatment regimens that treat all disease states. P&T ensures the formulary drug list provides appropriate access to drugs that are included in broadly accepted treatment guidelines and are indicative of general best practices at the time of the decision.

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

The Kaiser Permanente Pharmacy and Therapeutic Committee establishes and approves the formulary status for these drugs based on FDA approved indications, peer-reviewed scientific evidence, clinical practice guidelines, industry standard of care and quality and safety concerns. The Committee members are made up of trained and licensed clinical pharmacists, physicians and other clinicians as appropriate. The process of adding NQTLs follow the same evidentiary standards in the development of the criteria; this applies to prior authorization criteria for either behavioral health or medical/surgical drugs, as well as restricted prescribing and quantity limits for M/S. A pharmacist that is a part of the Pharmacy and Therapeutics Committee reviews the available information, including the prescribing information, independent studies, and other recognized authoritative compendia and creates a formulary status recommendation for review with assistance of Specialty Departments. The physician specialist provides input regarding the appropriate use of a specific drug and place in therapy. Formulary status is reviewed annually or when changes are made.

Restricted prescribing does not apply to MH/SUD medications and will not be considered as part of the remaining analysis.

Formulary status considerations are based on:

- Safety and effectiveness as determined by:
  - Medical evidence (nationally published clinical guidelines, primary research and clinical research studies, manufacturer package insert)
  - Expert opinion (nationally published consensus statements)
  - Relevant findings of appropriate external organizations (NCQA, AHRQ, AMA, NCCN, FDA, CDC)
- Additional information considered in making decisions include:

- Availability of current formulary drugs to meet the therapeutic need (drug monographs include utilization and cost comparisons for other treatment alternatives for indications covered by the drug)
- Reliability and quality control of the drug manufacturer
- Current utilization of the drug by practitioners within the program (assessment of off-label and prescribing by non-specialists)
- Comparative cost of alternative equivalent therapy (annualized cost impact assessments, available pharmacoeconomic studies)
- Utilization of the Non-formulary Exception Process (review of medical necessity justifications provided by physicians)
- Other unique attributes which may warrant inclusion of the drug (single-source procurement, FDA REMs requirements, high risk for discontinuation of drug due to significant adverse events)
- State and local mandates for benefit coverage and Medicare regulations (CMS guidance on formulary coverage, state Medicaid guidance (e.g. MD/VA Medicaid formularies and NQTLs), state regulations covering prior authorizations and specialty drugs)

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

Advisory Criteria for Formulary Evaluations and Decisions:

- New drug treatment for a disease where no previous drug treatment exists. All the following criteria must be met: (Patient population defined as to those who will benefit from treatment).
  - Improved clinical and acceptable pharmacoeconomic outcomes
  - Acceptable benefit to risk ratio
- New drug treatment with improved clinical outcome over existing agents
  - Improved clinical and acceptable pharmacoeconomic outcomes with comparable side effects
  - Reduced side effects and/or potential for serious drug interactions which significantly contribute to treatment failure with existing agents
  - Improved benefit to risk ratio
  - New mechanism of action which improves clinical outcome in a defined population subset (i.e.: treatment failures to existing drugs)
  - Could replace another drug on the formulary
- Therapeutic duplications (equivalent efficacy and side effects)
  - Improved pharmacoeconomic outcome (defined by cost minimization or cost effectiveness analysis)
  - Significant improvement in convenience/compliance
- Restrictions - a drug in any category may be restricted to (a) specialist(s) or to criteria for use if it meets one or more of the following:
  - Significant potential for inappropriate use
  - Narrow safety margin
  - Requires specialty expertise

  - Reserved for second- or third-line therapy
  - In actual or potential short supply
- Non-formulary - a drug may be designated non-formulary if it meets one or both of the following:
  - Does not meet inclusion criteria for addition to the formulary
  - Specifically excluded by the Health Plan benefits contract

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

Based on analysis provided in Step 5, MAS Commercial closed formulary criteria are not applied more stringently to MH/SUD medications. In addition, the number of NQTLs compared to the number of medications on formulary is less stringent for MH/SUD vs. M/S. For plans with an open formulary design, no NQTLs are applied to either Med/Surg or MH/SUD as they are out of scope. Prescriptions are not limited by quantity, step therapy, or prior authorization.

8. <u>Case Management</u>

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

Case management is a service provided to members and does not play a role in coverage or benefit decisions, there is no variation between M/S and MH/SUD.

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

Case management is a service provided to members and does not play a role in coverage or benefit decisions, there is no variation between M/S and MH/SUD.

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

Case management is a service provided to members and does not play a role in coverage or benefit decisions, there is no variation between M/S and MH/SUD.

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

Case management is a service provided to members and does not play a role in coverage or benefit decisions, there is no variation between M/S and MH/SUD.

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

Case management is a service provided to members and does not play a role in coverage or benefit decisions, there is no variation between M/S and MH/SUD.

9. Process for Assessment of New Technologies

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

The process for Assessment of New Technologies is comparable for both M/S and MH/SUD. The Interregional New Technologies Committee (INTC), an enterprise-wide research committee, and the regional level technology evaluating committees of Kaiser Permanente Technology Review and Implementation Committee (TRIC) and RUMC monitor and evaluate new technology and new applications of existing M/S and MH/SUD technologies including procedures, devices, and pharmaceutical/therapeutic items from regional review requests including but not limited to physician and member requests, member appeals & benefit requests.

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

The following are the considered factors:

- Safety
- Efficacy & Utility

New and emerging technologies for M/S or MH/SUD are evaluated by comparing their safety and efficacy with relative utility to current medical practice based on scientific evidence, information and data that are presented at the time of review.

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

Kaiser Permanente uses a combination of sources to evaluate the safety, efficacy and utility of new / emerging technologies. This includes but not limited to the following sources:

- Scientific evidence including strength, reliability and validity of scientific information/findings (including study design, research method and number of research participants) such as results of clinical trial, research studies, data from published evidence, scientific articles:
    - Clinical Trial
    - Adequate and well controlled randomized trials
    - Open label trials
    - Other research studies associated with the technology
    - Peer-reviewed medical literature

- Information from appropriate government regulatory agencies and professional organizations:
  - Center for Medicaid and Medicare System (CMS)
  - The Food and Drug Administration (FDA)
  - The National Institutes for Health (NIH)
  - The National Cancer Institute (NCI)
  - Centers for Disease Control (CDC)
  - The Agency for Healthcare Research and Quality (AHRQ)
- Position and recommendations from government agencies, professional societies, and summaries from organizations that rely on the judgment of experts when determining the effectiveness of new technology.
  - Medical Associations
    - Medical Specialty Societies
    - American Medical Association (AMA)
    - American Hospital Association (AHA)
  - Includes sources for MH/SUD Technologies:
    - American Psychiatric Association
    - American Psychological Association
    - National Institute of Mental Health
    - Anxiety Disorders Association of America
    - Substance Abuse and Mental Health Services Administration (SAMHSA)
- Recommendations of Technology Assessment Organizations
  - ECRI
  - HAYES, Inc.
  - CTAF/ICER
- Medical experts' opinion - consultation including relative utility to current medical practice
  - Physician experts internal to Kaiser Permanente
  - Physician experts external to Kaiser Permanente
- Technology experience within the region includes identified safety issues.
  - Post marketing experience with the technology
  - Safety profile of other drugs/pharmaceuticals or device in the class (inclusive of other indications)
- Assessment and evaluation of Kaiser Permanente committees who review & assess technologies and provide recommendations for inclusion or exclusion of new/emerging technologies, nationally and within each Kaiser Permanente region.

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

At an enterprise-wide level, the Kaiser Permanente INTC reviews all relevant information and evaluates the medical appropriateness of M/S and MH/SUD technologies based on demonstrated safety, efficacy, and comparative utility. When needed, the INTC refers the new technology topic to an ad-hoc or standing regional committee such as the National Transplant Network and its Clinical Advisory Groups, and the California Regional Biotechnology Committee for further review if the status of a particular technology requires more extensive evaluation.

INTC research members are composed of physicians and non-physicians from the Kaiser Permanente regions and program offices within the Kaiser Permanente medical care program. INTC's conclusions and recommendations associated with technologies are shared with each region that is part of the Kaiser Permanente enterprise.

At the regional level, the Kaiser Permanente TRIC and RUMC evaluates M/S and MH/SUD new/emerging technologies by assessing the efficacy, safety and clinical utility of the technology based on the overall quality, quantity and certainty of evidence for the intended patient, clinical indication and if the technology will improve the net health outcome for select patients. Technology conclusion, position statements and recommendations including limitations are then drawn by the committee to adopt or not adopt the inclusion of M/S and MH/SUD technology for the Kaiser Permanente region.

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

Kaiser Permanente's process to assess and evaluate new and emerging technologies for M/S technologies is comparable to MH/SUD technologies.

Kaiser Permanente evaluates non-behavioral health (NBH) or medical/surgical new /emerging technologies by assessing its' efficacy, safety, and clinical utility of the technology for the intended clinical indication(s) and its' designated population(s) of interest compared to stated therapeutic or diagnostic alternatives. Kaiser Permanente evaluates MH/SUD new /emerging technologies by assessing its' efficacy, safety, and clinical utility of the technology for the intended clinical indication(s) and its' designated population(s) of interest compared to stated therapeutic or diagnostic alternatives.

Recommendations made by the TRIC and RUMC falls into either of the following category:

- Sufficient evidence – Adopt the technology or adopt the technology with limitations
- Insufficient evidence – Do not adopt the technology guide

10. <u>Standards for Provider Credentialing and Contracting</u>

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

Credentialing and network admission policies are identified as an NQTL requiring a comparative analysis to ensure the process are applied no more stringently to MH/SUD providers than to M/S providers.

Kaiser Permanente's pharmacy network is comprised of Kaiser Permanente-owned and operated pharmacies and the pharmacy benefit manager contracted participating pharmacies.

Kaiser Permanente-owned-and-operated pharmacies meet the minimum state standards for pharmacy practice in accordance with standard of pharmacy practice policy and procedure.

Pharmacy Benefit Managers (PBM's) require contracted network pharmacies to comply with the minimum state standards for pharmacy practice.

Pharmacy providers provide prescription drug benefits to eligible beneficiaries in accordance with their benefit design based on the prescriber's directions, the pharmacy benefit plan, applicable laws, provider's professional judgement, and good pharmacy practice. This practice is consistent for both MH/SUD and M/S.

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

Credentialing and network admission factors were developed to ensure network providers meet minimum participation requirements including professional and clinical competency and to further ensure members have access to high quality providers. These factors also include adherence to network adequacy regulations, credentialing accreditation guidelines and federal, state and local requirements.

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

The following are the sources used for evaluation:

- NCQA Accreditation Standards
- Federal, State, and Local Credentialing Regulations
- Maryland Regulation-COMAR 31.10.44
- Kaiser Permanente Credentialing and Privileging Policy and Procedure manual

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

Kaiser Permanente conducted an analysis of the Credentialing and Network Admission written processes, procedures, factors and strategies used in determining network inclusion for providers. The review included 1) Contracting/Area Access requests and processes, 2) Interested Provider Procedures, 3) Financial/Utilization Analyses conducted, 4) Credentialing/Quality of Care Review Standards, 5) Network Access and Adequacy Analyses conducted, 5) Credentialing application acceptance and rejection rates and 6) Approval Processes, including but not limited to the composition of decision-making staff and time allocated for reviews.

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

All practitioners are credentialing to the same standard regardless of practice specialty and setting with the exception of hospital-based providers which are out of scope for Kaiser Permanente's credentialing program. The credentialing criteria described are no more stringently applied to any one provider population than another as evidenced in the credentialing decision data. Based on the analysis, Kaiser Permanente's credentialing processes are comparable to and no more stringently applied to MH/SUD providers than to M/S providers. Data from January 2021 through September 2021 was used in this analysis. The rejection percentage was higher for the MH/SUD practitioners as a result of the lower volume of MH/SUD applicants to the Kaiser Permanente network and not a disparity in the applied credentialing factors, concluding that the data shows no marked disparities between MH/SUD providers and M/S providers. Network Admission policies, processes and procedures for MH/SUD and M/S providers are impacted by many different factors and market forces. Comprehensive analyses of factors, processes and strategies used to determine network inclusion for MH/SUD providers, both written and in operation, were comparable and no more stringently applied than for M/S providers.

11. Exclusions for Failure to Complete a Course of Treatment

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

The Health Plan does not make determinations for a course of treatment based on a failure to complete any previous treatment, but rather on a medical necessity determination based on the patient's current clinical condition.

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

The Health Plan does not make determinations for a course of treatment based on a failure to complete any previous treatment, but rather on a medical necessity determination based on the patient's current clinical condition.

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

The Health Plan does not make determinations for a course of treatment based on a failure to complete any previous treatment, but rather on a medical necessity determination based on the patient's current clinical condition.

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

The Health Plan does not make determinations for a course of treatment based on a failure to complete any previous treatment, but rather on a medical necessity determination based on the patient's current clinical condition.

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

The Health Plan does not make determinations for a course of treatment based on a failure to complete any previous treatment, but rather on a medical necessity determination based on the patient's current clinical condition.

12. Restrictions that Limit Duration or Scope of Benefits for Services

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

This service does not limit the scope or duration of benefits that services our members may receive and there is no variation in how services are administered. There are no restrictions with regard to type of facility in which members can receive covered services for either M/S or MH/SUD.

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

This service does not limit the scope or duration of benefits that services our members may receive and there is no variation in how services are administered. There are no restrictions with regard to type of facility in which members can receive covered services for either M/S or MH/SUD.

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

This service does not limit the scope or duration of benefits that services our members may receive and there is no variation in how services are administered. There are no restrictions with regard to type of facility in which members can receive covered services for either M/S or MH/SUD.

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

This service does not limit the scope or duration of benefits that services our members may receive and there is no variation in how services are administered. There are no restrictions with regard to type of facility in which members can receive covered services for either M/S or MH/SUD.

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

This service does not limit the scope or duration of benefits that services our members may receive and there is no variation in how services are administered. There are no restrictions with regard to type of facility in which members can receive covered services for either M/S or MH/SUD.

13. Restrictions for Provider Specialty

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

MAPMG, our largest and exclusively contracted provider group, determines how mid-level providers will practice within the Kaiser Permanente facilities. Health Plan does not have scope of practice restrictions for any MH/SUD physician or non-physician practitioners. Health Plan doesn't impose any limitation on any other contracted providers.

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

Factors considered are quality control and level of training.

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

Quality control is ensuring the individual providing service to the member has the most appropriate experience and training for a positive service outcome for our members.

Training is physicians evaluate the training programs for mid-level providers and determine whether the training provides the level of experience and depth to ensure positive outcomes for our members.

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

An analysis was conducted to collect and identify the restrictions placed on providers. We then compared restrictions indicated for M/S and MH/SUD providers.

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

The measure used is the MAPMG assessment of the training available to mid-level providers in this jurisdiction. In accordance with the six-step approach and analysis of the factors for MH/SUD providers, both written and in operation, were comparable and no more stringently applied than for M/S providers. In fact, there are more restrictions imposed on M/S mid-level providers than for MH/SUD mid-level providers.

14. <u>Reimbursement for INN Providers, OON Providers, INN Facilities, OON Facilities (separately)</u>

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

The NQTL applied for Reimbursement for Medical and Surgical benefits is based on rate negotiation. In network (INN) providers and ancillary facilities reimbursement rates are established based upon market conditions. Out of Network (OON) providers and ancillary facilities reimbursement rates are calculated according to the formulas outlined by the Maryland Health Care Commission (MHCC). Both INN and OON Hospital Reimbursement rates are determined by Maryland's Health Services Cost Review Commission (HSCRC).

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

The following factors that are used in determining the appropriate reimbursement rates for both M/S and MH/SUD providers.

- The credential/provider type of the practitioner(s).
- Treatment protocols/type of service
- Inpatient/Outpatient practitioner/provider reimbursement
- Inpatient/Outpatient facility reimbursement
- Multi-specialty group
- Geographic area
- Reputation
- Market benchmarks
- Supply and demand conditions

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

The following are sources to evaluate the above factors:

- As noted above in (A.), hospital reimbursement is prescribed by Maryland law and determined by the Health Service Cost Review Commission
- Medicare reimbursement guidelines
- CPT code as found in the AMA official CPT Codebook
- RBRVS Factors

- MS-DRGs
- Facility Location
- Provider's market position
- Geographic area
- Reputation
- Existing contract rates
- Market rates - market analysis conducted by external entities (e.g., independent 3rd party analysis).
- CMS Medicare reimbursement rates
- Consumer Price Index ("CPI")
- Claims Data
- Supply and demand conditions
- Current CMS Medicare promulgated reimbursement rates and methodologies
- Claims Data extracts
- Internal market analysis
- External competitive market analysis

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

An analysis of the written processes, procedures, factors and strategies used to set reimbursement rates for in-network inpatient, in-network outpatient office, and in-network outpatient all other subclassification providers was conducted.

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

An analysis of the processes, procedures, factors and strategies used to operationalize reimbursement rates and adjust reimbursement rates for MH/SUD and M/S providers was conducted including analyzing the outcome data, working sessions with contract managers who negotiate reimbursement and with leadership around decision making processes and contracting strategies on reimbursement and rate adjustments. By reviewing the approach, analysis of these factors, along with the analysis of processes and strategies used to determine reimbursement for MH/SUD providers, both written and in operation, demonstrates that the approach and outcome were comparable and no more stringently applied to MH benefits, SUD benefits, and M/S benefits.