MHPAEA Summary Form Instructions

The below summary form is prepared to satisfy the requirements of §15-144 (m)(2), Insurance Article, Annotated Code of Maryland. The summary form must be made available to plan members and to the public on the carrier's website.

Confidential and proprietary information must be removed from the summary form. Confidential and proprietary information that is removed from the summary form must satisfy § 15-144(h)(1), Insurance Article, Annotated Code of Maryland.

The MHPAEA Summary Form includes the MHPAEA Data Report.

Carriers must use the terms defined in COMAR 31.10.51 and the *Instructions for MHPAEA NQTL Analysis Report and Data Report* to complete the summary form.

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. (i.e., Kaiser Permanente) 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 Permanente 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.

If you have any questions on this summary, please contact 1-800-777-7902.

If you have questions on your specific health plan, please call 1-800-777-7902.

Overview:

We have completed a comparative analysis for the five Non-Quantitative Treatment Limitations (NQTLs) prescribed by the Maryland Insurance Administration (MIA) for the 2024 MHPAEA filing. What these NQTL's are and how the health plans achieve parity are discussed below.

Prior Authorization Review

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 process in which a request by a member or provider, prior to services being rendered, is completed to determine if coverage for the service will be provided. Prior authorization includes consideration of the member's benefits, medical necessity, level of care, appropriateness of the service, provider type, and geographic location.

Prior Authorization is the requirement that the Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc, ("Kaiser") Health Plan is notified prior to care being provided and includes reauthorization of services when prior authorization has lapsed. Kaiser members are referred first for non-emergency inpatient and outpatient covered services to an in-network provider within the Kaiser's care delivery system. If a member requires covered services not available from an in-network provider, they will be referred to an out-of-network provider inside or outside the Kaiser's service area with review and approval by our Utilization Management (UM) Department.

No prior authorization is required for emergency services. 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. When a member receives treatment for an emergency medical condition, Kaiser covers emergency services received from in-network providers or out-of-network providers.

In accordance with internal standards, external regulations, and accreditation standards, Kaiser, through its regional Member Relations (MR) Department, processes Grievances and Appeals for members under the appropriate grievance and/or appeals process. There are no distinctions within the Member Relations Grievance and Appeals process between benefit classifications.

The process for pre-service prior authorization appeals, including contact information for the MR Department, is located within the member's Evidence of Coverage (EOC) and/or Certificate of Insurance (COI). This information is also located in the initial denial letter.

The Kaiser Permanente Pharmacy and Therapeutic Committee establishes and approves the specific prior authorization criteria for drugs 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. The Kaiser formulary posted on kp.org lists medications requiring prior authorization.

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

Kaiser considers the following factors as it relates to Prior Authorization:

1. Severity or chronicity of an illness
2. Clinical efficiency of treatment or service
3. Appropriate level of care

Prior Authorization Appeals (design and application of expedited review for grievances/appeals for MH/SUD and M/S services)

4. Confirm whether services are pre-service
5. An expediated review request by a health care professional with knowledge of the member's health condition
6. An expediated review request by a member
7. The Initial Determination was processed under the expedited timeframe
8. Member's medical condition and diagnoses
9. Member safety
10. Public Safety/Safety of Others
11. Continued care/treatments
12. Services related to Emergency Care/Post-Stabilization Care -
13. Determine whether applying the standard time for deciding may seriously jeopardize the life or health of the member or the member's ability to attain, maintain, or regain maximum function.
14. State/Federal Law

Pre-service Prior Authorization Appeals (for grievances and appeals for both MH/SUD and M/S services)

15. Ensure benefits are applied correctly based on the member's evidence of coverage
16. Medical Necessity
17. State and Federal Regulations related to Prior Authorization Appeals
18. Accreditation standards

Prescription

19. Significant potential for off label indications without data to support widespread utilization or multiple medical uses where appropriate prescribing needs to be ensured
20. Significant safety concerns -.
21. High-cost drugs with the potential for inappropriate use or waste
22. Medications that may not be a first line agent for a particular condition, higher in cost, and/or there is a cost-effective therapeutic agent available that is considered “first line” and should be used prior to trying a second or third-line agent.
23. Drugs that are outside of the scope of a provider’s expertise
24. Appropriate setting

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

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
1. Severity or chronicity of an illness	The extent of organ system derangement or physiologic decompensation for a patient. It gives a medical classification into minor, moderate, major, and extreme. The severity of illness class is meant to provide a basis for evaluating hospital resource use or to establish patient care guidelines.	MCG criteria, InterQual (for transplant only); ASAM criteria; clinical trial or research; evidence-based medicine
2. Clinical efficiency of treatment or service	The capacity of a given intervention under ideal or controlled conditions. The current clinical information is compared to the progress toward clearly defined milestones specific to the condition under review to determine if the desired effect has been achieved or is/is not, trending in the desired direction, and if there is evidence to believe that the desired effect can be reached. This determination is made in conjunction with our medical expert review and through use of nationally recognized, evidence-based criteria.	MCG criteria, InterQual (for transplant only); ASAM criteria; clinical trial or research; evidence-based medicine
3. Appropriate level of care	The level of care required to best manage a client's illness or injury based on the severity of illness presentation and the intensity of services received or requested. Kaiser looks at the provider type, (e.g., hospital, clinic, practitioner, and/or specialty center) to determine if the current or proposed provider type is sufficiently able/unable to provide the level of care being requested.	MCG criteria, InterQual (for transplant only); ASAM criteria; clinical trial or research; evidence-based medicine
Prior Authorization Appeals		
4. Confirm whether services are pre-service	Expedited appeals are only available for pre-service requests. If the appeal occurs prior to the service being rendered, the service is eligible for the expedited appeals process. If the appeal is retrospective to the service being rendered, the service is not eligible for the expedited appeals process.	Member/Advocate appeal submission, electronic medical record (e.g., Kaiser HealthConnect) and review of initial denial letter

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
5. An expediated review request by a health care professional with knowledge of the member's health condition	Whether the health care professional making the request for expedited appeal consideration makes the request or had knowledge of the member's medical condition, and whether the requests states that applying the standard decision-making time for a prior authorization appeal would seriously jeopardize the life or health of the member or the member's ability to attain, maintain, or regain maximum function.	Health Care professional's appeal submission request
6. An expediated review request by a member	In instances where the Program representative educates the member or advocate as to when a request meets expedited criteria, and that the member or advocate's request will be addressed with the appropriate course of action within the standard timeframe, yet, the member or advocate still requests that their appeal be processed under the expedited timeframe.	Member/Advocate appeal submission
7. The Initial Determination was processed under the expedited timeframe	If the initial prior authorization request was processed under the expedited timeframe, the Plan will automatically process the appeal under the expedited timeframe.	Initial denial letter and electronic medical record (e.g., Kaiser HealthConnect, Tapestry)
8. Member's medical condition and diagnoses	Whether the appeal request is related to the treatment of a cancer diagnosis or other terminal illness, including investigational and experimental treatments.	Member/advocate or health care professional's appeal submission, and review of electronic medical record (e.g., Kaiser HealthConnect)
9. Member safety	Whether a member, advocate, or health care professional with knowledge of the member's medical condition is making a pre-service request, and makes the assertion that if the member does not obtain the care or treatment that is the subject of the request, the delay in obtaining the service/item will pose an imminent and serious threat to the health of the member, severe pain, or potential loss of life, limb, or major bodily function	Member/advocate or health care professional's appeal submission, and review of electronic medical record (e.g., Kaiser HealthConnect)

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
10. Public Safety/Safety of Others	When a member, advocate, or health care professional with knowledge of the member's medical condition is making a pre-service request, and if the member does not obtain the care or treatment that is the subject of the request, the delay in obtaining the service/item will pose an imminent and serious threat to another individual	Member/advocate or health care professional's appeal submission, and review of electronic medical record (e.g., Kaiser HealthConnect)
11. Continued care/treatments	When the appeal includes a request to continue current care/treatment which is due to expire or end, where the absence of the care/treatment could seriously jeopardize the life or physical or mental health of the member or the ability of the member to attain, maintain, or regain maximum function if the non-urgent time period were applied or if a health care professional indicates such on behalf of a member; e.g., home health, acute hospitalization care, skilled nursing care, acute rehabilitation, chemical	Member/advocate or health care professional's appeal submission, review of electronic medical record (e.g., Kaiser HealthConnect), and initial denial letter
12. Services related to Emergency Care/Post-Stabilization Care	When an appeal request is concerning admissions, continued stay, or other health care services for a member who has received emergency services but has not been discharged from a facility, it is eligible for the expedited process.	Member/advocate or health care professional's appeal submission, review of electronic medical record (e.g., Kaiser HealthConnect), and initial denial letter
13. Determine whether applying the standard time for deciding may seriously jeopardize the life or health of the member or the member's ability to attain, maintain, or regain maximum function.	When a member, advocate, or health care professional with knowledge of the member's medical condition is making a pre-service request, and the member not obtaining the care or treatment that is the subject of the request expeditiously could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function.	Member/advocate or health care professional's appeal submission, and review of electronic medical record (e.g., Kaiser HealthConnect)

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
14. State/Federal Law	Whether the appeal request fulfills the expedited criteria as outlined in applicable state and federal regulations.	Internal policies related to Maryland regulation COMAR § 31.10.29.02(B)(12).
Pre-service Prior Authorization Appeals		
15. Ensure benefits are applied correctly based on the member's evidence of coverage	Whether the requested service or item is covered under the member's health plan benefit.	Evidence of Coverage, Plan Formulary (e.g., Durable Medical Equipment or pharmacy), and benefits analysis
16. Medical Necessity	Please see the reference to Medical Necessity in Section 1a.	Please see the reference to Medical Necessity in Section 1a.
17. State and Federal Regulations related to Prior Authorization Appeals	Whether the decision-making process, including decision maker credentials, adheres to all applicable state and federal regulations.	Maryland Insurance Sections: §15–10A–02., §15-10D-02., and Federal Regulations: 29 CFR 2560.503-1, and 45 CFR § 147.136
18. Accreditation standards	Whether the decision-making process, including decision maker credentials, adheres to all accreditation standards.	Internal Policies

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
Prescription		
19. Significant potential for off label indications without data to support widespread utilization or multiple medical uses where appropriate prescribing needs to be ensured.	Consensus of regional clinical experts that off-label use would be clinically inappropriate.	Published literature or single-use case reports, utilization data/drug utilization reviews, clinical consensus of regional experts.
20. Significant safety concerns	In evaluating clinical trial data and real-world data, statistical standard applied is statistically significance (p value <0.05) that the medication increases harm to patient. There is no minimum clinical standard aside from the consensus of regional clinical experts that use of these medications would require close monitoring or would be expected to cause harm to a patient if routinely used.	Drug monographs, manufacturer drug dossier, real-world safety data, drug utilization review data, clinical consensus from regional experts, drug compendiums.
21. High-cost drugs with the potential for inappropriate use or waste	A consensus of regional clinical experts are responsible for determining if the unlimited use of the therapy would lead to increased waste or inappropriate use after taking into consideration clinical and real-world data demonstrating significant likelihood that treatment is not expected to be successful or where the prescribing physician acknowledges the treatment is likely to not be successful.	Cost utilization: established controls from DEA, FDA, or other regulatory bodies to reduce misuse, diversion, or abuse; real-world practice data or clinical trial data supporting very specific dosing or treatment regimen, treatment guidelines, published literature, clinical consensus from regional experts, data demonstrating significant likelihood that treatment is not expected to be successful or where the prescribing physician acknowledges the treatment is likely to not be successful.

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
22. Medications that may not be a first line agent for a particular condition, higher in cost, and/or there is a cost-effective therapeutic agent available that is considered "first-line" and should be used prior to trying a second or third-line agent.	A medication that is listed as first-line therapy (i.e., a medication where in clinical treatment guidelines is listed as treatment option further along in the treatment pathway), is not necessarily precluded from prior authorization if other factors are met, however a group of regional clinical experts would take that into consideration and generally avoid applying prior authorization.	Clinical guidelines, national consensus guidelines, treatment pathways, standard of care, clinical consensus from regional experts, drug utilization review data indicating existing patient situations where first-line therapies are being intentionally bypassed due to patient or physician preference.
23. Drugs that are outside of the scope of a provider's expertise	A medication that would be prescribed by a specific specialty due to a requirement of specialty knowledge to establish a bona fide treatment relationship.	Clinical consensus from regional experts that treatment or appropriate monitoring of drug prescribing requires specialty knowledge to establish a bona fide relationship.
24. Appropriate setting	An outpatient drug, which is then eligible for consideration of prior authorization, to be one that is available in drug databases as one that is dispensed at a pharmacy for patient self-administration.	Drug availability in drug databases as outpatient drug.

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

The scope of the Utilization Program includes Regional Utilization Management Committee (RUMC) oversight of development, review, and evaluation to consistently adopt criteria that are approved based on the active involvement of appropriate and actively credentialed practitioners. All MCP (Medical Coverage Policies) 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).

Measurable, evidence-based, and objective decision-making criteria ensure that decisions are fair, impartial, and consistent. Kaiser utilizes and adopts nationally recognized UM criteria and internally developed medical coverage policies (MCP). Additionally, subject matter experts currently certified in the specific field of medical practice are actively engaged in the guideline development process. All criteria sets are reviewed and revised annually, then approved by the Regional Utilization Management Committee (RUMC) as delegated by the Regional Quality Improvement Committee (RQIC). Our UM criteria are not designed to be the final determinant of the need for care but have been developed in alignment with local practice patterns and are applied based upon the needs and stability of the individual patient. In the absence of applicable criteria or MCPs, the UM staff refers the case for review to a licensed, board-certified practitioner in the same or similar specialty as the requested service. The reviewing practitioners base their determination on their training, experience, the current standards of practice in the community, published peer -reviewed literature, the needs of individual patients (age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment when applicable), and characteristics of the local delivery system.

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 criteria for review with the 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 Pharmacy and Therapeutics 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.

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 considers the same processes, strategies, factors, sources, evidentiary standards, and sources for evidentiary standards for both M/S and MH/SUD benefits and a committee with representation from clinically appropriate decision-makers for both M/S and MH/SUD benefits drive prior authorization decisions. For these reasons, this NQTL is comparable to, and no more stringently applied to MH/SUD benefits than to M/S benefits.

Once it has been determined that Prior Authorization must be applied, a medical necessity review will occur for M/S and MH/SUD services, after determining if the benefit exists for the service. If the benefit does not exist, then the request is denied for lack of benefit and there is then no need to review for medical necessity.

The design of the application of criteria for use in making prior authorization medical necessity decisions for M/S and MH/SUD is required when Medically Necessary means that the service or benefit is:

- Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition
- Consistent with current accepted standards of good medical practice
- The most cost-efficient service that can be provided without sacrificing effectiveness or access to care
- Not primarily for the convenience of the consumer, the consumer's family, or the provider

Decisions about the following do not require medical necessity review:

- Services in the member's benefits plan that are limited by number, duration, or frequency.
- Extension of treatments beyond the specific limitations and restrictions imposed by the member's benefits plan.
- Care that does not depend on any circumstances.
- Requests for personal care services, such as cooking, grooming, transportation, cleaning, and assistance with other ADL-related activities.

Prescription

Operationally, behavioral health and medical/surgical medications follow the same workflow requiring a prescribing physician request for the drug with documentation of criteria adherence. These drug requests are processed by the UM pharmacy team and forwarded to a UM physician when the criteria are not explicitly met for final review.

Prescription Drug Formulary Design

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 formulary is a list of drugs approved by the Regional Pharmacy and Therapeutics (P&T) Committee for general use. The purpose of the formulary is to promote rational, safe, and cost-effective drug use. Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. ("Kaiser") Commercial plans have a closed formulary. The Kaiser Pharmacy and Therapeutic ("P&T") 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.

Any FDA-approved drug, both M/S and MH/SUD, 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.

The P&T Committee has a formulary review process that applies in the same way to MH/SUD and M/S medications. The P&T 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.

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

Kaiser considers the following factors as it relates to Prescription Formulary Design:

1. Safety and Effectiveness
2. Availability of current formulary drugs to meet the therapeutic need
3. Reliability and quality control of the drug manufacturer
4. Current utilization of the drug by practitioners within the program
5. Comparative cost of alternative equivalent therapy
6. Utilization of the Non-Formulary Exception Process
7. Other unique attributes which may warrant inclusion of the drug
8. State and local mandates for benefit coverage and Medicare regulations
9. Whether drug is a specialty drug
10. Whether drug is a brand or generic drug
11. Inclusion in the health benefit package
12. Improved clinical and acceptable pharmacoeconomic outcomes
13. Acceptable benefit to risk ratio
14. Improved clinical and acceptable pharmacoeconomic outcomes with comparable side effects
15. Reduced side effects and/or potential for serious drug interactions which significantly contribute to treatment failure with existing agents
16. Improved benefit to risk ratio
17. New mechanism of action which improves clinical outcome in a defined population subset (i.e.: treatment failures to existing drugs)
18. Could replace another drug on the formulary
19. Improved pharmacoeconomic outcome (defined by cost minimization or cost effectiveness analysis)
20. Significant improvement in convenience/compliance

21. Significant Potential for Inappropriate Use
22. Narrow Safety Margin
23. Need for specialty expertise
24. Reserved for Second- or Third-Line Therapy
25. In Actual or Potential Short Supply

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

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
1.Safety and Effectiveness	Using defined clinical endpoints defined in research studies, the P&T Committee reviews outcomes for the new drug under consideration as compared to current formulary and non-formulary drugs. Determine whether the medication demonstrates better clinical outcomes and/or reduced risk of patient harm.	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
2.Availability of current formulary drugs to meet the therapeutic need	Current formulary drugs are available to meet the therapeutic need if there is at least one formulary drug in each therapeutic class (GPI 6) that meets clinical treatment needs	Kaiser Formulary and preferred alternatives drug list, clinical guidelines, standard of care,

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
3.Reliability and quality control of the drug manufacturer	Determine whether manufacturer has any known deficiency/reliability issues in the manufacturing processes that would disrupt access to medication. Review available evidence of FDA MedWatch or notifications of inadequate safeguards during FDA inspections. This is supplied by national supply chain recommendations after reviewing FDA manufacturer audits, quality control inspections and potential violations/issues.	FDA approval process, Medwatch
4.Current utilization of the drug by practitioners within the program	Frequency with which physicians are ordering a new drug before formulary placement. Additional review may be warranted to determine which providers are prescribing the new medication and the clinical circumstances which warranted the prescribing. There is no minimum or maximum threshold for utilization that would definitively impact decision-making, although a prescription with no history of prescribing may be evaluated alongside regional physician consensus on whether they would likely be interested in utilizing the medication if it were added or not added to formulary.	Kaiser Utilization Data
5.Comparative cost of alternative equivalent therapy	Compare the cost impact between the M/S or MH/SUD medication under consideration compared to one or more standard of care medications. There is no minimum threshold for what constitutes an improvement in comparative cost; the P&T Committee would consider any reduction in cost an improvement but would not preclude a medication from formulary consideration even if the comparative cost were higher if it resulted in improved therapeutic outcomes.	Available pharmacoeconomic studies

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
6. Utilization of the Non-Formulary Exception Process	Number of requests physicians have made to permit medical necessity exception to cover a medication under a patient's benefit. If the number of requests is significant, an additional review will be taken to determine whether the medical necessity is justified considering existing formulary options. There is no minimum threshold that is defined that triggers this additional review; any P&T member can request the review as part of the formulary design process.	Non-Formulary Report, utilization reports
7. Other unique attributes which may warrant inclusion of the drug	Drug-specific attributes generally provided by the manufacturer as part of the drug dossier. There is no one attribute that defines inclusion of the drug, but these would be taken into consideration by the P&T Committee to formulate a decision. Examples include: single-source procurement, FDA REMs requirements, or high risk for discontinuation of drug due to significant adverse events.	National published consensus statements
8. State and local mandates for benefit coverage and Medicare regulations	P&T Committee will ensure that any requirements are met by having at least one medication (and more if clinically warranted) that meets all of these mandates and regulations.	Code of Maryland Regulations (COMAR), Code of Federal Regulations (CFR), accreditation standards (NCQA), applicable statutes/regulations

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
9. Whether drug is a specialty drug	A medication is classified on specialty tier if it: (1) is prescribed for an individual with a Complex or Chronic Medical Condition; (2) meets a predefined cost threshold for up to a 30-day supply; (3) is not typically stocked at retail pharmacies; (4) requires a difficult or unusual process of delivery to the Member in the preparation, handling, storage, inventory, or distribution of the drug. The cost threshold identified in this definition is updated each year to align with Medicare cost threshold for specialty medications.	Defined cost threshold from Medicare, manufacturer contract price, standards of care, National clinical guidelines, manufacturer drug dossier.
10. Whether drug is a brand or generic drug	Medications are classified as brand or generic drugs, and this classification is used to determine tier placement. Brand Drug is medicine sold under a specific name or trademark protected by a patent. Generic Drug has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as brand-name drugs.	MNOY multi-source indicator from Medi-Span, product package insert. **M**: Single-Source, co-licensed product from multiple labelers, without generics. **N**: Single-Source product available from one labeler, without generics. **O**: Multi-Source, originator product available from multiple labelers, with generics. **Y**: Multi-Source product available from multiple labelers, usually generic.

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
11. Inclusion in the health benefit package	Kaiser may exclude a drug from the formulary even if other criteria are met if it is not a covered drug.	Internal Policies
12. Improved clinical and acceptable pharmacoeconomic outcomes	Improved Clinical Outcomes: Clinical outcomes are identified by clinical specialists depending on the specialty and condition being treated. Improvement of clinical outcome is assessed by clinical specialists based on standard of care. Clinical improvement data must demonstrate statistical significance, but it is up to the consensus of regional clinical experts and physician specialists as to whether it is clinically significant in practice for both MH/SUD and M/S medications. Acceptable pharmacoeconomic outcomes: We compare available data for new MH/SUD and M/S medications under consideration for formulary addition with existing standard of care and formulary medications. Clinical trial data, real-world data, or published pharmacoeconomic comparisons at a minimum should demonstrate statistical significance but there is no minimum standard for what qualifies as improvement, so long as the data indicates superior clinical outcomes and reduction in adverse events, morbidity, and mortality. It is up to the consensus of regional clinical experts and physician specialists to determine if the improved pharmacoeconomic outcomes meets the standard for formulary inclusion based on standard of care, even if the improvement is minimal.	National clinical guidelines, standard of care, clinical trial and pharmacoeconomic analysis publications, manufacturer drug dossier.

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
13. Acceptable benefit to risk ratio	Evaluate the efficacy of each medication using clinical trial data and compare it against the safety profile, including adverse effects, contraindications, drug interactions. There is no quantitative ratio that is calculated, but rather P&T relies on the consensus of regional clinical experts and physician specialists, along with existing clinical guidelines and clinical trial data that patients are more likely to benefit from treatment than to be harmed by it. A drug with an unfavorable benefit-to-risk ratio (patient harm is more likely than treatment) would not necessarily be precluded from formulary addition based on other factors but might result in consideration of NQTLs to maximize patient safety.	National clinical guidelines, standard of care, clinical trial and pharmacoeconomic analysis publications, manufacturer drug dossier.
14. Improved clinical and acceptable pharmacoeconomic outcomes with comparable side effects	Clinical outcomes are identified by clinical specialists depending on the specialty and condition being treated. Improvement of clinical outcome is assessed by clinical specialists based on standard of care. Clinical improvement data must demonstrate statistical significance, but it is up to the consensus of regional clinical experts and physician specialists as to whether it is clinically significant in practice for both MH/SUD and M/S medications. Acceptable pharmacoeconomic outcomes: We compare available data for new MH/SUD and M/S medications under consideration for formulary addition with existing standard of care and formulary medications. Clinical trial data, real-world data, or published pharmacoeconomic comparisons at a minimum should demonstrate statistical significance, but there is no minimum standard for what qualifies as improvement, so long as the data indicates superior clinical outcomes and reduction in adverse events, morbidity, and mortality. It is up to the consensus of regional clinical experts and physician specialists to determine if the improved pharmacoeconomic outcomes meets the standard for formulary inclusion based on standard of care, even if the improvement is minimal.	National clinical guidelines, standard of care, clinical trial and pharmacoeconomic analysis publications, manufacturer drug dossier.

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
15. Reduced side effects and/or potential for serious drug interactions which significantly contribute to treatment failure with existing agents	Compare available data for new MH/SUD and M/S medications under consideration for formulary addition with existing standard of care and formulary medications. Clinical trial data at a minimum should demonstrate statistical significance, but there is no minimum standard for what qualifies as a reduction, so long as the data indicates decreased incidence and/or severity of side effects as well as a reduction in adverse events, morbidity, and/or mortality. It is up to the consensus of regional clinical experts and physician specialists to determine if the data demonstrating reduced side effects meets the standards for formulary inclusion based on standard of care, even if the reduction in side effects is minimal. Potential for serious drug interactions: We evaluate the adverse events presented from clinical trial and/or real-world data analysis, known pharmacologic data, and clinical experience shared by our regional clinical experts to assess if patients are at risk for drug interactions or safety concerns. Serious drug interactions and significant safety concerns are defined as those creating a measurable change in pharmacologic or clinical response that could cause patient increased harm (adverse effect, hospitalization, morbidity, or mortality). There is no minimum threshold for safety, but increased focus is placed on any clinical trial data that demonstrates statistical significance for any increase in risk or harm to patients, as well as any manufacturer drug dossier information that highlights a side effect that our regional clinical experts would consider an increased risk for patient harm (adverse effect, hospitalization, morbidity, or mortality).	National clinical guidelines, standard of care, clinical trial and pharmacoeconomic analysis publications, manufacturer drug dossier.

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
16. Improved benefit to risk ratio	We evaluate the safety and efficacy of each medication using clinical trial data against the existing formulary medication and standard of care. There is no minimum threshold required for what qualifies as an improvement, so long as the data demonstrates either improvement in benefit (efficacy) and/or a reduction in risk (safety/adverse events). In situations where benefit and risk both increase or both decrease, it is up to the consensus of regional clinical experts and physician specialists to determine if the clinical data suggests an improvement compared to standard of care or existing formulary medications.	National clinical guidelines, standard of care, clinical trial and pharmacoeconomic analysis publications, manufacturer drug dossier.
17. New mechanism of action which improves clinical outcome in a defined population subset (i.e.: treatment failures to existing drugs)	Medications are classified by their mechanism of action into specific drug classes and functions. A medication with a new mechanism of action would be identified through the manufacturer drug dossier. Improvement of clinical outcome is assessed by clinical specialists based on standard of care. Clinical improvement data must demonstrate statistical significance, but it is up to the consensus of regional clinical experts and physician specialists as to whether it is clinically significant in practice.	National clinical guidelines, standard of care, clinical trial and pharmacoeconomic analysis publications, manufacturer drug dossier.
18. Could replace another drug on the formulary	A drug is determined to be able to replace another drug on the formulary through an assessment by the P&T clinical experts and input from physician specialty chiefs who review the collective information provided above to determine if a new M/S or MH/SUD medication has one or more of the following: • Improved pharmacoeconomic outcomes • Improved efficacy and/or safety outcomes • Improvement in convenience/compliance • Improved benefit/risk ratio	Current formulary, National clinical guidelines, standard of care, clinical trial and pharmacoeconomic analysis publications, manufacturer drug dossier.

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
19. Improved pharmacoeconomic outcome (defined by cost minimization or cost effectiveness analysis)	Cost effectiveness takes into overall cost of care, including costs from side effects resulting in harm as well as cost savings in care resulting from clinical efficacy. We compare available data for new MH/SUD and M/S medications under consideration for formulary addition with existing standard of care and formulary medications. Clinical trial data, real-world data, or published pharmacoeconomic comparisons at a minimum should demonstrate statistical significance, but there is no minimum standard for what qualifies as improvement, so long as the data indicates superior clinical outcomes and reduction in adverse events, morbidity, and mortality. It is up to the consensus of regional clinical experts and physician specialists to determine if the improved pharmacoeconomic outcomes meets the standard for formulary inclusion based on standard of care, even if the improvement is minimal.	National clinical guidelines, standard of care, clinical trial and pharmacoeconomic analysis publications, manufacturer drug dossier

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
20. Significant improvement in convenience/ compliance	Whether patients would be more adherent to therapy as a result of any route of administration/dose frequency changes. A significant improvement in convenience/compliance is determined through an evaluation in the route of administration and dose frequency of a new M/S or MH/SUD medication compared to existing medications or standard of care. Route of administration reviewed include size of oral products, including whether the product can be dissolved/crushed. Oral products are generally considered an improvement in convenience/compliance relative to subcutaneous products. In addition, different formulations for topical products may increase or decrease compliance based on comfort level for patients. We rely on existing practical experience from our clinical experts to inform the committee on what patients prefer. In terms of dose frequency, we consider any reduction in number of daily doses to be a significant improvement, and any dose that is reduced to weekly, biweekly, or monthly dosing is also considered to be a significant improvement. There is no defined threshold for what qualifies as a significant improvement, but our regional clinical experts will provide a consensus on whether they believe their patients would be more adherent to therapy as a result of any route of administration/dose frequency changes.	National clinical guidelines, standard of care, clinical trial and pharmacoeconomic analysis publications, manufacturer drug dossier.

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
21. Significant Potential for Inappropriate Use	Medications are reviewed for existing controls and warnings by the DEA, FDA, state pharmacy boards, and historical data on misuse or fraudulent prescriptions, with no specific cost threshold needed.-We evaluate existing controls placed by the DEA and FDA on certain medication classes as well as any warnings/alerts provided by the state boards of pharmacy and compliance officers about fraudulent prescriptions. In addition, there are certain medications where the FDA has placed REMS monitoring. While there is no specified threshold for medication cost, it is considered as an element to determine potential for misuse or abuse as it increases the risk for diversion, whether it is a M/S or MH/SUD medication. There is no minimum threshold to set to categorize something as a high potential for misuse or abuse, but presence of one or more of the elements listed above (controls by DEA and/or FDA, manufacturer/distributor controls, warnings/alerts/historical evidence of fraudulent prescriptions), would increase the likelihood that the regional clinical experts would classify a medication as one with high potential for misuse or abuse	National clinical guidelines, standard of care, clinical trial and pharmacoeconomic analysis publications, manufacturer drug dossier. historical safety data.
22. Narrow Safety Margin	A drug has a narrow safety margin where the dose range allowed to achieve clinical efficacy is limited, and clinical data demonstrates that an increase or decrease in dose would lead to an increase in patient harm. Additional consideration may be given to drugs that are on a high-risk drug list (e.g., Beers criteria) or one with REMs/black box warnings or strict monitoring requirements as set by the manufacturer or regulatory body.	National clinical guidelines, standard of care, clinical trial and pharmacoeconomic analysis publications, manufacturer drug dossier. historical safety data.

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
23. Need for specialty expertise	A drug requires specialty expertise where the drug that would require a bona fide relationship with a specialty practitioner in a specialty department to accurately assess whether the patient meets the clinical parameters and approved indications for use. This would also include consideration as to whether a non-specialty practitioner could accurately differentiate between selecting between different therapeutic options to optimize treatment based on the input of our specialty practitioners during the P&T review process.	National clinical guidelines, standard of care, clinical trial and pharmacoeconomic analysis publications, manufacturer drug dossier.
24. Reserved for Second- or Third-Line Therapy	Some medications/medication classes are reserved for second- or third-line therapy due to the increased risk for side effects/adverse events, reduced cost-effectiveness and availability of the medication, and treatment basis of the drug. Medications used for palliative purposes or adjunct therapy may be used in later stages of treatment.	National clinical guidelines, standard of care, clinical trial and pharmacoeconomic analysis publications, manufacturer drug dossier.
25. In Actual or Potential Short Supply	This is defined as a drug with an active shortage notification, either from our internal supply chain group or from manufacturer/drug distributor. Potential short supply is defined as a drug that does not yet have an active shortage notification but is demonstrating increased utilization as a result of the drug being utilized as an alternative to another drug with actual short supply.	National shortage memos, inventory data.

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

The Kaiser P&T Committee is made up of trained and licensed clinical pharmacists, physicians, and other clinicians as appropriate; representatives include physician specialists from pediatrics, infectious diseases, behavioral health, adult family medicine, pulmonology, and neurology. All formulary recommendations are further reviewed by physician specialists and chiefs of service for impacted specialties both M/S and MH/SUD.

A pharmacist that is a part of the P&T 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.

The P&T Committee decisions are based on the collective clinical expertise of P&T Committee members and specialty physician chiefs consulted as part of the process and includes specialists who would prescribe MH/SUD and/or M/S medications.

The P&T Committee 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. The P&T Committee 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.

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 NQTL is comparable to and no more stringently applied to MH/SUD services than to medical/surgical services both as written and in operation. Kaiser has a formulary determination process that does not differ for MH/SUD and M/S drugs. All drugs are evaluated using the same process, by the same decisionmakers, and with application of the same factors, sources, and evidentiary standards. The P&T Committee includes representation from both MH/SUD and M/S specialties. The factors, sources, and evidentiary standards are clearly defined and the same in both environments. The NQTL is applied comparably as written.

Further, Kaiser is comparable in operation. Formulary Design is designed and applied comparably in operation in both the M/S and BH/SUD environments. The factors, evidentiary standards, and sources that Kaiser uses are specific and provide clear parameters that the P&T Committee follows in making decisions regarding the application of the NQTL. As such, Kaiser is comparable in operation.

Reimbursement for INN Providers, OON Providers, INN Facilities, OON Facilities

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);

1. Credential/provider type of the practitioner(s)
2. Treatment protocols/type of service
3. Inpatient/Outpatient utilization
4. Geographic area in which the provider serves
5. Provider's reputation in the community
6. Market reimbursement benchmarks
7. Supply and demand conditions
8. Financial analysis processes
9. HSCRC Rates - HSCRC Rate Schedule
10. State Regulated Methodology for Reimbursement Rates
    - Maryland State law/regulation
11. Rate Negotiation
    - Financial analysis process
12. State Regulated Methodology for Reimbursement Rates - Maryland State law/regulation.

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

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
1. Credential/provider type of the practitioner(s)	Rate Negotiation - Level of licensure or professional credentialing will impact the level of service they provide and, thus, the level reimbursement they are paid. Kaiser also uses the CMS Medicare established reimbursement rate as a basis for negotiations. Final	Vetting polices by our Provider Practitioner Quality Assurance (PPQA) Department; CMS Medicare established reimbursement rate.

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
	reimbursement rates may vary based on licensure or professional credentialing.	
2. Treatment protocols/type of service	Providers are reimbursed based on the level of intensity and complexity of the services they provide. Treatment protocols and types of services with higher levels of intensity and complexity may result in a higher reimbursement rate.	Coding guidelines are followed according to CPT and ICD-10 https://www.cms.gov/cms-guide-medical-technology-companies-and-other-interested-parties/coding/overview-coding-classification-systems
3. Inpatient/Outpatient utilization	Examine historical provider utilization to compare OON reimbursement to the rate we are looking to achieve as in-network or for an amendment to existing rates. This includes a review of the number of referrals, cases, visits, and treatments used by a provider, and a review that the practitioner or provider covers the type of services needed in the network.	Kaiser's claims payment systems
4. Geographic area in which the provider serves	General location where a provider renders services and the availability of local resources in determining whether to include the provider in the network, which impacts reimbursement rates as a means of ensuring there are a sufficient number of providers within the network to meet the needs of our members. This affects the quality and availability of the network coverage.	CMS-identified geographical locations; mapping software
5. Provider's reputation in the community	Providers' standing on consumer safety and accreditation reports and surveys. General positive feedback on providers from various sources/the lack of negative feedback/reviews or red flags.	CMS Consumer Assessments of Healthcare Providers and System (CAHPS) scores; patient satisfaction surveys; reviews on hospital/provider websites; online ratings and reviews; patient safety surveys; hospital provider accreditation reports; peer-reviewed medical journals; reviews from medical colleagues and other

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
		healthcare professionals, internally or externally; reports from the Centers for Medicare and Medicaid Services (e.g., Medicare CMS Stars); performance data from hospital compare websites (e.g., Leapfrog), state health department reports and ratings.
6. Market reimbursement benchmarks	As applicable and when available, Kaiser reviews sources on market benchmarks for provider and facility reimbursement. Proposal must be below the high end of market benchmarks reports.	Medicare Fee Schedules; Healthcare Bluebook; Third-party fee schedule developers; health insurance plan reimbursements, i.e., Coordination of Benefit claims; Milliman Benchmark; Virginia Health Information (VHI).
7. Supply and demand conditions	Kaiser uses supply and demand conditions to determine leverage in negotiations of reimbursement rates for services, as well as other contract terms.	Utilization data, (i.e., if a provider is generating a significant amount of out of network referrals for a specific service type in comparison to a similarly licensed provider in the same geographic area, appointment wait time metrics, service exclusivity based on time of service, target demography, or geographic location).
8. Financial analysis processes	Comparison between other providers with similar services in same geographic area. Analyses on referral utilization patterns, cost competitiveness of rates against internal benchmarks, geographic access to care in accordance with regulatory and internal access standards, and the general configurability of the terms being negotiated by the provider.	Internal Kaiser Claims data; contract rates; and Provider proposed rates.

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
9. HSCRC Rates - HSCRC Rate Schedule	State of Maryland Health Services Cost Review Committee	HSCRC Rates, State of Maryland Health Services Cost Review Committee
10. State Regulated Methodology for Reimbursement Rates • Maryland State law/regulation	State Regulated Methodology for Reimbursement Rates, Maryland Health General Code 19-710.1.	State Regulated Methodology for Reimbursement Rates, Maryland Health General Code 19-710.1.
11. Rate Negotiation • Financial analysis process	Internal Kaiser Claims data; contract rates; and Provider proposed rates are reviewed to keep in alignment with contracted providers of similar services and provider type	Rate Negotiation, Internal Kaiser Claims data; contract rates; and Provider proposed rates
12. State Regulated Methodology for Reimbursement Rates - Maryland State law/regulation	Same "Evidentiary Standards and Applicable Thresholds" as the In Network Inpatient Benefit Classification with the addition of Practitioner State Regulated Methodology for Reimbursement Rates - Maryland Health General Code 19-710.1.	Same "Source(s) for Each Evidentiary Standard" as the In Network Inpatient Benefit Classification with the addition of Practitioner State Regulated Methodology for Reimbursement Rates - Maryland Health General Code 19-710.1.

D. Identify the methods and analysis used in the development of the limitation(s); and
The methodology to determine reimbursement rates is receiving the initial rate proposal from the requesting provider, completing an analysis of how those proposed rates compare to existing contracted providers and negotiating the provider into the range of existing providers. All contracts and rate amendments are reviewed by the contracting department Directors, Medical Director, Chief Financial Officer, and/or President.

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.

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.

A comparative analysis of the written processes, factors, and strategies used to set reimbursement rates for in-network inpatient, out-of-network impatient, in-network outpatient office, out-of-network outpatient office, and all other subclassification providers was conducted. The reimbursement methodology, including the pricing and negotiation processes, for in-network providers is the same for MH/SUD and M/S services.

This review shows, Kaiser follows comparable processes for Med/Surg and MH/SUD, demonstrating that reimbursement for providers and facilities is no more stringently applied to MH/SUD for both inpatient and outpatient settings. There is no fundamental difference between M/S and MH/SUD.

Strategies for Addressing Provider Shortages

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.

Kaiser Permanente is comprised of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (“Health Plan”), the Mid-Atlantic Permanente Medical Group, P.C., (“MAPMG”), an independent medical group of physicians who provide or arrange professional services for patients throughout the area, and Kaiser Foundation Hospitals (“KFH”), which contracts with community hospitals for the provision of hospital services to our patients. Where MAPMG is unable to provide services with its own employed professionals, it contracts with community providers to furnish these services. The largest portion of the KP network is made up by MAPMG and KP-owned medical and pharmacy facilities. Health Plan, MAPMG and KFH provide both M/S and MH/SUD services.

The KP provider network is open with network inclusion conditions. From time to time, KP enhances its network by admitting hospitals, ancillary facilities, and health care professional that are not members of KFH or MAPMG. Decisions about the admission to KP’s network of health care professionals and health care facilities and their respective service lines are based on criteria outlined on the Scorecard of Services and Affiliations. KP’s Health System Strategy Committee (HSC) convenes senior executive to evaluate

network participation based on these key measures. The Care Continuum leadership is engaged to monitor trends in care delivery for patients— from preventive care to treatment for medical concerns, rehabilitation, and maintenance. The Maryland Insurance Administration requires all provider contract templates to be filed and approved before they are used for health care facilities and health care providers furnishing M/S and MH/SUD services.

The Health Professional Contracting team is responsible for developing strategy and oversight for the inclusion of health professionals into KP's network. These designated contracting/clinical/operations staff are responsible for making recommendations to maintain an appropriate network for both MH/SUD and M/S providers.

The Health Professional Contracting team identifies specialty gaps and makes network admission decisions. We also partner and contract with large provider network services, offering telehealth/in-person care to our vast patient population.

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

1. Capacity: Network capacity is the ability of network providers and facilities to serve KP membership based on level of services, staff composition, and number of beds.
2. Growth: is the ability of network providers and facilities to support a potentially growing KP membership.
3. Affordability/Market Rate: KP analyzes its own network contracting data and compares fees by service line to set the standard rates paid to professionals based on market conditions.
4. Geoaccess: KP assess the geographic location of its network providers and facilities to make sure that members have access to benefits based upon guidelines established by the MIA.
5. Quality/Safety: KP ensures that it only contracts with providers who provide high-quality care to patients.
6. Regulatory Changes: Regulatory changes may require that a carrier make certain changes to its network.
7. Brand Strength: KP analyzes a provider's reputation among members and in the community.

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

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
1. Network Capacity	The ability of network providers and facilities to serve Kaiser membership based on level of services, staff composition, and number of beds	Provider Systems' data: monthly and quarterly reports that measure network adequacy, practitioner to member ratios, and appointment wait times for facilities and health care professionals, travel time, and distance requirements.
2. Growth:	The ability of network providers and facilities to support a potentially growing KP membership.	KP membership data; market data; census data; monthly and quarterly reports that measures network adequacy, practitioner to member ratios, and appointment wait times for facilities and health care professionals.
3. Affordability/Market Rate:	Analyze contracting data and compare fees by service line to set the standard rates paid to professionals based on market conditions.	Details regarding KP's provider reimbursement strategy, oversight and contracting processes and procedures are found in KP's NTQL written comparative analysis titled "Reimbursement for INN Providers, OON Providers, INN Facilities, OON Facilities.
4. Geoaccess:	Assess geographic location of network providers and facilities to ensure members have access to benefits based upon guidelines established by the MIA.	Internal Policies
5. Quality/Safety:	Ensure Kaiser only contracts with providers who provide high-quality care to patients (including passing all credentialing qualifications. Board certified)	CMS Hospital Compare data - ttps://www.medicare.gov/care-compare/?providerType=Hospital
6. Regulatory Changes:	Monitor regulatory changes including requirements that may require a carrier to make changes to its network.	Federal and state statutes, regulations, and guidance issued by applicable regulators, including CMS and MIA.

7. Brand Strength:	Analyzes a provider's reputation among members and in the community.	Customer surveys

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

The process, strategy and oversight for facility and health professional network admission (i.e. provider directory) are applied comparably and no more stringently to MH/SUD providers. KP's inclusion of professionals and facilities into its network is informed by the same factors, sources, evidentiary standards, and sources for evidentiary standards for MH/SUD and M/S providers, including MIA regulations. MH/SUD and M/S professional providers and facilities are also measured against the same Scorecard of Services and Affiliations.

Similarly, Kaiser and its Pharmacy Benefit Manager (PBM) use the same measures to develop and maintain Kaiser's pharmacy networks and to ensure compliance with state standards for pharmacy practice, through which members have access to both M/S and MH/SUD prescriptions services.

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.

Our assessment of the oversight process, mechanisms involved, and contracting applications indicated that the factors, sources, evidentiary standards, and sources for evidentiary standards are the same for MH/SUD and M/S services. As a result, we conclude that these are comparable.

Similarly, the policies, procedures and processes that guide Kaiser's work with its PBMs ensure that members access to prescription services for M/S and BH/SUD conditions within the KP pharmacy network is comparable and applied no more stringently.

Provider Network Directories

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;

Kaiser Permanente (“KP”) is comprised of Kaiser Foundation Kaiser of the Mid-Atlantic States, Inc., (“Kaiser”), Kaiser Foundation Hospitals (“KFH”) and the Mid-Atlantic Permanente Medical Group, P.C., (“MAPMG”). MAPMG, an independent medical group of physicians who provides or arranges professional services for patients throughout the area. Kaiser Foundation Hospitals (“KFH”), contracts with community hospitals for the provision of hospital services to our patients. Where MAPMG is unable to provide services with its own employed professionals, it contracts with community providers to furnish these services. Kaiser employs non-physician providers to deliver medical care at Kaiser Permanente-owned multispecialty centers in Maryland, Virginia, and the District of Columbia. The largest portion of the KP’s network is made up of MAPMG and KP-owned medical and pharmacy facilities.

These providers and facilities are listed in the printed and online directories available to members. The providers in both the online and printed directories are the same.

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

1. MAPMG physicians and Kaiser non-physician providers
2. Contracted and credentialed providers.
3. Delegated contracted providers.
4. Contracted and credentialed facilities
5. Provider system load and maintenance.
6. Ongoing confirmation of provider demographic accuracy.
7. Internal Kaiser Pharmacies located within a KP medical office building

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

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
1. MAPMG physicians and Kaiser non-physician providers	MAPMG physicians and Kaiser non-physician providers make up the core of Kaiser's Provider Directory – The provider directory includes providers employed by MAPMG and HealthPlan. The physicians are hired by MAPMG and non-physician providers are hired by Kaiser. These providers are credentialed by the Provider Practitioner Quality Assurance department (PPQA).	MAPMG and Kaiser Human Resources and Provider and Practitioner Quality Assurance (PPQA) provide information for providers who have passed credentialing
2. Contracted and credentialed providers.	Contracted and Credentialed Providers - The provider directory includes providers with which we have contracts and are credentialed. The organization credentials providers and verifies their information including board certification, licensure, medical school, specialization, practice locations etc. to ensure that the provider information is accurate, and the provider can see members. After credentialing is complete, we execute the contract.	Health Professional Contracting and Provider Facility Contracting confirm that the provider has fully executed contract and has passed credentialing.
3. Delegated contracted providers.	Delegated Contracted Providers - We also include contracted provider groups associated with regional hospitals and health systems with whom we have delegated credentialing agreements.	Provider is a part of a contracted entity to whom we delegate credentialing and appears on the delegated entity's provider roster.
4. Contracted and credentialed facilities	Contracted and Credentialed Facilities - Facilities included in the provider directory are credentialed by the Provider and Practitioner Quality Assurance (PPQA). They verify licensure, location and other compliance aspects.	Provider Facility Contracting and PPQA confirm that the facility has fully executed contract and has passed credentialing.
5. Provider system load and maintenance.	Provider System Load and maintenance - KP Internal and external contracted providers are entered and maintained in the provider systems by National Provider System Administration (NPSA).	National Provider System Administration (NPSA) loads provider demographic data in the provider systems and updates provider data is when changes are received.

Factors	Evidentiary Standards and Applicable Thresholds	Source(s) for Each Evidentiary Standard
6. Ongoing confirmation of provider demographic accuracy.	Ongoing confirmation of provider demographic accuracy - Quarterly data quality checks are performed to ensure that the directory data is accurate. Provider availability is measured by quarterly surveys, data reconciliations, provider self-reporting, and contractual obligations with providers to update availability.	The Provider Experience Team conducts the ongoing verification of provider demographic data and provides updated information to NPSA for processing.
7. Internal Kaiser Pharmacies located within a KP medical office building	Inclusion of all internal Kaiser Pharmacies located within a KP medical office building	As new KP medical office buildings are built containing pharmacies, those pharmacies are added to the directories

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

The processes and oversight for the initial provider demographic data loads and maintenance for MAPMG Physicians and Kaiser non-physician providers, contracted and credentialed providers, delegated contracted providers, contracted and credentialed facilities are the same and applied comparably, and no more stringently, to both MS and MH/SUD providers. These processes and procedures have been developed over time to address system modifications, regulatory updates, and end to end workflow modifications related to provider demographic updates.

. Each week, the National Provider System Administration (NPSA) team receives new provider information from MAPMG and Kaiser Human Resources departments via the Customer Relationship Management (CRM) process. These departments also regularly update the NPSA team with any provider changes for integration into the provider system for both M/S and MH/SUD providers.

Kaiser follows identical rigorous processes for initial data entry, updates, and verification for both M/S and MH/SUD providers. The online and printed directories are managed with the same standards for both for MH/SUD providers and M/S providers, ensuring comprehensive, accurate, and up-to-date listings. This includes demographic data updates, detailed provider information, user-friendly search options, and multilingual support.

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 consistently collects and updates data for both MAPMG Physicians and Kaiser non-physician providers, contracted and credentialed providers, delegated contracted providers, contracted, and credentialed facilities in the same manner with the same considerations (i.e., factors, sources, evidentiary standards) for both MS and MH/SUD providers. Therefore, the processes and oversight for the network provider directories is the same for both M/S and MH/SUD, and are applied comparably to and no more stringently to MH/SUD than to M/S providers.