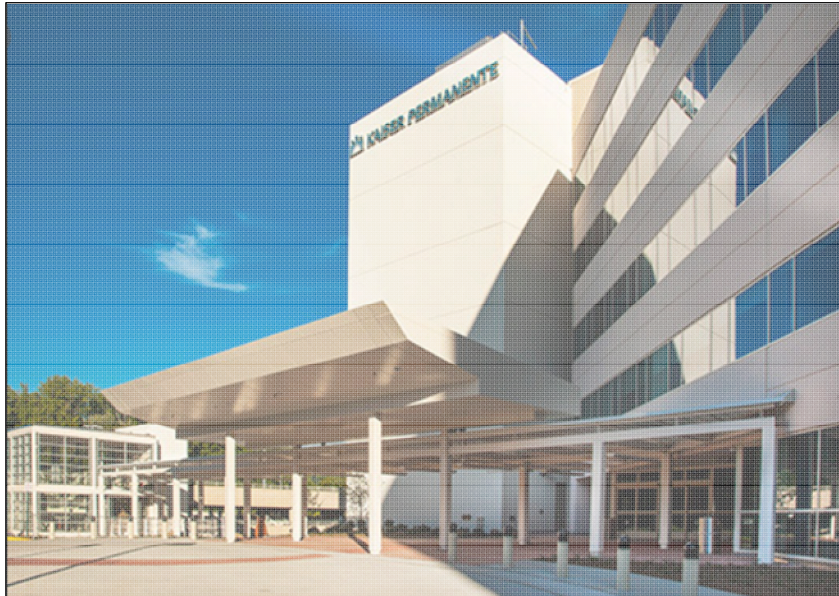


Kaiser Permanente Insurance Company (KPIC) Georgia

Non-Quantitative Treatment Limits (NQTL)



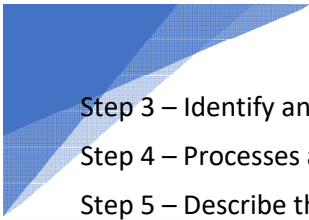
NQTL: Concurrent Review (PPO/POS)

Last Reviewed: December 20, 2023



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Benefits		Classifications					
Is NQTL applied to Medical/Surgical benefits?	Is NQTL applied to Mental Health/Substance Use Disorder benefits?	Is NQTL applied to In Network Inpatient classification?	Is NQTL applied to Out of Network Inpatient classification?	Is NQTL applied to In Network Outpatient classification?	Is NQTL applied to Out of Network Outpatient classification?	Is NQTL applied to Emergency classification?	Is NQTL applied to Prescription classification?
Yes	Yes	Yes	Yes	Yes	Yes	No	No

Benefit Classification 1: Inpatient – In Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage POS:</u> N/A	<u>Permanente Advantage POS:</u> N/A
<u>Permanente Advantage PPO:</u> <ul style="list-style-type: none"> Inpatient Medical / Surgical Hospital Care Inpatient Medically Necessary Bariatric Surgery (Morbid Obesity Services) Inpatient Infertility Services Inpatient Rehabilitation and Habilitation Services Skilled Nursing Facility Inpatient Transplant Services 	<u>Permanente Advantage PPO:</u> <ul style="list-style-type: none"> Inpatient Behavioral Health (BH)/Mental Health (MH) Hospital Care Inpatient Substance Use Disorder (SUD) Services

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Pre-certification Procedures:</u> The Covered Person or his or her attending Physician must notify the Medical Review Program for an extension of a Hospital Confinement - as soon as reasonably possible prior to extending the number of days of Hospital Confinement beyond the number of days originally Precertified or within 48 hours following a vaginal delivery or 96 hours following a cesarean section, or as soon as reasonably possible, for Hospital Confinement in connection with childbirth expected to extend beyond the 48 or 96-hour period.	<u>Pre-certification Procedures:</u> The Covered Person or his or her attending Physician must notify the Medical Review Program for an extension of a Hospital Confinement - as soon as reasonably possible prior to extending the number of days of Hospital Confinement beyond the number of days originally Precertified If a Hospital Confinement or other inpatient care is extended beyond the number of days first Precertified without further Precertification (concurrent review), benefits for the extra days: (1) will similarly

Medical/Surgical

If a Hospital Confinement or other inpatient care is extended beyond the number of days first Precertified without further Precertification (concurrent review), benefits for the extra days: (1) will similarly be denied; or (2) will not be covered if deemed not to be Medically Necessary.

Permanente Advantage utilizes the same concurrent review procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Concurrent review requests are reviewed and processed within the regulatory turnaround times.

Qualifications/Training:

Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing concurrent review requests are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

Mental Health/Substance Use Disorder

be denied; or (2) will not be covered if deemed not to be Medically Necessary.

Permanente Advantage utilizes the same concurrent review procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Concurrent review requests are reviewed and processed within the regulatory turnaround times.

Qualifications/Training:

Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing concurrent review requests are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical

Factors:

High variability in cost of care
Variation in length of stay
Variability and/or lack of adherence to criteria
Clinical effectiveness of the treatment or service
Appropriate level of care
Severity or chronicity of medical surgical conditions
Consistency in concurrent review within market

Sources:

Utilization data
Internal quality audits

Mental Health/Substance Use Disorder

Factors:

High variability in cost of care
Variation in length of stay
Variability and/or lack of adherence to criteria
Clinical effectiveness of the treatment or service
Appropriate level of care
Severity or chronicity of MH/SUD conditions
Consistency in concurrent review within market

Sources:

Utilization data
Internal quality audits

Medical/Surgical

National Accreditation standards
Electronic medical record
Internal and external market comparative
Certification of Insurance

Mental Health/Substance Use Disorder

National Accreditation standards
Electronic medical record
Internal and external market comparative
Certification of Insurance

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical

The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as Milliman Care Guidelines (MCG™) are utilized for M/S services. This standard applies to the following factors:

1. Variation in length of stay:
 - a. MCG guideline goal length of stay is condition or diagnosis-specific length of stay, assuming optimal recovery and decision making. MCG statistical benchmarks and data apply data science to clinical improvement efforts. They are available for utilization and management in inpatient, post-acute, and ambulatory settings of care.
2. Variability and/or lack of adherence to quality standards/ criteria and provider discretion and variation in determining medical necessity:
 - a. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards.
3. Effectiveness of the treatment or service:
 - a. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and

Mental Health/Substance Use Disorder

The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as American Society of Addiction Medicine (ASAM) criteria/guidelines are utilized for SUD services, Milliman Care Guidelines (MCG™) are utilized for MH services and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. This standard applies to the following factors:

1. Variation in length of stay:
 - a. ASAM criteria concepts has moved from a fixed length of service to a variable length of service. The length of stay must be individualized, based on severity of illness and level of functioning, as well as response to treatment, progress, and outcomes.
 - b. MCG guideline goal length of stay is condition or diagnosis-specific length of stay, assuming optimal recovery and decision making. MCG statistical benchmarks and data apply data science to clinical improvement efforts. They are available for utilization and management in inpatient, post-acute, and ambulatory settings of care.
2. Variability and/or lack of adherence to quality standards/ criteria and provider discretion and variation in determining medical necessity:

Medical/Surgical

national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes.

4. Severity or chronicity of the M/S conditions:
 - a. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.
5. Appropriate level of care:
 - a. MCG care guidelines offer evidence-based criteria, goals, and optimal care pathways to move the patient through the continuum of care. Clinical indications for admission or procedure, continued stay, extended stay, goal length of stay, readmission risk, and discharge planning. Transitions of care guidelines address transitions between care settings.
6. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, effectiveness of the treatment or service, severity or chronicity of the M/S conditions, and the appropriate level of care.
7. Pre-certification claim cost include concurrent review if the utilization of services or treatment is in-network utilizing direct contracts (per diem), rental network and/or letter of agreements (% of billed charges); out-of-network (100%) billed charges for facilities. This standard applies to the following factors: High variability of cost of care per episode.
 - a. Utilization Management (pre-certification / concurrent review) assists in managing costs, ensure medical necessity, and reducing unnecessary services. Our ability to encourage or channel patient's to in-network providers or obtain letter of agreement for out-of-network providers (continuity of care, network inadequacy, transition of care) reduces variability in cost of care and reduces cost share of Covered Persons and reduces the cost of care. Improving quality of care by using evidence-based criteria reduces variability or reduction of cost of care.

Mental Health/Substance Use Disorder

- a. ASAM criteria developed to replace the 40-50 criteria sets of criteria used, proactively offer clinically sound alternatives to proprietary and variable criteria used by payers who funded or managed care. Coalition of National Clinical Criteria continues to work towards a national set of criteria (ASAM) accepted by providers, payers, managed care, and policy makers to reduce variability and/or adherence to standards of care.
- b. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards.
- c. WPATH standards of care are international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health, including gender dysphoria.
3. Effectiveness of the treatment or service:
 - a. ASAM criteria encourages moving from seeing diagnosis as sufficient justification for treatment, vs a treatment that is holistic and address multiple needs. Treatment tailored to needs of individual, guided by individual treatment plan in consultation with patient contributes to a significantly to treatment outcomes.
 - b. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes.
 - c. WPATH clinical guidance for health professionals to assist TGD people, including gender dysphoria with safe and effective pathways to achieving lasting personal comfort with their gendered selves, with the aim of optimizing their overall health, psychological well-being, and self-fulfillment.
4. Severity or chronicity of the MH/BH/SUD conditions:
 - a. ASAM addresses co-occurring and complexity capability, recognizing that co-occurring mental health is an expectation, not an exception. This has been incorporated into the ASAM patient placement criteria utilized. Matrix is available for matching severity and level of function with type and intensity of service.
 - b. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.
 - c. WPATH standards of care incorporate the evaluation of coexisting mental health concerns as one of the steps in the assessment and referral process: assess, diagnose,

and discuss treatment options for coexisting mental health concerns.

5. Appropriate level of care:
 - a. ASAM describes treatment as a continuum of care marked by 4 broad levels of care and an early intervention level. Diagnostic admission criteria for levels of care ensures appropriate level of care at admission. Levels of care 0.5 (early intervention) through 4 (medically managed intensive inpatient services). Movement through any level of service(s) the patient's progress in all six dimensions is assessed at regular intervals.
 - b. MCG care guidelines offer evidence-based criteria, goals, and optimal care pathways to move the patient through the continuum of care. Clinical indications for admission or procedure, continued stay, extended stay, goal length of stay, readmission risk, and discharge planning. Transitions of care guidelines address transitions between care settings. MCG behavioral health level of care comparison charts address 5 levels of care; inpatient, residential, partial hospital, intensive outpatient, and outpatient care.
6. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, effectiveness of the treatment or service, severity or chronicity of the MH/SUD conditions, and the appropriate level of care.
7. Pre-certification claim cost include concurrent review if the utilization of services or treatment is in-network utilizing direct contracts (per diem), rental network and/or letter of agreements (% of billed charges); out-of-network (100%) billed charges for facilities. This standard applies to the following factors: High variability of cost of care per episode.
 - a. Utilization Management (pre-certification/concurrent review) assists in managing costs, ensure medical necessity, and reducing unnecessary services. Our ability to encourage or channel patient's to in-network providers or obtain letter of agreement for out-of-network providers (continuity of care, network inadequacy, transition of care) reduces variability in cost of care and reduces cost share of Covered Persons and reduces the cost of care. Improving quality of care by using evidence-based criteria reduces variability or reduction of cost of care.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
<ol style="list-style-type: none">1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of concurrent review indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, providing comparable medical necessity reviews.2. Market analysis of comparable Plans identified 100% of plans require prior authorization / concurrent review for all Inpatient services for MH/SUD and M/S.3. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.4. Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #3, #4	<ol style="list-style-type: none">1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of concurrent review indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, providing comparable medical necessity reviews.2. Market analysis of comparable Plans identified 100% of plans require prior authorization / concurrent review for all Inpatient services for MH/SUD and M/S.3. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.4. Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #3, #4

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
<ol style="list-style-type: none">1. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.	<ol style="list-style-type: none">1. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.

Medical/Surgical	Mental Health/Substance Use Disorder
<ol style="list-style-type: none"> Internal audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6 Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024. Analysis of utilization data identified (81) concurrent review cases for In Network Inpatient M/S services, where (71) were approved and (10) were denied. 	<ol style="list-style-type: none"> Internal audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6 Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024. Analysis of utilization data identified (8) concurrent review case for In Network Inpatient MH/SUD services, which (2) were approved and (6) were denied as the members required a lower level of care per ASAM and MCG criteria.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Permanente Advantage's market analysis for the KPIC Plans confirmed all comparable plans require prior authorization / concurrent review for all In-Network Inpatient services for MH/SUD and M/S. If a Covered Person requires an extended stay of inpatient services, Permanente Advantage will perform concurrent review within the required timeframe. Alignment of concurrent review and criteria with KFHP provides consistency, whether Point-of-Service (POS) members are utilizing inpatient services under the Kaiser Permanente HMO Tier benefit level or KPIC Tier benefit level. KPIC plans utilize a rental network to provide contracted providers and facilities. Covered persons have a choice to utilize contracted (in-network) or non-contracted (out-of-network) providers and facilities. In comparing the utilization data for concurrent review, there is less volume for In Network Inpatient MH/SUD cases with few denials in each category, which we deem comparable. The URAC audit of Permanente Advantage's Utilization Management (UM) policies, procedures, as well as clinical chart review of denial and appeal charts concluded Permanente Advantage met the URAC accreditation standards and were consistent and comparable as written and in operation for MH/SUD and M/S. Internal audits and inter-rater reliability confirmed the competency of selection and utilization of the Medical Necessity criteria for services requiring pre-certification / concurrent review, as written and in operation, the caveat being that ASAM criteria is utilized for SUD, MCG is utilized for MH and M/S and WPATH is used for MH TGD people. Permanente Advantage concludes that as written and in operation, the UM policies, process, factors, and evidentiary standards used to develop and apply concurrent review NQTL for all MH/SUD In Network Inpatient services is comparable and no more stringent than M/S for the KPIC Plans, and therefore are compliant with the final regulation of the Mental Health Parity and Addiction Equity Act.

Benefit Classification 2: Inpatient – Out-of-Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage POS:

- Inpatient Medical / Surgical Hospital Care
- Skilled Nursing Facility

Permanente Advantage PPO:

- Inpatient Medical / Surgical Hospital Care
- Inpatient Medically Necessary Bariatric Surgery (Morbid Obesity Services)
- Inpatient Infertility Services
- Inpatient Rehabilitation and Habilitation Services
- Skilled Nursing Facility
- Inpatient Transplant Services

Permanente Advantage POS:

- Inpatient Behavioral Health (BH)/Mental Health (MH) Hospital Care
- Inpatient Substance Use Disorder (SUD) Services

Permanente Advantage PPO:

- Inpatient Behavioral Health (BH)/Mental Health (MH) Hospital Care
- Inpatient Substance Use Disorder (SUD) Services

Step 1 – Describe the NQTL's requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical

Mental Health/Substance Use Disorder

Pre-certification Procedures:

The Covered Person or his or her attending Physician must notify the Medical Review Program for an extension of a Hospital Confinement - as soon as reasonably possible prior to extending the number of days of Hospital Confinement beyond the number of days originally Precertified or within 48 hours following a vaginal delivery or 96 hours following a cesarean section, or as soon as reasonably possible, for Hospital Confinement in connection with childbirth expected to extend beyond the 48 or 96-hour period.

If a Hospital Confinement or other inpatient care is extended beyond the number of days first Precertified without further Precertification (concurrent review), benefits for the extra days: (1) will similarly be denied; or (2) will not be covered if deemed not to be Medically Necessary.

Permanente Advantage utilizes the same concurrent review procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Concurrent review requests are reviewed and processed within the regulatory turnaround times.

Pre-certification Procedures:

The Covered Person or his or her attending Physician must notify the Medical Review Program for an extension of a Hospital Confinement - as soon as reasonably possible prior to extending the number of days of Hospital Confinement beyond the number of days originally Precertified If a Hospital Confinement or other inpatient care is extended beyond the number of days first Precertified without further Precertification (concurrent review), benefits for the extra days: (1) will similarly be denied; or (2) will not be covered if deemed not to be Medically Necessary.

Permanente Advantage utilizes the same concurrent review procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Concurrent review requests are reviewed and processed within the regulatory turnaround times.

Qualifications/Training:

Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained

Medical/Surgical

Mental Health/Substance Use Disorder

Qualifications/Training:

Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing concurrent review requests are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing concurrent review requests are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical

Mental Health/Substance Use Disorder

Factors:

High variability in cost of care
Variation in length of stay
Variability and/or lack of adherence to criteria
Clinical effectiveness of the treatment or service
Appropriate level of care
Severity or chronicity of medical surgical conditions
Consistency in concurrent review within market

Sources:

Utilization data
Internal quality audits
National Accreditation standards
Electronic medical record
Internal and external market comparative
Certification of Insurance

Factors:

High variability in cost of care
Variation in length of stay
Variability and/or lack of adherence to criteria
Clinical effectiveness of the treatment or service
Appropriate level of care
Severity or chronicity of MH/SUD conditions
Consistency in concurrent review within market

Sources:

Utilization data
Internal quality audits
National Accreditation standards
Electronic medical record
Internal and external market comparative
Certification of Insurance

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

Please note, the term “evidentiary standards” is not limited to a means for defining “factors”. Evidentiary standards also include all evidence considered in designing and applying its NQTL protocols such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research

studies, treatment guidelines created by professional guild associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations.

Medical/Surgical	Mental Health/Substance Use Disorder
<p>The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as Milliman Care Guidelines (MCG™) are utilized for M/S services. This standard applies to the following factors:</p> <ol style="list-style-type: none"> 1. Variation in length of stay: <ol style="list-style-type: none"> a. MCG guideline goal length of stay is condition or diagnosis-specific length of stay, assuming optimal recovery and decision making. MCG statistical benchmarks and data apply data science to clinical improvement efforts. They are available for utilization and management in inpatient, post-acute, and ambulatory settings of care. 2. Variability and/or lack of adherence to quality standards/ criteria and provider discretion and variation in determining medical necessity: <ol style="list-style-type: none"> a. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards. 3. Effectiveness of the treatment or service: <ol style="list-style-type: none"> a. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes. 4. Severity or chronicity of the M/S conditions: <ol style="list-style-type: none"> a. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions. 5. Appropriate level of care: <ol style="list-style-type: none"> a. MCG care guidelines offer evidence-based criteria, goals, and optimal care pathways to move the patient through the continuum of care. Clinical indications for admission or procedure, continued stay, extended stay, goal length of stay, readmission risk, and discharge planning. Transitions of care guidelines address transitions between care settings. 6. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven 	<p>The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as American Society of Addiction Medicine (ASAM) criteria/guidelines are utilized for SUD services, Milliman Care Guidelines (MCG™) are utilized for MH services and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. This standard applies to the following factors:</p> <ol style="list-style-type: none"> 1. Variation in length of stay: <ol style="list-style-type: none"> a. ASAM criteria concepts has moved from a fixed length of service to a variable length of service. The length of stay must be individualized, based on severity of illness and level of functioning, as well as response to treatment, progress, and outcomes. b. MCG guideline goal length of stay is condition or diagnosis-specific length of stay, assuming optimal recovery and decision making. MCG statistical benchmarks and data apply data science to clinical improvement efforts. They are available for utilization and management in inpatient, post-acute, and ambulatory settings of care. 2. Variability and/or lack of adherence to quality standards/ criteria and provider discretion and variation in determining medical necessity: <ol style="list-style-type: none"> a. ASAM criteria developed to replace the 40-50 criteria sets of criteria used, proactively offer clinically sound alternatives to proprietary and variable criteria used by payers who funded or managed care. Coalition of National Clinical Criteria continues to work towards a national set of criteria (ASAM) accepted by providers, payers, managed care, and policy makers to reduce variability and/or adherence to standards of care. b. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards. c. WPATH standards of care are international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health, including gender dysphoria. 3. Effectiveness of the treatment or service:

Medical/Surgical

commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, effectiveness of the treatment or service, severity or chronicity of the M/S conditions, and the appropriate level of care.

7. Pre-certification claim cost include concurrent review if the utilization of services or treatment is in-network utilizing direct contracts (per diem), rental network and/or letter of agreements (% of billed charges); out-of-network (100%) billed charges for facilities. This standard applies to the following factors: High variability of cost of care per episode.
 - a. Utilization Management (pre-certification / concurrent review) assists in managing costs, ensure medical necessity, and reducing unnecessary services. Our ability to encourage or channel patient's to in-network providers or obtain letter of agreement for out-of-network providers (continuity of care, network inadequacy, transition of care) reduces variability in cost of care and reduces cost share of Covered Persons and reduces the cost of care. Improving quality of care by using evidence-based criteria reduces variability or reduction of cost of care.

Mental Health/Substance Use Disorder

- a. ASAM criteria encourages moving from seeing diagnosis as sufficient justification for treatment, vs a treatment that is holistic and address multiple needs. Treatment tailored to needs of individual, guided by individual treatment plan in consultation with patient contributes to a significantly to treatment outcomes.
- b. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes.
- c. WPATH clinical guidance for health professionals to assist TGD people, including gender dysphoria with safe and effective pathways to achieving lasting personal comfort with their gendered selves, with the aim of optimizing their overall health, psychological well-being, and self-fulfillment.
4. Severity or chronicity of the MH/BH/SUD conditions:
 - a. ASAM addresses co-occurring and complexity capability, recognizing that co-occurring mental health is an expectation, not an exception. This has been incorporated into the ASAM patient placement criteria utilized. Matrix is available for matching severity and level of function with type and intensity of service.
 - b. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.
 - c. WPATH standards of care incorporate the evaluation of coexisting mental health concerns as one of the steps in the assessment and referral process: assess, diagnose, and discuss treatment options for coexisting mental health concerns.
5. Appropriate level of care:
 - a. ASAM describes treatment as a continuum of care marked by 4 broad levels of serve and an early intervention level. Diagnostic admission criteria for levels of care ensures appropriate level of care at admission. Levels of care 0.5 (early intervention) through 4 (medically managed intensive inpatient services). Movement through any level of service(s) the patient's progress in all six dimensions is assessed at regular intervals.
 - b. MCG care guidelines offer evidence-based criteria, goals, and optimal care pathways to move the patient through the continuum of care. Clinical indications for admission or procedure, continued stay, extended stay, goal length of stay, readmission risk, and discharge planning. Transitions of care guidelines address transitions between care settings. MCG behavioral health level of care comparison charts address 5 levels of care; inpatient,

Medical/Surgical

Mental Health/Substance Use Disorder

residential, partial hospital, intensive outpatient, and outpatient care.

6. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, effectiveness of the treatment or service, severity or chronicity of the MH/SUD conditions, and the appropriate level of care.
7. Pre-certification claim cost include concurrent review if the utilization of services or treatment is in-network utilizing direct contracts (per diem), rental network and/or letter of agreements (% of billed charges); out-of-network (100%) billed charges for facilities. This standard applies to the following factors: High variability of cost of care per episode.
 - a. Utilization Management (pre-certification/concurrent review) assists in managing costs, ensure medical necessity, and reducing unnecessary services. Our ability to encourage or channel patient's to in-network providers or obtain letter of agreement for out-of-network providers (continuity of care, network inadequacy, transition of care) reduces variability in cost of care and reduces cost share of Covered Persons and reduces the cost of care. Improving quality of care by using evidence-based criteria reduces variability or reduction of cost of care.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical

Mental Health/Substance Use Disorder

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| <ol style="list-style-type: none"> 1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of concurrent review indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, providing comparable medical necessity reviews. 2. Market analysis of comparable Plans identified 100% of plans require prior authorization / concurrent review for all Inpatient services for MH/SUD and M/S. | <ol style="list-style-type: none"> 1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of concurrent review indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, providing comparable medical necessity reviews. 2. Market analysis of comparable Plans identified 100% of plans require prior authorization / concurrent review for all Inpatient services for MH/SUD and M/S. |
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Medical/Surgical	Mental Health/Substance Use Disorder
<p>3. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.</p> <p>4. Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #3, #4</p>	<p>3. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.</p> <p>4. Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #3, #4</p>

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
<p>1. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.</p> <p>2. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.</p> <p>3. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6</p> <p>4. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.</p> <p>5. Analysis of the utilization data identified (2) concurrent review cases for Out-of-Network Inpatient M/S services, which (1) was approved and (1) was denied.</p>	<p>1. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.</p> <p>2. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.</p> <p>3. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6</p> <p>4. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.</p> <p>5. Analysis of the utilization data identified (1) concurrent review case for Out-of-Network Inpatient MH/SUD services, which was approved.</p>

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Permanente Advantage's market analysis for the KPIC Plans confirmed all comparable plans require prior authorization / concurrent review for all Out-of-Network Inpatient services for MH/SUD and M/S. If a Covered Person requires an extended stay of inpatient services, Permanente Advantage will perform concurrent review within the required timeframe. Alignment of concurrent review and criteria with KFHP provides consistency, whether Point-of-Service (POS) members are utilizing inpatient services under the Kaiser Permanente HMO Tier benefit level or KPIC Tier benefit level. KPIC plans utilize a rental network to provide contracted providers and facilities. Covered persons have a choice to utilize contracted (in-network) or non-contracted (out-of-network) providers and facilities. In reviewing the utilization data, there were very few concurrent review cases for Out-of-Network Inpatient services with only (1) MH/SUD case wherein it was approved; which we deem comparable. The URAC audit of Permanente Advantage's Utilization Management (UM) policies, procedures, as well as clinical chart review of denial and appeal charts concluded Permanente Advantage met the URAC accreditation standards and were consistent and comparable as written and in operation for MH/SUD and M/S. Internal audits and inter-rater reliability confirmed the competency of selection and utilization of the Medical Necessity criteria for services requiring pre-certification / concurrent review, as written and in operation, the caveat being that ASAM criteria is utilized for SUD, MCG is utilized for MH and M/S and WPATH is used for MH TGD people. Permanente Advantage concludes that as written and in operation, the UM policies, process, factors, and evidentiary standards used to develop and apply concurrent review NQTL for all MH/SUD Out-of-Network Inpatient services is comparable and no more stringent than M/S for the KPIC Plans, and therefore are compliant with the final regulation of the Mental Health Parity and Addiction Equity Act.

Benefit Classification 3: Outpatient – In Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage POS:</u> N/A	<u>Permanente Advantage POS:</u> N/A
<u>Permanente Advantage PPO:</u> <ul style="list-style-type: none">• Chemotherapy, Radiation, and Infusion Therapy• Hospital Outpatient (includes Facility and Professional Charges)• Clinical Trials• Medically Necessary Durable Medical Equipment (DME)• Home Health Care• Hospice Care• Outpatient Infertility Services• Office / Outpatient Administered Drugs Supplies Supplements• Rehabilitation Services and Habilitative Services<ul style="list-style-type: none">○ Speech Therapy○ Physical and Occupational Therapy	<u>Permanente Advantage PPO:</u> <ul style="list-style-type: none">• Autism Spectrum Disorder Services<ul style="list-style-type: none">○ Applied Behavior Analysis Program (Limited to Children through age 20)○ Speech Therapy (Limited to Children through age 20)○ Physical and Occupational Therapy (Limited to Children through age 20)• Clinical Trials

Medical/Surgical

- Pulmonary Therapy (in-home only)
- Cognitive Therapy for Traumatic Brain Injury
- Multi-disciplinary Rehabilitation

Mental Health/Substance Use Disorder

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical

Mental Health/Substance Use Disorder

Pre-certification Procedures:

The Covered Person or his or her attending Physician must notify the Medical Review Program for other treatments or procedures requiring Precertification - As soon as reasonably possible after the Covered Person learns of the need for any other treatment or service requiring Precertification but at least three days prior to performance of any other treatment or service requiring Precertification.

Permanente Advantage utilizes the same concurrent review procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Concurrent review requests are reviewed and processed within the regulatory turnaround times.

Qualifications/Training:

Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing concurrent review requests are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

Pre-certification Procedures:

The Covered Person or his or her attending Physician must notify the Medical Review Program for other treatments or procedures requiring Precertification - As soon as reasonably possible after the Covered Person learns of the need for any other treatment or service requiring Precertification but at least three days prior to performance of any other treatment or service requiring Precertification.

Permanente Advantage utilizes the same concurrent review procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Concurrent review requests are reviewed and processed within the regulatory turnaround times.

Qualifications/Training:

Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing concurrent review requests are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
Factors: High variability in cost of care Variability and/or lack of adherence to criteria Clinical effectiveness of the treatment or service Severity or chronicity of medical surgical conditions Consistency in concurrent review within market Sources: Utilization data Internal quality audits National Accreditation standards Electronic medical record Internal and external market comparative Certification of Insurance	Factors: High variability in cost of care Variability and/or lack of adherence to criteria Clinical effectiveness of the treatment or service Severity or chronicity of MH/SUD conditions Consistency in concurrent review within market Sources: Utilization data Internal quality audits National Accreditation standards Electronic medical record Internal and external market comparative Certification of Insurance

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as Milliman Care Guidelines (MCG™) are utilized for M/S services. This standard applies to the following factors: 1. Variability and/or lack of adherence to quality standards/ criteria and provider discretion and variation in determining medical necessity:	The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as American Society of Addiction Medicine (ASAM) criteria/guidelines are utilized for SUD services, Milliman Care Guidelines (MCG™) are utilized for MH services and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. This standard applies to the following factors:

Medical/Surgical

- a. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards.
2. Effectiveness of the treatment or service:
 - a. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes.
3. Severity or chronicity of the M/S conditions:
 - a. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.
4. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, effectiveness of the treatment or service and severity or chronicity of the M/S conditions.
5. Pre-certification claim cost include concurrent review if the utilization of services or treatment is in-network utilizing direct contracts (per diem), rental network and/or letter of agreements (% of billed charges); out-of-network (100%) billed charges for facilities. This standard applies to the following factors: High variability of cost of care per episode.
 - a. Utilization Management (pre-certification / concurrent review) assists in managing costs, ensure medical necessity, and reducing unnecessary services. Our ability to encourage or channel patient's to in-network providers or obtain letter of agreement for out-of-network providers (continuity of care, network inadequacy, transition of care) reduces variability in cost of care and reduces cost share of Covered Persons and reduces the cost of care. Improving quality of care by using evidence-based criteria reduces variability or reduction of cost of care.

Mental Health/Substance Use Disorder

1. Variability and/or lack of adherence to quality standards/ criteria and provider discretion and variation in determining medical necessity:
 - a. ASAM criteria developed to replace the 40-50 criteria sets of criteria used, proactively offer clinically sound alternatives to proprietary and variable criteria used by payers who funded or managed care. Coalition of National Clinical Criteria continues to work towards a national set of criteria (ASAM) accepted by providers, payers, managed care, and policy makers to reduce variability and/or adherence to standards of care.
 - b. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards.
 - c. WPATH standards of care are international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health, including gender dysphoria.
2. Effectiveness of the treatment or service:
 - a. ASAM criteria encourages moving from seeing diagnosis as sufficient justification for treatment, vs a treatment that is holistic and address multiple needs. Treatment tailored to needs of individual, guided by individual treatment plan in consultation with patient contributes to a significantly to treatment outcomes.
 - b. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes.
 - c. WPATH clinical guidance for health professionals to assist TGD people, including gender dysphoria with safe and effective pathways to achieving lasting personal comfort with their gendered selves, with the aim of optimizing their overall health, psychological well-being, and self-fulfillment.
3. Severity or chronicity of the MH/BH/SUD conditions:
 - a. ASAM addresses co-occurring and complexity capability, recognizing that co-occurring mental health is an expectation, not an exception. This has been incorporated into the ASAM patient placement criteria utilized. Matrix is available for matching severity and level of function with type and intensity of service.
 - b. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.

Medical/Surgical

Mental Health/Substance Use Disorder

- c. WPATH standards of care incorporate the evaluation of coexisting mental health concerns as one of the steps in the assessment and referral process: assess, diagnose, and discuss treatment options for coexisting mental health concerns.
- 4. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, effectiveness of the treatment or service and severity or chronicity of the MH/SUD conditions.
- 5. Pre-certification claim cost include concurrent review if the utilization of services or treatment is in-network utilizing direct contracts (per diem), rental network and/or letter of agreements (% of billed charges); out-of-network (100%) billed charges for facilities. This standard applies to the following factors: High variability of cost of care per episode.
 - a. Utilization Management (pre-certification/concurrent review) assists in managing costs, ensure medical necessity, and reducing unnecessary services. Our ability to encourage or channel patient's to in-network providers or obtain letter of agreement for out-of-network providers (continuity of care, network inadequacy, transition of care) reduces variability in cost of care and reduces cost share of Covered Persons and reduces the cost of care. Improving quality of care by using evidence-based criteria reduces variability or reduction of cost of care.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical

Mental Health/Substance Use Disorder

1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of concurrent review indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, providing comparable medical necessity reviews.

1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of concurrent review indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, providing comparable medical necessity reviews.

Medical/Surgical	Mental Health/Substance Use Disorder
<p>2. Market analysis of comparable Plans identified 100% of plans require Prior-Authorization / concurrent review for selected M/S Outpatient services which is comparable with KPIC M/S Prior Authorizations / concurrent reviews. Additionally, comparable Plans identified 33% require Prior-Authorization / concurrent review for Outpatient MH/SUD Intensive Outpatient Program (IOP) and 100% for Partial Hospitalization Programs (PHP) services, wherein KPIC plans do not require prior authorization / concurrent review for IOP or PHP.</p> <p>3. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.</p> <p>4. Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #3, #4</p>	<p>2. Market analysis of comparable Plans identified 100% of plans require Prior-Authorization / concurrent review for selected M/S Outpatient services which is comparable with KPIC M/S Prior Authorizations / concurrent reviews. Additionally, comparable Plans identified 33% require Prior-Authorization / concurrent review for Outpatient MH/SUD Intensive Outpatient Program (IOP) and 100% for Partial Hospitalization Programs (PHP) services, wherein KPIC plans do not require prior authorization / concurrent review for IOP or PHP.</p> <p>3. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.</p> <p>4. Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #3, #4</p>

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
<p>1. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.</p> <p>2. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.</p> <p>3. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6</p>	<p>1. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.</p> <p>2. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.</p> <p>3. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6</p>

Medical/Surgical	Mental Health/Substance Use Disorder
<p>4. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.</p> <p>5. Analysis of utilization data identified (30) concurrent review cases for In Network Outpatient M/S services, which (17) were approved, and (13) denied.</p>	<p>4. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.</p> <p>5. Analysis of the utilization data identified (1) concurrent review case for In Network Outpatient MH/SUD, wherein it was approved.</p>

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Permanente Advantage's market analysis for the KPIC Plans confirmed all comparable plans require prior authorization / concurrent review for selected In Network Outpatient M/S services, yet KPIC plans were less restrictive, not requiring prior authorization or concurrent review of Outpatient MH/SUD: Partial Hospitalization or Intensive Outpatient Programs. KPIC plans utilize a rental network to provide contracted providers and facilities. Covered persons have a choice to utilize contracted (in-network) or non-contracted (out-of-network) providers and facilities. In comparing the utilization data there was only (1) MH / SUD In Network Outpatient concurrent review, which was approved, therefore we are less stringent to MH/SUD cases compared to M/S. The URAC audit of Permanente Advantage's Utilization Management (UM) policies, procedures, as well as, clinical chart review of denial and appeal charts, concluded Permanente Advantage met the URAC accreditation standards and were consistent and comparable as written and in operation for MH/SUD and M/S. Internal audits and inter-rater reliability confirmed the competency of selection and utilization of the Medical Necessity criteria for services requiring pre-certification / concurrent review, as written and in operation. Permanente Advantage concludes that as written and in operation, the UM policies, process, factors, and evidentiary standards used to develop and apply concurrent review NQTL for all MH/SUD In Network Outpatient services is comparable and no more stringent than M/S for the KPIC Plans, and therefore are compliant with the final regulation of the Mental Health Parity and Addiction Equity Act.

Benefit Classification 4: Outpatient – Out-of-Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
<p>Permanente Advantage POS:</p> <ul style="list-style-type: none"> Chemotherapy, Radiation, and Infusion Therapy Hospital Outpatient (includes Facility and Professional Charges) Clinical Trials Medically Necessary Durable Medical Equipment (DME) 	<p>Permanente Advantage POS:</p> <ul style="list-style-type: none"> Autism Spectrum Disorder Services <ul style="list-style-type: none"> Applied Behavior Analysis Program (Limited to Children through age 20) Speech Therapy (Limited to Children through age 20)

Medical/Surgical	Mental Health/Substance Use Disorder
<ul style="list-style-type: none"> • Home Health Care • Hospice Care • Office / Outpatient Administered Drugs Supplies Supplements • Rehabilitation Services <ul style="list-style-type: none"> ○ Speech Therapy ○ Physical and Occupational Therapy <p><u>Permanente Advantage PPO:</u></p> <ul style="list-style-type: none"> • Chemotherapy, Radiation, and Infusion Therapy • Hospital Outpatient (includes Facility and Professional Charges) • Clinical Trials • Medically Necessary Durable Medical Equipment (DME) • Home Health Care • Hospice Care • Outpatient Infertility Services • Office / Outpatient Administered Drugs Supplies Supplements • Rehabilitation Services and Habilitative Services <ul style="list-style-type: none"> ○ Speech Therapy ○ Physical and Occupational Therapy ○ Pulmonary Therapy (in-home only) ○ Cognitive Therapy for Traumatic Brain Injury ○ Multi-disciplinary Rehabilitation 	<ul style="list-style-type: none"> ○ Physical and Occupational Therapy (Limited to Children through age 20) • Clinical Trials <p><u>Permanente Advantage PPO:</u></p> <ul style="list-style-type: none"> • Autism Spectrum Disorder Services <ul style="list-style-type: none"> ○ Applied Behavior Analysis Program (Limited to Children through age 20) ○ Speech Therapy (Limited to Children through age 20) ○ Physical and Occupational Therapy (Limited to Children through age 20) • Clinical Trials

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Pre-certification Procedures:</u></p> <p>The Covered Person or his or her attending Physician must notify the Medical Review Program for other treatments or procedures requiring Precertification - As soon as reasonably possible after the Covered Person learns of the need for any other treatment or service requiring Precertification but at least three days prior to performance of any other treatment or service requiring Precertification.</p> <p>Permanente Advantage utilizes the same concurrent review procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are</p>	<p><u>Pre-certification Procedures:</u></p> <p>The Covered Person or his or her attending Physician must notify the Medical Review Program for other treatments or procedures requiring Precertification - As soon as reasonably possible after the Covered Person learns of the need for any other treatment or service requiring Precertification but at least three days prior to performance of any other treatment or service requiring Precertification.</p> <p>Permanente Advantage utilizes the same concurrent review procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are</p>

Medical/Surgical	Mental Health/Substance Use Disorder
provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Concurrent review requests are reviewed and processed within the regulatory turnaround times.	provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Concurrent review requests are reviewed and processed within the regulatory turnaround times.
<u>Qualifications/Training:</u> Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing concurrent review requests are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.	<u>Qualifications/Training:</u> Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing concurrent review requests are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
Factors: High variability in cost of care Variability and/or lack of adherence to criteria Clinical effectiveness of the treatment or service Severity or chronicity of medical surgical conditions Consistency in concurrent review within market Sources: Utilization data Internal quality audits National Accreditation standards Electronic medical record Internal and external market comparative Certification of Insurance	Factors: High variability in cost of care Variability and/or lack of adherence to criteria Clinical effectiveness of the treatment or service Severity or chronicity of MH/SUD conditions Consistency in concurrent review within market Sources: Utilization data Internal quality audits National Accreditation standards Electronic medical record Internal and external market comparative Certification of Insurance

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
<p>The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as Milliman Care Guidelines (MCG™) are utilized for M/S services. This standard applies to the following factors:</p> <ol style="list-style-type: none"> 1. Variability and/or lack of adherence to quality standards/criteria and provider discretion and variation in determining medical necessity: <ol style="list-style-type: none"> a. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards. 2. Effectiveness of the treatment or service: <ol style="list-style-type: none"> a. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes. 3. Severity or chronicity of the M/S conditions: <ol style="list-style-type: none"> a. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions. 4. Health plan accreditation standards for quality assurance. URAC’s HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, effectiveness of the treatment or service and severity or chronicity of the M/S conditions. 5. Pre-certification claim cost include concurrent review if the utilization of services or treatment is in-network utilizing direct contracts (per diem), rental network and/or letter of agreements (% of billed charges); out-of-network (100%) 	<p>The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as American Society of Addiction Medicine (ASAM) criteria/guidelines are utilized for SUD services, Milliman Care Guidelines (MCG™) are utilized for MH services and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. This standard applies to the following factors:</p> <ol style="list-style-type: none"> 1. Variability and/or lack of adherence to quality standards/criteria and provider discretion and variation in determining medical necessity: <ol style="list-style-type: none"> a. ASAM criteria developed to replace the 40-50 criteria sets of criteria used, proactively offer clinically sound alternatives to proprietary and variable criteria used by payers who funded or managed care. Coalition of National Clinical Criteria continues to work towards a national set of criteria (ASAM) accepted by providers, payers, managed care, and policy makers to reduce variability and/or adherence to standards of care. b. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards. c. WPATH standards of care are international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health, including gender dysphoria. 2. Effectiveness of the treatment or service: <ol style="list-style-type: none"> a. ASAM criteria encourages moving from seeing diagnosis as sufficient justification for treatment, vs a treatment that is holistic and address multiple needs. Treatment tailored to needs of individual, guided by individual treatment plan in consultation with patient contributes to a significantly to treatment outcomes. b. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and

Medical/Surgical

billed charges for facilities. This standard applies to the following factors: High variability of cost of care per episode.

- a. Utilization Management (pre-certification / concurrent review) assists in managing costs, ensure medical necessity, and reducing unnecessary services. Our ability to encourage or channel patient's to in-network providers or obtain letter of agreement for out-of-network providers (continuity of care, network inadequacy, transition of care) reduces variability in cost of care and reduces cost share of Covered Persons and reduces the cost of care. Improving quality of care by using evidence-based criteria reduces variability or reduction of cost of care.

Mental Health/Substance Use Disorder

national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes.

- c. WPATH clinical guidance for health professionals to assist TGD people, including gender dysphoria with safe and effective pathways to achieving lasting personal comfort with their gendered selves, with the aim of optimizing their overall health, psychological well-being, and self-fulfillment.
3. Severity or chronicity of the MH/BH/SUD conditions:
 - a. ASAM addresses co-occurring and complexity capability, recognizing that co-occurring mental health is an expectation, not an exception. This has been incorporated into the ASAM patient placement criteria utilized. Matrix is available for matching severity and level of function with type and intensity of service.
 - b. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.
 - c. WPATH standards of care incorporate the evaluation of coexisting mental health concerns as one of the steps in the assessment and referral process: assess, diagnose, and discuss treatment options for coexisting mental health concerns.
4. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, effectiveness of the treatment or service and severity or chronicity of the MH/SUD conditions.
5. Pre-certification claim cost include concurrent review if the utilization of services or treatment is in-network utilizing direct contracts (per diem), rental network and/or letter of agreements (% of billed charges); out-of-network (100%) billed charges for facilities. This standard applies to the following factors: High variability of cost of care per episode.
 - a. Utilization Management (pre-certification/concurrent review) assists in managing costs, ensure medical necessity, and reducing unnecessary services. Our ability to encourage or channel patient's to in-network providers or obtain letter of agreement for out-of-network providers (continuity of care, network inadequacy, transition of care) reduces variability in cost of care and reduces cost share of Covered Persons and reduces the cost of care. Improving quality of care by using evidence-based criteria reduces variability or reduction of cost of care.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
<ol style="list-style-type: none">1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of concurrent review indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, providing comparable medical necessity reviews.2. Market analysis of comparable Plans identified 100% of plans require Prior-Authorization / concurrent review for selected M/S Outpatient services which is comparable with KPIC M/S Prior Authorizations / concurrent reviews. Additionally, comparable Plans identified 33% require Prior-Authorization / concurrent review for Outpatient MH/SUD Intensive Outpatient Program (IOP) and 100% for Partial Hospitalization Programs (PHP) services, wherein KPIC plans do not require prior authorization / concurrent review for IOP or PHP.3. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.4. Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #3, #4	<ol style="list-style-type: none">1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of concurrent review indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, providing comparable medical necessity reviews.2. Market analysis of comparable Plans identified 100% of plans require Prior-Authorization / concurrent review for selected M/S Outpatient services which is comparable with KPIC M/S Prior Authorizations/ concurrent reviews. Additionally, comparable Plans identified 33% require Prior-Authorization / concurrent review for Outpatient MH/SUD Intensive Outpatient Program (IOP) and 100% for Partial Hospitalization Programs (PHP) services, wherein KPIC plans do not require prior authorization / concurrent review for IOP or PHP.3. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.4. Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #3, #4

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
<ol style="list-style-type: none"> 1. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%. 2. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%. 3. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6 4. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024. 5. Analysis of the utilization data identified (2) concurrent review cases for Out-of-Network Outpatient M/S services, which (1) was approved and (1) was denied. 	<ol style="list-style-type: none"> 1. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%. 2. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%. 3. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6 4. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024. 5. There was no concurrent review utilization data identified for Out-of-Network Outpatient MH/SUD services.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Permanente Advantage's market analysis for the KPIC Plans confirmed all comparable plans require prior authorization / concurrent review for selected Out-of-Network Outpatient M/S services, yet KPIC plans were less restrictive, not requiring prior authorization or concurrent review of Outpatient MH/SUD: Partial Hospitalization or Intensive Outpatient Programs. No Pre-Certification of emergency services is required. KPIC plans utilize a rental network to provide contracted providers and facilities. Covered persons have a choice to utilize contracted (in-network) or non-contracted (out-of-network) providers and facilities. There was no utilization of Out-of-Network Outpatient MH/SUD services to compare to M/S. The URAC audit of Permanente Advantage's Utilization Management (UM) policies, procedures, as well as, clinical chart review of denial and appeal charts, concluded Permanente Advantage met the URAC accreditation standards and were consistent and comparable as written and in operation for MH/SUD and M/S. Internal audits and inter-rater reliability confirmed the competency of selection and utilization of the Medical Necessity criteria for services requiring pre-certification / concurrent review, as written and in operation. Permanente Advantage concludes that as written and in operation, the UM policies, process, factors, and evidentiary standards used to develop and apply concurrent review NQTL for all MH/SUD Out-of-Network Outpatient services is comparable and no more stringent than M/S for the KPIC Plans, and therefore are compliant with the final regulation of the Mental Health Parity and Addiction Equity Act.

Benefit Classification 5: Emergency Services

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion
N/A

Benefit Classification 6: Pharmacy Services

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
Pharmacy POS & PPO	Pharmacy POS & PPO
N/A PBM, MedImpact does not make treatment authorization determinations concurrent to the delivery of treatment. All	N/A PBM, MedImpact does not make treatment authorization determinations concurrent to the delivery of treatment. All

Medical/Surgical

Mental Health/Substance Use Disorder

authorization requests are determined prior to the delivery or dispensing of the drug or other treatment.

authorization requests are determined prior to the delivery or dispensing of the drug or other treatment.

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical

Mental Health/Substance Use Disorder

N/A

N/A

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical

Mental Health/Substance Use Disorder

N/A

N/A

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical

Mental Health/Substance Use Disorder

N/A

N/A

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion
N/A

Kaiser Permanente Insurance Company (KPIC) Georgia

Non-Quantitative Treatment Limits (NQTL)



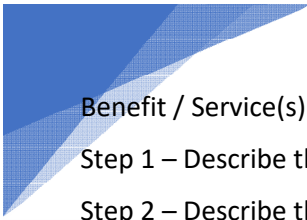
NQTL: Experimental/Investigational Georgia POS/PPO

Last Reviewed: December 20, 2023



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Benefits		Classifications					
Is NQTL applied to Medical/Surgical benefits?	Is NQTL applied to Mental Health/Substance Use Disorder benefits?	Is NQTL applied to In Network Inpatient classification?	Is NQTL applied to Out of Network Inpatient classification?	Is NQTL applied to In Network Outpatient classification?	Is NQTL applied to Out of Network Outpatient classification?	Is NQTL applied to Emergency classification?	Is NQTL applied to Prescription classification?
Yes	Yes	Yes	Yes	Yes	Yes	No	Yes

Benefit Classification 1: Inpatient – In Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – this is an exclusion	N/A – this is an exclusion

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage PPO</u></p> <p><u>Experimental or Investigational</u> means that one of the following is applicable:</p> <ol style="list-style-type: none"> 1. The service is not recognized in accord with generally accepted medical standards as safe and effective for treating the condition in question, whether or not the service is authorized by law or use in testing or other studies on human patients; or 2. The service requires approval by any governmental authority prior to use and such approval has not been granted when the service is to be rendered. <p>Unless specifically stated otherwise in the Group Policy or elsewhere in the Certificate of Insurance (COI), or in the Schedule of Coverage, or any Rider or Endorsement that may be attached to the Group Policy, no payment will be made under any benefit of the Group Policy for Expenses Incurred in connection with the following:</p> <ul style="list-style-type: none"> • Any treatment, procedure, drug or equipment, or device which KPIC determines to be experimental or investigational. This exclusion does not apply to Services covered under Clinical 	<p><u>Permanente Advantage PPO</u></p> <p><u>Experimental or Investigational</u> means that one of the following is applicable:</p> <ol style="list-style-type: none"> 1. The service is not recognized in accord with generally accepted medical standards as safe and effective for treating the condition in question, whether or not the service is authorized by law or use in testing or other studies on human patients; or 2. The service requires approval by any governmental authority prior to use and such approval has not been granted when the service is to be rendered. <p>Unless specifically stated otherwise in the Group Policy or elsewhere in the Certificate of Insurance (COI), or in the Schedule of Coverage, or any Rider or Endorsement that may be attached to the Group Policy, no payment will be made under any benefit of the Group Policy for Expenses Incurred in connection with the following:</p> <ul style="list-style-type: none"> • Any treatment, procedure, drug or equipment, or device which KPIC determines to be experimental or investigational. This exclusion does not apply to Services covered under Clinical

Medical/Surgical

Trials in the GENERAL BENEFITS section of the COI and to experimental or investigational drugs that are used to treat cancer if one or more of the following conditions is met:

- The drug is recognized for treatment of the Covered Person's particular type of cancer in the United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations or The American Hospital Formulary Service Drug Information publication; or
- The drug is recommended for treatment of the Covered Person's particular type of cancer and has been found to be safe and effective in formal clinical studies, the results of which have been published in either the United States or Great Britain.
- Coverage for Routine Patient Care Costs incurred in connection with the provision of goods, services, and benefits to such dependent children in connection with approved clinical trial programs for the treatment of children's cancer with respect to those dependent children who:
 - Have been diagnosed with cancer prior to their nineteenth birthday;
 - Are enrolled in an approved clinical trial program for treatment of children's cancer; and
 - Are not otherwise eligible for benefits, payments, or reimbursements from any other third-party payors or other similar sources.

Medically Necessary means the service that, in the judgement of KPIC are:

1. Essential for the diagnosis and treatment of Covered Person's injury or sickness;
2. In accord with generally accepted medical practice and professional recognized standards in the community;
3. Appropriate with regard to standards of medical care;
4. Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;
5. Not provided solely for the convenience of the covered person or the convenience of the healthcare provider or facility;
6. Not primarily custodial care; and
7. Provided at the most appropriate supply, level and facility.

When applied to confinement in a hospital or other facility, this test means the Covered Person needs to be confined to as an inpatient due to the nature of the services rendered or due to the Covered Person's condition and that the Covered Person cannot receive safe and adequate care through outpatient treatment.

The fact that a physician may prescribe, authorize, or direct a service, does not in itself make it Medically Necessary or covered by the Group Policy

Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to

Mental Health/Substance Use Disorder

Trials in the GENERAL BENEFITS section of the COI and to experimental or investigational drugs that are used to treat cancer if one or more of the following conditions is met:

- The drug is recognized for treatment of the Covered Person's particular type of cancer in the United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations or The American Hospital Formulary Service Drug Information publication; or
- The drug is recommended for treatment of the Covered Person's particular type of cancer and has been found to be safe and effective in formal clinical studies, the results of which have been published in either the United States or Great Britain.
- Coverage for Routine Patient Care Costs incurred in connection with the provision of goods, services, and benefits to such dependent children in connection with approved clinical trial programs for the treatment of children's cancer with respect to those dependent children who:
 - Have been diagnosed with cancer prior to their nineteenth birthday;
 - Are enrolled in an approved clinical trial program for treatment of children's cancer; and
 - Are not otherwise eligible for benefits, payments, or reimbursements from any other third-party payors or other similar sources.

Medically Necessary means the service that, in the judgement of KPIC are:

1. Essential for the diagnosis and treatment of Covered Person's injury or sickness;
2. In accord with generally accepted medical practice and professional recognized standards in the community;
3. Appropriate with regard to standards of medical care;
4. Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;
5. Not provided solely for the convenience of the covered person or the convenience of the healthcare provider or facility;
6. Not primarily custodial care; and
7. Provided at the most appropriate supply, level and facility.

When applied to confinement in a hospital or other facility, this test means the Covered Person needs to be confined to as an inpatient due to the nature of the services rendered or due to the Covered Person's condition and that the Covered Person cannot receive safe and adequate care through outpatient treatment.

The fact that a physician may prescribe, authorize, or direct a service, does not in itself make it Medically Necessary or covered by the Group Policy

Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to

Medical/Surgical

determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person's health care needs; and (3) manages Your plan of care. Precertification/Precertified means the required assessment of the necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review Program. If the Medical Review Program determines that the care is not Medically Necessary, Precertification will be denied.

A Covered Person must provide all necessary information to the Medical Review Program in order for it to make its determination. This means the Covered Person may be required to:

1. Obtain a second opinion from a Physician selected from a panel of three or more Physicians designated by the Medical Review Program. If the Covered Person is required to obtain a second medical opinion, it will be provided at no charge to the Covered Person;
2. Participate in the Medical Review Program's case management, Hospital discharge planning and long term case management programs; and/or
3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the requested treatment or service. If the Covered Person or the Covered Person's provider does not provide the necessary information or will not release necessary information, Precertification will be denied.

Permanente Advantage utilizes the same Medical Necessity Review procedures and forms for both MH/SUD and M/S experimental / investigational requests. The requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. Permanente Advantage applies relevant Utilization Management (UM) criteria to make medical necessity decisions and the relevant UM criteria is applied to MH/SUD and M/S 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 approved by the Utilization and Quality Management Committee. Permanente Advantage utilizes American Society of Addiction Medicine (ASAM) for SUD, Milliman Care Guidelines (MCG™) for Med/Surg and MH and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. Medical Necessity decisions are based on sound clinical evidence to make utilization decisions and specifies procedures for appropriately applying the criteria. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring

Mental Health/Substance Use Disorder

determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person's health care needs; and (3) manages Your plan of care. Precertification/Precertified means the required assessment of the necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review Program. If the Medical Review Program determines that the care is not Medically Necessary, Precertification will be denied.

A Covered Person must provide all necessary information to the Medical Review Program in order for it to make its determination. This means the Covered Person may be required to:

1. Obtain a second opinion from a Physician selected from a panel of three or more Physicians designated by the Medical Review Program. If the Covered Person is required to obtain a second medical opinion, it will be provided at no charge to the Covered Person;
2. Participate in the Medical Review Program's case management, Hospital discharge planning and long term case management programs; and/or
3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the requested treatment or service. If the Covered Person or the Covered Person's provider does not provide the necessary information or will not release necessary information, Precertification will be denied.

Permanente Advantage utilizes the same Medical Necessity Review procedures and forms for both MH/SUD and M/S experimental / investigational requests. The requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. Permanente Advantage applies relevant Utilization Management (UM) criteria to make medical necessity decisions and the relevant UM criteria is applied to MH/SUD and M/S 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 approved by the Utilization and Quality Management Committee. Permanente Advantage utilizes American Society of Addiction Medicine (ASAM) for SUD, Milliman Care Guidelines (MCG™) for Med/Surg and MH and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. Medical Necessity decisions are based on sound clinical evidence to make utilization decisions and specifies procedures for appropriately applying the criteria. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring

Medical/Surgical

provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Medical Necessity cases are reviewed and processed within the regulatory turnaround times.

Qualifications/Training:

Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing medical necessity reviews are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. If any of the attributes indicate that the UM criteria are not appropriate, the case is referred to the UM Physician Reviewer for discussion, and final decision. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

The scope of the Utilization Management Program includes oversight, review, approval, and adoption annually, of the evidenced based criteria to make medical necessity determinations, with involvement of the appropriate and credentialed practitioners. Currently, Permanente Advantage does not modify or revise any nationally developed and recognized treatment guidelines approved and adopted. We apply medical necessity criteria to subclassification and/or subclassification of benefits that require medical necessity review.

Mental Health/Substance Use Disorder

provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Medical Necessity cases are reviewed and processed within the regulatory turnaround times.

Qualifications/Training:

Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing medical necessity reviews are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. If any of the attributes indicate that the UM criteria are not appropriate, the case is referred to the UM Physician Reviewer for discussion, and final decision. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

The scope of the Utilization Management Program includes oversight, review, approval, and adoption annually, of the evidenced based criteria to make medical necessity determinations, with involvement of the appropriate and credentialed practitioners. Currently, Permanente Advantage does not modify or revise any nationally developed and recognized treatment guidelines approved and adopted. We apply medical necessity criteria to subclassification and/or subclassification of benefits that require medical necessity review.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical

Permanente Advantage PPO

Factors

Variability and/or lack of adherence to criteria
Provider discretion and variation in determining medical necessity
Clinical effectiveness of the treatment or service
Severity or chronicity of medical surgical (M/S) or Mental Health (MH) / Substance Use Disorder (SUD) conditions

Sources

Internal quality audits
National Accreditation standards
Electronic medical record

Mental Health/Substance Use Disorder

Permanente Advantage PPO

Factors

Variability and/or lack of adherence to criteria
Provider discretion and variation in determining medical necessity
Clinical effectiveness of the treatment or service
Severity or chronicity of medical surgical (M/S) or Mental Health (MH) / Substance Use Disorder (SUD) conditions

Sources

Internal quality audits
National Accreditation standards
Electronic medical record

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage PPO</u></p> <p>The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as Milliman Care Guidelines (MCG™) are utilized for M/S services. This standard applies to the following factors:</p> <ol style="list-style-type: none"> Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity: <ol style="list-style-type: none"> MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards. Effectiveness of the treatment or service: <ol style="list-style-type: none"> MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes. Severity or chronicity of the M/S conditions: <ol style="list-style-type: none"> MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions. 	<p><u>Permanente Advantage PPO</u></p> <p>The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as American Society of Addiction Medicine (ASAM) criteria/guidelines are utilized for SUD services, Milliman Care Guidelines (MCG™) are utilized for MH services and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. This standard applies to the following factors:</p> <ol style="list-style-type: none"> Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity: <ol style="list-style-type: none"> ASAM criteria developed to replace the 40-50 criteria sets of criteria used, proactively offer clinically sound alternatives to proprietary and variable criteria used by payers who funded or managed care. Coalition of National Clinical Criteria continues to work towards a national set of criteria (ASAM) accepted by providers, payers, managed care, and policy makers to reduce variability and/or adherence to standards of care. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards. WPATH standards of care are international, multidisciplinary, professional association whose

Medical/Surgical

Mental Health/Substance Use Disorder

4. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, provider discretion and variation in determining medical necessity, effectiveness of the treatment or service and severity or chronicity of the M/S conditions.

- mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health, including gender dysphoria.
2. Effectiveness of the treatment or service:
 - a. ASAM criteria encourages moving from seeing diagnosis as sufficient justification for treatment, vs a treatment that is holistic and address multiple needs. Treatment tailored to needs of individual, guided by individual treatment plan in consultation with patient contributes to a significantly to treatment outcomes.
 - b. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes.
 - c. WPATH clinical guidance for health professionals to assist TGD people, including gender dysphoria with safe and effective pathways to achieving lasting personal comfort with their gendered selves, with the aim of optimizing their overall health, psychological well-being, and self-fulfillment.
 3. Severity or chronicity of the MH/BH/SUD conditions:
 - a. ASAM addresses co-occurring and complexity capability, recognizing that co-occurring mental health is an expectation, not an exception. This has been incorporated into the ASAM patient placement criteria utilized. Matrix is available for matching severity and level of function with type and intensity of service.
 - b. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.
 - c. WPATH standards of care incorporate the evaluation of coexisting mental health concerns as one of the steps in the assessment and referral process: assess, diagnose, and discuss treatment options for coexisting mental health concerns.
 4. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, provider discretion and variation in determining medical necessity, effectiveness of the treatment or service and severity or chronicity of the MH/SUD conditions.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage PPO</u> <ol style="list-style-type: none">1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of Experimental or Investigational indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, concluding comparable.2. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.3. Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #4	<u>Permanente Advantage PPO</u> <ol style="list-style-type: none">1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of Experimental or Investigational indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, concluding comparable.2. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.3. Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #4

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage PPO</u> <ol style="list-style-type: none">1. Permanente Advantage utilizes the same medical necessity review procedures and forms for MH/SUD and M/S	<u>Permanente Advantage PPO</u> <ol style="list-style-type: none">1. Permanente Advantage utilizes the same medical necessity review procedures and forms for MH/SUD and M/S

Medical/Surgical

experimental / investigational requests. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how the member can file for an appeal. Medical Necessity requests are reviewed and processed within the regulatory turnaround times.

2. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.
3. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.
4. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6
5. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.

Mental Health/Substance Use Disorder

experimental / investigational requests. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how the member can file for an appeal. Medical Necessity requests are reviewed and processed within the regulatory turnaround times.

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Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Permanente Advantage PPO

Permanente Advantage utilizes the same Medical Necessity Review procedures for all In Network Inpatient for both MH/SUD and M/S experimental / investigational requests. Review of the Kaiser Permanente Insurance Company (KPIC) Certificate of Insurance exclusion of experimental or investigational services indicates one exclusion applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S. The URAC audit of Utilization Management (UM) policies, procedures, as well as clinical chart review of denial and appeal charts, concluded Permanente Advantage met the URAC accreditation standards and were consistent and comparable as written and in operation for MH/SUD and M/S. Internal audits and inter-rater testing confirmed the competency of selection and utilization of the Medical Necessity criteria for services requiring medical necessity review, as written and in operation; the caveat being that ASAM criteria is utilized for SUD, MCG is utilized for MH and M/S and WPATH Standards of Care for Mental Health (MH) TGD people. Permanente Advantage concludes that as written and in operation, the UM policies,

Summary Conclusion

process, factors, and evidentiary standards used to develop and apply Medical Necessity Review for the Experimental or Investigational NQTL for all MH/SUD In Network Inpatient services is comparable and no more stringent than M/S for the KPIC plans, and therefore are compliant with the final regulation of the Mental Health Parity and Addiction Equity Act.

Benefit Classification 2: Inpatient – Out-of-Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – this is an exclusion	N/A – this is an exclusion

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage PPO & POS</u></p> <p><u>Experimental or Investigational</u> means that one of the following is applicable:</p> <ol style="list-style-type: none">1. The service is not recognized in accord with generally accepted medical standards as safe and effective for treating the condition in question, whether or not the service is authorized by law or use in testing or other studies on human patients; or2. The service requires approval by any governmental authority prior to use and such approval has not been granted when the service is to be rendered. <p>Unless specifically stated otherwise in the Group Policy or elsewhere in the Certificate of Insurance (COI), or in the Schedule of Coverage, or any Rider or Endorsement that may be attached to the Group Policy, no payment will be made under any benefit of the Group Policy for Expenses Incurred in connection with the following:</p> <ul style="list-style-type: none">• Any treatment, procedure, drug or equipment, or device which KPIC determines to be experimental or investigational. This exclusion does not apply to Services covered under Clinical Trials in the GENERAL BENEFITS section of the COI and to experimental or investigational drugs that are used to treat cancer if one or more of the following conditions is met:<ul style="list-style-type: none">• The drug is recognized for treatment of the Covered Person’s particular type of cancer in the United States Pharmacopoeia Drug Information, The American	<p><u>Permanente Advantage PPO & POS</u></p> <p><u>Experimental or Investigational</u> means that one of the following is applicable:</p> <ol style="list-style-type: none">1. The service is not recognized in accord with generally accepted medical standards as safe and effective for treating the condition in question, whether or not the service is authorized by law or use in testing or other studies on human patients; or2. The service requires approval by any governmental authority prior to use and such approval has not been granted when the service is to be rendered. <p>Unless specifically stated otherwise in the Group Policy or elsewhere in the Certificate of Insurance (COI), or in the Schedule of Coverage, or any Rider or Endorsement that may be attached to the Group Policy, no payment will be made under any benefit of the Group Policy for Expenses Incurred in connection with the following:</p> <ul style="list-style-type: none">• Any treatment, procedure, drug or equipment, or device which KPIC determines to be experimental or investigational. This exclusion does not apply to Services covered under Clinical Trials in the GENERAL BENEFITS section of the COI and to experimental or investigational drugs that are used to treat cancer if one or more of the following conditions is met:<ul style="list-style-type: none">• The drug is recognized for treatment of the Covered Person’s particular type of cancer in the United States Pharmacopoeia Drug Information, The American

Medical/Surgical

Medical Association Drug Evaluations or The American Hospital Formulary Service Drug Information publication; or

- The drug is recommended for treatment of the Covered Person's particular type of cancer and has been found to be safe and effective in formal clinical studies, the results of which have been published in either the United States or Great Britain.
- Coverage for Routine Patient Care Costs incurred in connection with the provision of goods, services, and benefits to such dependent children in connection with approved clinical trial programs for the treatment of children's cancer with respect to those dependent children who:
 - Have been diagnosed with cancer prior to their nineteenth birthday;
 - Are enrolled in an approved clinical trial program for treatment of children's cancer; and
 - Are not otherwise eligible for benefits, payments, or reimbursements from any other third-party payors or other similar sources.

Medically Necessary means the service that, in the judgement of KPIC are:

1. Essential for the diagnosis and treatment of Covered Person's injury or sickness;
2. In accord with generally accepted medical practice and professional recognized standards in the community;
3. Appropriate with regard to standards of medical care;
4. Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;
5. Not provided solely for the convenience of the covered person or the convenience of the healthcare provider or facility;
6. Not primarily custodial care; and
7. Provided at the most appropriate supply, level and facility.

When applied to confinement in a hospital or other facility, this test means the Covered Person needs to be confined to as an inpatient due to the nature of the services rendered or due to the Covered Person's condition and that the Covered Person cannot receive safe and adequate care through outpatient treatment.

The fact that a physician may prescribe, authorize, or direct a service, does not in itself make it Medically Necessary or covered by the Group Policy

Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person's health care needs; and (3) manages Your plan of care.

Precertification/Precertified means the required assessment of the necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review

Mental Health/Substance Use Disorder

Medical Association Drug Evaluations or The American Hospital Formulary Service Drug Information publication; or

- The drug is recommended for treatment of the Covered Person's particular type of cancer and has been found to be safe and effective in formal clinical studies, the results of which have been published in either the United States or Great Britain.
- Coverage for Routine Patient Care Costs incurred in connection with the provision of goods, services, and benefits to such dependent children in connection with approved clinical trial programs for the treatment of children's cancer with respect to those dependent children who:
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Precertification/Precertified means the required assessment of the necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review

Medical/Surgical

Program. If the Medical Review Program determines that the care is not Medically Necessary, Precertification will be denied.

A Covered Person must provide all necessary information to the Medical Review Program in order for it to make its determination. This means the Covered Person may be required to:

1. Obtain a second opinion from a Physician selected from a panel of three or more Physicians designated by the Medical Review Program. If the Covered Person is required to obtain a second medical opinion, it will be provided at no charge to the Covered Person;
2. Participate in the Medical Review Program's case management, Hospital discharge planning and long term case management programs; and/or
3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the requested treatment or service. If the Covered Person or the Covered Person's provider does not provide the necessary information or will not release necessary information, Precertification will be denied.

Permanente Advantage utilizes the same Medical Necessity Review procedures and forms for both MH/SUD and M/S experimental / investigational requests. The requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. Permanente Advantage applies relevant Utilization Management (UM) criteria to make medical necessity decisions and the relevant UM criteria is applied to MH/SUD and M/S 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 approved by the Utilization and Quality Management Committee. Permanente Advantage utilizes American Society of Addiction Medicine (ASAM) for SUD, Milliman Care Guidelines (MCG™) for Med/Surg and MH and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. Medical Necessity decisions are based on sound clinical evidence to make utilization decisions and specifies procedures for appropriately applying the criteria. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Medical Necessity cases are reviewed and processed within the regulatory turnaround times.

Qualifications/Training:

Mental Health/Substance Use Disorder

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2. Participate in the Medical Review Program's case management, Hospital discharge planning and long term case management programs; and/or
3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the requested treatment or service. If the Covered Person or the Covered Person's provider does not provide the necessary information or will not release necessary information, Precertification will be denied.

Permanente Advantage utilizes the same Medical Necessity Review procedures and forms for both MH/SUD and M/S experimental / investigational requests. The requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. Permanente Advantage applies relevant Utilization Management (UM) criteria to make medical necessity decisions and the relevant UM criteria is applied to MH/SUD and M/S 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 approved by the Utilization and Quality Management Committee. Permanente Advantage utilizes American Society of Addiction Medicine (ASAM) for SUD, Milliman Care Guidelines (MCG™) for Med/Surg and MH and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. Medical Necessity decisions are based on sound clinical evidence to make utilization decisions and specifies procedures for appropriately applying the criteria. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Medical Necessity cases are reviewed and processed within the regulatory turnaround times.

Qualifications/Training:

Medical/Surgical

Mental Health/Substance Use Disorder

Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing medical necessity reviews are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. If any of the attributes indicate that the UM criteria are not appropriate, the case is referred to the UM Physician Reviewer for discussion, and final decision. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

The scope of the Utilization Management Program includes oversight, review, approval, and adoption annually, of the evidenced based criteria to make medical necessity determinations, with involvement of the appropriate and credentialed practitioners. Currently, Permanente Advantage does not modify or revise any nationally developed and recognized treatment guidelines approved and adopted. We apply medical necessity criteria to subclassification and/or subclassification of benefits that require medical necessity review.

Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing medical necessity reviews are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. If any of the attributes indicate that the UM criteria are not appropriate, the case is referred to the UM Physician Reviewer for discussion, and final decision. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

The scope of the Utilization Management Program includes oversight, review, approval, and adoption annually, of the evidenced based criteria to make medical necessity determinations, with involvement of the appropriate and credentialed practitioners. Currently, Permanente Advantage does not modify or revise any nationally developed and recognized treatment guidelines approved and adopted. We apply medical necessity criteria to subclassification and/or subclassification of benefits that require medical necessity review.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO & POS

Factors

Variability and/or lack of adherence to criteria
Provider discretion and variation in determining medical necessity
Clinical effectiveness of the treatment or service
Severity or chronicity of medical surgical (M/S) or Mental Health (MH) / Substance Use Disorder (SUD) conditions

Sources

Internal quality audits
National Accreditation standards
Electronic medical record
Certification of Insurance

Permanente Advantage PPO & POS

Factors

Variability and/or lack of adherence to criteria
Provider discretion and variation in determining medical necessity
Clinical effectiveness of the treatment or service
Severity or chronicity of medical surgical (M/S) or Mental Health (MH) / Substance Use Disorder (SUD) conditions

Sources

Internal quality audits
National Accreditation standards
Electronic medical record
Certification of Insurance

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are

comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage PPO & POS</u></p> <p>The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as Milliman Care Guidelines (MCG™) are utilized for M/S services. This standard applies to the following factors:</p> <ol style="list-style-type: none"> 1. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity: <ol style="list-style-type: none"> a. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards. 2. Effectiveness of the treatment or service: <ol style="list-style-type: none"> a. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes. 3. Severity or chronicity of the M/S conditions: <ol style="list-style-type: none"> a. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions. 4. Health plan accreditation standards for quality assurance. URAC’s HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality 	<p><u>Permanente Advantage PPO & POS</u></p> <p>The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as American Society of Addiction Medicine (ASAM) criteria/guidelines are utilized for SUD services, Milliman Care Guidelines (MCG™) are utilized for MH services and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. This standard applies to the following factors:</p> <ol style="list-style-type: none"> 1. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity: <ol style="list-style-type: none"> a. ASAM criteria developed to replace the 40-50 criteria sets of criteria used, proactively offer clinically sound alternatives to proprietary and variable criteria used by payers who funded or managed care. Coalition of National Clinical Criteria continues to work towards a national set of criteria (ASAM) accepted by providers, payers, managed care, and policy makers to reduce variability and/or adherence to standards of care. b. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards. c. WPATH standards of care are international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health, including gender dysphoria. 2. Effectiveness of the treatment or service: <ol style="list-style-type: none"> a. ASAM criteria encourages moving from seeing diagnosis as sufficient justification for treatment, vs a treatment that is holistic and address multiple needs. Treatment tailored to needs of individual, guided by

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standards, provider discretion and variation in determining medical necessity, effectiveness of the treatment or service and severity or chronicity of the M/S conditions.

Mental Health/Substance Use Disorder

- individual treatment plan in consultation with patient contributes to a significantly to treatment outcomes.
- b. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes.
- c. WPATH clinical guidance for health professionals to assist TGD people, including gender dysphoria with safe and effective pathways to achieving lasting personal comfort with their gendered selves, with the aim of optimizing their overall health, psychological well-being, and self-fulfillment.
- 3. Severity or chronicity of the MH/BH/SUD conditions:
 - a. ASAM addresses co-occurring and complexity capability, recognizing that co-occurring mental health is an expectation, not an exception. This has been incorporated into the ASAM patient placement criteria utilized. Matrix is available for matching severity and level of function with type and intensity of service.
 - b. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.
 - c. WPATH standards of care incorporate the evaluation of coexisting mental health concerns as one of the steps in the assessment and referral process: assess, diagnose, and discuss treatment options for coexisting mental health concerns.
- 4. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, provider discretion and variation in determining medical necessity, effectiveness of the treatment or service and severity or chronicity of the MH/SUD conditions.

Step 4 – Processes and strategies used to design NQTL as written

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

These processes may include, but are not limited to, the composition and deliberations of decision-making staff, e.g., the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence

considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations.

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage PPO & POS</u> <ol style="list-style-type: none"> 1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of Experimental or Investigational indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, concluding comparable. 2. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024. 3. Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #4 	<u>Permanente Advantage PPO & POS</u> <ol style="list-style-type: none"> 1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of Experimental or Investigational indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, concluding comparable. 2. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024. 3. Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #4

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage PPO & POS</u> <ol style="list-style-type: none"> 1. Permanente Advantage utilizes the same medical necessity review procedures and forms for MH/SUD and M/S experimental / investigational requests. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how the 	<u>Permanente Advantage PPO & POS</u> <ol style="list-style-type: none"> 1. Permanente Advantage utilizes the same medical necessity review procedures and forms for MH/SUD and M/S experimental / investigational requests. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how the

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Mental Health/Substance Use Disorder

member can file for an appeal. Medical Necessity requests are reviewed and processed within the regulatory turnaround times.

2. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.
3. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.
4. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6
5. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.

member can file for an appeal. Medical Necessity requests are reviewed and processed within the regulatory turnaround times.

2. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.
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Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Permanente Advantage PPO & POS

Permanente Advantage utilizes the same Medical Necessity Review procedures for all Out of Network Inpatient for both MH/SUD and M/S experimental / investigational requests. Review of the Kaiser Permanente Insurance Company (KPIC) Certificate of Insurance exclusion of experimental or investigational services indicates one exclusion applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S. The URAC audit of Utilization Management (UM) policies, procedures, as well as clinical chart review of denial and appeal charts, concluded Permanente Advantage met the URAC accreditation standards and were consistent and comparable as written and in operation for MH/SUD and M/S. Internal audits and inter-rater testing confirmed the competency of selection and utilization of the Medical Necessity criteria for services requiring medical necessity review, as written and in operation; the caveat being that ASAM criteria is utilized for SUD, MCG is utilized for MH and M/S and WPATH Standards of Care for Mental Health (MH) TGD people. Permanente Advantage concludes that as written and in operation, the UM policies, process, factors, and evidentiary standards used to develop and apply Medical Necessity Review for the Experimental or Investigational NQTL for all MH/SUD Out of Network Inpatient services is comparable and no more stringent than M/S for the KPIC plans, and therefore are compliant with the final regulation of the Mental Health Parity and Addiction Equity Act.

Benefit Classification 3: Outpatient – In Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – this is an exclusion	N/A – this is an exclusion

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage PPO</u></p> <p><u>Experimental or Investigational</u> means that one of the following is applicable:</p> <ol style="list-style-type: none"> 1. The service is not recognized in accord with generally accepted medical standards as safe and effective for treating the condition in question, whether or not the service is authorized by law or use in testing or other studies on human patients; or 2. The service requires approval by any governmental authority prior to use and such approval has not been granted when the service is to be rendered. <p>Unless specifically stated otherwise in the Group Policy or elsewhere in the Certificate of Insurance (COI), or in the Schedule of Coverage, or any Rider or Endorsement that may be attached to the Group Policy, no payment will be made under any benefit of the Group Policy for Expenses Incurred in connection with the following:</p> <ul style="list-style-type: none"> • Any treatment, procedure, drug or equipment, or device which KPIC determines to be experimental or investigational. This exclusion does not apply to Services covered under Clinical Trials in the GENERAL BENEFITS section of the COI and to experimental or investigational drugs that are used to treat cancer if one or more of the following conditions is met: <ul style="list-style-type: none"> • The drug is recognized for treatment of the Covered Person’s particular type of cancer in the United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations or The American Hospital Formulary Service Drug Information publication; or • The drug is recommended for treatment of the Covered Person’s particular type of cancer and has been found to be safe and effective in formal clinical studies, the results of which have been published in either the United States or Great Britain. • Coverage for Routine Patient Care Costs incurred in connection with the provision of goods, services, and 	<p><u>Permanente Advantage PPO</u></p> <p><u>Experimental or Investigational</u> means that one of the following is applicable:</p> <ol style="list-style-type: none"> 1. The service is not recognized in accord with generally accepted medical standards as safe and effective for treating the condition in question, whether or not the service is authorized by law or use in testing or other studies on human patients; or 2. The service requires approval by any governmental authority prior to use and such approval has not been granted when the service is to be rendered. <p>Unless specifically stated otherwise in the Group Policy or elsewhere in the Certificate of Insurance (COI), or in the Schedule of Coverage, or any Rider or Endorsement that may be attached to the Group Policy, no payment will be made under any benefit of the Group Policy for Expenses Incurred in connection with the following:</p> <ul style="list-style-type: none"> • Any treatment, procedure, drug or equipment, or device which KPIC determines to be experimental or investigational. This exclusion does not apply to Services covered under Clinical Trials in the GENERAL BENEFITS section of the COI and to experimental or investigational drugs that are used to treat cancer if one or more of the following conditions is met: <ul style="list-style-type: none"> • The drug is recognized for treatment of the Covered Person’s particular type of cancer in the United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations or The American Hospital Formulary Service Drug Information publication; or • The drug is recommended for treatment of the Covered Person’s particular type of cancer and has been found to be safe and effective in formal clinical studies, the results of which have been published in either the United States or Great Britain. • Coverage for Routine Patient Care Costs incurred in connection with the provision of goods, services, and

Medical/Surgical

benefits to such dependent children in connection with approved clinical trial programs for the treatment of children's cancer with respect to those dependent children who:

- Have been diagnosed with cancer prior to their nineteenth birthday;
- Are enrolled in an approved clinical trial program for treatment of children's cancer; and
- Are not otherwise eligible for benefits, payments, or reimbursements from any other third-party payors or other similar sources.

Medically Necessary means the service that, in the judgement of KPIC are:

1. Essential for the diagnosis and treatment of Covered Person's injury or sickness;
2. In accord with generally accepted medical practice and professional recognized standards in the community;
3. Appropriate with regard to standards of medical care;
4. Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;
5. Not provided solely for the convenience of the covered person or the convenience of the healthcare provider or facility;
6. Not primarily custodial care; and
7. Provided at the most appropriate supply, level and facility.

When applied to confinement in a hospital or other facility, this test means the Covered Person needs to be confined to as an inpatient due to the nature of the services rendered or due to the Covered Person's condition and that the Covered Person cannot receive safe and adequate care through outpatient treatment.

The fact that a physician may prescribe, authorize, or direct a service, does not in itself make it Medically Necessary or covered by the Group Policy

Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person's health care needs; and (3) manages Your plan of care.

Precertification/Precertified means the required assessment of the necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review Program. If the Medical Review Program determines that the care is not Medically Necessary, Precertification will be denied.

A Covered Person must provide all necessary information to the Medical Review Program in order for it to make its determination. This means the Covered Person may be required to:

1. Obtain a second opinion from a Physician selected from a panel of three or more Physicians designated by the Medical Review Program. If the Covered Person is required to obtain a

Mental Health/Substance Use Disorder

benefits to such dependent children in connection with approved clinical trial programs for the treatment of children's cancer with respect to those dependent children who:

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1. Obtain a second opinion from a Physician selected from a panel of three or more Physicians designated by the Medical Review Program. If the Covered Person is required to obtain a

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second medical opinion, it will be provided at no charge to the Covered Person;

2. Participate in the Medical Review Program's case management, Hospital discharge planning and long term case management programs; and/or
3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the requested treatment or service. If the Covered Person or the Covered Person's provider does not provide the necessary information or will not release necessary information, Precertification will be denied.

Permanente Advantage utilizes the same Medical Necessity Review procedures and forms for both MH/SUD and M/S experimental / investigational requests. The requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. Permanente Advantage applies relevant Utilization Management (UM) criteria to make medical necessity decisions and the relevant UM criteria is applied to MH/SUD and M/S 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 approved by the Utilization and Quality Management Committee. Permanente Advantage utilizes American Society of Addiction Medicine (ASAM) for SUD, Milliman Care Guidelines (MCG™) for Med/Surg and MH and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. Medical Necessity decisions are based on sound clinical evidence to make utilization decisions and specifies procedures for appropriately applying the criteria. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Medical Necessity cases are reviewed and processed within the regulatory turnaround times.

Qualifications/Training:

Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing medical necessity reviews are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. If any of the attributes indicate that the UM criteria are not appropriate, the case is referred to the UM Physician Reviewer for discussion, and final decision. The

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second medical opinion, it will be provided at no charge to the Covered Person;

2. Participate in the Medical Review Program's case management, Hospital discharge planning and long term case management programs; and/or
3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the requested treatment or service. If the Covered Person or the Covered Person's provider does not provide the necessary information or will not release necessary information, Precertification will be denied.

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licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

The scope of the Utilization Management Program includes oversight, review, approval, and adoption annually, of the evidenced based criteria to make medical necessity determinations, with involvement of the appropriate and credentialed practitioners. Currently, Permanente Advantage does not modify or revise any nationally developed and recognized treatment guidelines approved and adopted. We apply medical necessity criteria to subclassification and/or sub-classification of benefits that require medical necessity review.

Mental Health/Substance Use Disorder

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The scope of the Utilization Management Program includes oversight, review, approval, and adoption annually, of the evidenced based criteria to make medical necessity determinations, with involvement of the appropriate and credentialed practitioners. Currently, Permanente Advantage does not modify or revise any nationally developed and recognized treatment guidelines approved and adopted. We apply medical necessity criteria to subclassification and/or sub-classification of benefits that require medical necessity review.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical

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Factors

Variability and/or lack of adherence to criteria
Provider discretion and variation in determining medical necessity
Clinical effectiveness of the treatment or service
Severity or chronicity of medical surgical (M/S) or Mental Health (MH) / Substance Use Disorder (SUD) conditions

Sources

Internal quality audits
National Accreditation standards
Electronic medical record
Certification of Insurance

Mental Health/Substance Use Disorder

Permanente Advantage PPO

Factors

Variability and/or lack of adherence to criteria
Provider discretion and variation in determining medical necessity
Clinical effectiveness of the treatment or service
Severity or chronicity of medical surgical (M/S) or Mental Health (MH) / Substance Use Disorder (SUD) conditions

Sources

Internal quality audits
National Accreditation standards
Electronic medical record
Certification of Insurance

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

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1. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity:
 - a. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards.
2. Effectiveness of the treatment or service:
 - a. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes.
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 - a. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.
4. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, provider discretion and variation in determining medical necessity, effectiveness of the treatment or service and severity or chronicity of the M/S conditions.

Permanente Advantage PPO

The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as American Society of Addiction Medicine (ASAM) criteria/guidelines are utilized for SUD services, Milliman Care Guidelines (MCG™) are utilized for MH services and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. This standard applies to the following factors:

1. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity:
 - a. ASAM criteria developed to replace the 40-50 criteria sets of criteria used, proactively offer clinically sound alternatives to proprietary and variable criteria used by payers who funded or managed care. Coalition of National Clinical Criteria continues to work towards a national set of criteria (ASAM) accepted by providers, payers, managed care, and policy makers to reduce variability and/or adherence to standards of care.
 - b. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards.
 - c. WPATH standards of care are international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health, including gender dysphoria.
2. Effectiveness of the treatment or service:
 - a. ASAM criteria encourages moving from seeing diagnosis as sufficient justification for treatment, vs a treatment that is holistic and address multiple needs. Treatment tailored to needs of individual, guided by individual treatment plan in consultation with patient contributes to a significantly to treatment outcomes.
 - b. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes.

Medical/Surgical

Mental Health/Substance Use Disorder

- c. WPATH clinical guidance for health professionals to assist TGD people, including gender dysphoria with safe and effective pathways to achieving lasting personal comfort with their gendered selves, with the aim of optimizing their overall health, psychological well-being, and self-fulfillment.
3. Severity or chronicity of the MH/BH/SUD conditions:
 - a. ASAM addresses co-occurring and complexity capability, recognizing that co-occurring mental health is an expectation, not an exception. This has been incorporated into the ASAM patient placement criteria utilized. Matrix is available for matching severity and level of function with type and intensity of service.
 - b. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.
 - c. WPATH standards of care incorporate the evaluation of coexisting mental health concerns as one of the steps in the assessment and referral process: assess, diagnose, and discuss treatment options for coexisting mental health concerns.
4. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, provider discretion and variation in determining medical necessity, effectiveness of the treatment or service and severity or chronicity of the MH/SUD conditions.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO

1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of Experimental or Investigational indicates one definition applicable to

Permanente Advantage PPO

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Medical/Surgical

Mental Health/Substance Use Disorder

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|---|---|
| <p>MH/SUD and M/S, with no differences documented between MH/SUD and M/S, concluding comparable.</p> <ol style="list-style-type: none"> 2. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024. 3. Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #4 | <p>MH/SUD and M/S, with no differences documented between MH/SUD and M/S, concluding comparable.</p> <ol style="list-style-type: none"> 2. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024. 3. Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #4 |
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Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO

1. Permanente Advantage utilizes the same medical necessity review procedures and forms for MH/SUD and M/S experimental / investigational requests. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how the member can file for an appeal. Medical Necessity requests are reviewed and processed within the regulatory turnaround times.
2. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.

Permanente Advantage PPO

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2. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.

3. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.
4. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6
5. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.

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Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Permanente Advantage PPO

Permanente Advantage utilizes the same Medical Necessity Review procedures for all selected In Network Outpatient for both MH/SUD and M/S experimental / investigational requests. Review of the Kaiser Permanente Insurance Company (KPIC) Certificate of Insurance exclusion of experimental or investigational services indicates one exclusion applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S. The URAC audit of Utilization Management (UM) policies, procedures, as well as clinical chart review of denial and appeal charts, concluded Permanente Advantage met the URAC accreditation standards and were consistent and comparable as written and in operation for MH/SUD and M/S. Internal audits and inter-rater testing confirmed the competency of selection and utilization of the Medical Necessity criteria for services requiring medical necessity review, as written and in operation; the caveat being that ASAM criteria is utilized for SUD, MCG is utilized for MH and M/S and WPATH Standards of Care for Mental Health (MH) TGD people. Permanente Advantage concludes that as written and in operation, the UM policies, process, factors, and evidentiary standards used to develop and apply Medical Necessity Review for the Experimental or Investigational NQTL for all selected MH/SUD selected In Network Outpatient services is comparable and no more stringent than M/S for the KPIC plans, and therefore are compliant with the final regulation of the Mental Health Parity and Addiction Equity Act.

Benefit Classification 4: Outpatient – Out-of-Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – this is an exclusion	N/A – this is an exclusion

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage PPO & POS</u></p> <p><u>Experimental or Investigational</u> means that one of the following is applicable:</p> <ol style="list-style-type: none">1. The service is not recognized in accord with generally accepted medical standards as safe and effective for treating the condition in question, whether or not the service is authorized by law or use in testing or other studies on human patients; or2. The service requires approval by any governmental authority prior to use and such approval has not been granted when the service is to be rendered. <p>Unless specifically stated otherwise in the Group Policy or elsewhere in the Certificate of Insurance (COI), or in the Schedule of Coverage, or any Rider or Endorsement that may be attached to the Group Policy, no payment will be made under any benefit of the Group Policy for Expenses Incurred in connection with the following:</p> <ul style="list-style-type: none">• Any treatment, procedure, drug or equipment, or device which KPIC determines to be experimental or investigational. This exclusion does not apply to Services covered under Clinical Trials in the GENERAL BENEFITS section of the COI and to experimental or investigational drugs that are used to treat cancer if one or more of the following conditions is met:<ul style="list-style-type: none">• The drug is recognized for treatment of the Covered Person’s particular type of cancer in the United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations or The American Hospital Formulary Service Drug Information publication; or• The drug is recommended for treatment of the Covered Person’s particular type of cancer and has been found to be safe and effective in formal clinical studies, the results of which have been published in either the United States or Great Britain.• Coverage for Routine Patient Care Costs incurred in connection with the provision of goods, services, and benefits to such dependent children in connection with approved clinical trial programs for the treatment of children’s cancer with respect to those dependent children who:<ul style="list-style-type: none">• Have been diagnosed with cancer prior to their nineteenth birthday;• Are enrolled in an approved clinical trial program for treatment of children’s cancer; and	<p><u>Permanente Advantage PPO & POS</u></p> <p><u>Experimental or Investigational</u> means that one of the following is applicable:</p> <ol style="list-style-type: none">1. The service is not recognized in accord with generally accepted medical standards as safe and effective for treating the condition in question, whether or not the service is authorized by law or use in testing or other studies on human patients; or2. The service requires approval by any governmental authority prior to use and such approval has not been granted when the service is to be rendered. <p>Unless specifically stated otherwise in the Group Policy or elsewhere in the Certificate of Insurance (COI), or in the Schedule of Coverage, or any Rider or Endorsement that may be attached to the Group Policy, no payment will be made under any benefit of the Group Policy for Expenses Incurred in connection with the following:</p> <ul style="list-style-type: none">• Any treatment, procedure, drug or equipment, or device which KPIC determines to be experimental or investigational. This exclusion does not apply to Services covered under Clinical Trials in the GENERAL BENEFITS section of the COI and to experimental or investigational drugs that are used to treat cancer if one or more of the following conditions is met:<ul style="list-style-type: none">• The drug is recognized for treatment of the Covered Person’s particular type of cancer in the United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations or The American Hospital Formulary Service Drug Information publication; or• The drug is recommended for treatment of the Covered Person’s particular type of cancer and has been found to be safe and effective in formal clinical studies, the results of which have been published in either the United States or Great Britain.• Coverage for Routine Patient Care Costs incurred in connection with the provision of goods, services, and benefits to such dependent children in connection with approved clinical trial programs for the treatment of children’s cancer with respect to those dependent children who:<ul style="list-style-type: none">• Have been diagnosed with cancer prior to their nineteenth birthday;• Are enrolled in an approved clinical trial program for treatment of children’s cancer; and

Medical/Surgical

- Are not otherwise eligible for benefits, payments, or reimbursements from any other third-party payors or other similar sources.

Medically Necessary means the service that, in the judgement of KPIC are:

1. Essential for the diagnosis and treatment of Covered Person's injury or sickness;
 2. In accord with generally accepted medical practice and professional recognized standards in the community;
 3. Appropriate with regard to standards of medical care;
 4. Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;
 5. Not provided solely for the convenience of the covered person or the convenience of the healthcare provider or facility;
 6. Not primarily custodial care; and
 7. Provided at the most appropriate supply, level and facility.
- When applied to confinement in a hospital or other facility, this test means the Covered Person needs to be confined to as an inpatient due to the nature of the services rendered or due to the Covered Person's condition and that the Covered Person cannot receive safe and adequate care through outpatient treatment.

The fact that a physician may prescribe, authorize, or direct a service, does not in itself make it Medically Necessary or covered by the Group Policy

Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person's health care needs; and (3) manages Your plan of care.

Precertification/Precertified means the required assessment of the necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review Program. If the Medical Review Program determines that the care is not Medically Necessary, Precertification will be denied.

A Covered Person must provide all necessary information to the Medical Review Program in order for it to make its determination. This means the Covered Person may be required to:

1. Obtain a second opinion from a Physician selected from a panel of three or more Physicians designated by the Medical Review Program. If the Covered Person is required to obtain a second medical opinion, it will be provided at no charge to the Covered Person;
2. Participate in the Medical Review Program's case management, Hospital discharge planning and long term case management programs; and/or
3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the requested treatment or service.

Mental Health/Substance Use Disorder

- Are not otherwise eligible for benefits, payments, or reimbursements from any other third-party payors or other similar sources.

Medically Necessary means the service that, in the judgement of KPIC are:

1. Essential for the diagnosis and treatment of Covered Person's injury or sickness;
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3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the requested treatment or service.

Medical/Surgical

If the Covered Person or the Covered Person's provider does not provide the necessary information or will not release necessary information, Precertification will be denied.

Permanente Advantage utilizes the same Medical Necessity Review procedures and forms for both MH/SUD and M/S experimental / investigational requests. The requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. Permanente Advantage applies relevant Utilization Management (UM) criteria to make medical necessity decisions and the relevant UM criteria is applied to MH/SUD and M/S 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 approved by the Utilization and Quality Management Committee. Permanente Advantage utilizes American Society of Addiction Medicine (ASAM) for SUD, Milliman Care Guidelines (MCG™) for Med/Surg and MH and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. Medical Necessity decisions are based on sound clinical evidence to make utilization decisions and specifies procedures for appropriately applying the criteria. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Medical Necessity cases are reviewed and processed within the regulatory turnaround times.

Qualifications/Training:

Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing medical necessity reviews are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. If any of the attributes indicate that the UM criteria are not appropriate, the case is referred to the UM Physician Reviewer for discussion, and final decision. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

The scope of the Utilization Management Program includes oversight, review, approval, and adoption annually, of the evidenced based criteria to make medical necessity determinations, with involvement of the appropriate and

Mental Health/Substance Use Disorder

If the Covered Person or the Covered Person's provider does not provide the necessary information or will not release necessary information, Precertification will be denied.

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Medical/Surgical

Mental Health/Substance Use Disorder

credentialed practitioners. Currently, Permanente Advantage does not modify or revise any nationally developed and recognized treatment guidelines approved and adopted. We apply medical necessity criteria to subclassification and/or subclassification of benefits that require medical necessity review.

credentialed practitioners. Currently, Permanente Advantage does not modify or revise any nationally developed and recognized treatment guidelines approved and adopted. We apply medical necessity criteria to subclassification and/or subclassification of benefits that require medical necessity review.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO & POS

Factors

Variability and/or lack of adherence to criteria
Provider discretion and variation in determining medical necessity
Clinical effectiveness of the treatment or service
Severity or chronicity of medical surgical (M/S) or Mental Health (MH) / Substance Use Disorder (SUD) conditions

Sources

Internal quality audits
National Accreditation standards
Electronic medical record
Certification of Insurance

Permanente Advantage PPO & POS

Factors

Variability and/or lack of adherence to criteria
Provider discretion and variation in determining medical necessity
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Severity or chronicity of medical surgical (M/S) or Mental Health (MH) / Substance Use Disorder (SUD) conditions

Sources

Internal quality audits
National Accreditation standards
Electronic medical record
Certification of Insurance

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO & POS

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Permanente Advantage PPO & POS

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Medical/Surgical

manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as Milliman Care Guidelines (MCG™) are utilized for M/S services. This standard applies to the following factors:

1. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity:
 - a. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards.
2. Effectiveness of the treatment or service:
 - a. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes.
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4. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, provider discretion and variation in determining medical necessity, effectiveness of the treatment or service and severity or chronicity of the M/S conditions.

Mental Health/Substance Use Disorder

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 - a. ASAM criteria encourages moving from seeing diagnosis as sufficient justification for treatment, vs a treatment that is holistic and address multiple needs. Treatment tailored to needs of individual, guided by individual treatment plan in consultation with patient contributes to a significantly to treatment outcomes.
 - b. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes.
 - c. WPATH clinical guidance for health professionals to assist TGD people, including gender dysphoria with safe and effective pathways to achieving lasting personal comfort with their gendered selves, with the aim of optimizing their overall health, psychological well-being, and self-fulfillment.

Medical/Surgical

Mental Health/Substance Use Disorder

3. Severity or chronicity of the MH/BH/SUD conditions:
 - a. ASAM addresses co-occurring and complexity capability, recognizing that co-occurring mental health is an expectation, not an exception. This has been incorporated into the ASAM patient placement criteria utilized. Matrix is available for matching severity and level of function with type and intensity of service.
 - b. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.
 - c. WPATH standards of care incorporate the evaluation of coexisting mental health concerns as one of the steps in the assessment and referral process: assess, diagnose, and discuss treatment options for coexisting mental health concerns.
4. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, provider discretion and variation in determining medical necessity, effectiveness of the treatment or service and severity or chronicity of the MH/SUD conditions.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO & POS

1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of Experimental or Investigational indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, concluding comparable.
2. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with

Permanente Advantage PPO & POS

1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of Experimental or Investigational indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, concluding comparable.
2. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with

Medical/Surgical

Mental Health/Substance Use Disorder

UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.

- Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #4

UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.

- Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #4

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO & POS

- Permanente Advantage utilizes the same medical necessity review procedures and forms for MH/SUD and M/S experimental / investigational requests. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how the member can file for an appeal. Medical Necessity requests are reviewed and processed within the regulatory turnaround times.
- Internal audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.
- Internal audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.

Permanente Advantage PPO & POS

- Permanente Advantage utilizes the same medical necessity review procedures and forms for MH/SUD and M/S experimental / investigational requests. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how the member can file for an appeal. Medical Necessity requests are reviewed and processed within the regulatory turnaround times.
- Internal audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.
- Internal audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.

Medical/Surgical	Mental Health/Substance Use Disorder
<p>4. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6</p> <p>5. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.</p>	<p>4. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6</p> <p>5. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.</p>

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Permanente Advantage PPO & POS

Permanente Advantage utilizes the same Medical Necessity Review procedures for all selected Out of Network Outpatient for both MH/SUD and M/S experimental / investigational requests. Review of the Kaiser Permanente Insurance Company (KPIC) Certificate of Insurance exclusion of experimental or investigational services indicates one exclusion applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S. The URAC audit of Utilization Management (UM) policies, procedures, as well as clinical chart review of denial and appeal charts, concluded Permanente Advantage met the URAC accreditation standards and were consistent and comparable as written and in operation for MH/SUD and M/S. Internal audits and inter-rater testing confirmed the competency of selection and utilization of the Medical Necessity criteria for services requiring medical necessity review, as written and in operation; the caveat being that ASAM criteria is utilized for SUD, MCG is utilized for MH and M/S and WPATH Standards of Care for Mental Health (MH) TGD people. Permanente Advantage concludes that as written and in operation, the UM policies, process, factors, and evidentiary standards used to develop and apply Medical Necessity Review for the Experimental or Investigational NQTL for all selected MH/SUD selected Out of Network Outpatient services is comparable and no more stringent than M/S for the KPIC plans, and therefore are compliant with the final regulation of the Mental Health Parity and Addiction Equity Act.

Benefit Classification 5: Emergency Services

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – Pre-certification is not required for Emergency Services	N/A – Pre-certification is not required for Emergency Services

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – Pre-certification is not required for Emergency Services	N/A – Pre-certification is not required for Emergency Services

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – Pre-certification is not required for Emergency Services	N/A – Pre-certification is not required for Emergency Services

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – Pre-certification is not required for Emergency Services	N/A – Pre-certification is not required for Emergency Services

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical

Mental Health/Substance Use Disorder

N/A – Pre-certification is not required for Emergency Services

N/A – Pre-certification is not required for Emergency Services

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical

Mental Health/Substance Use Disorder

N/A – Pre-certification is not required for Emergency Services

N/A – Pre-certification is not required for Emergency Services

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

N/A – Pre-certification is not required for Emergency Services

Benefit Classification 6: Pharmacy Services

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical

Mental Health/Substance Use Disorder

N/A

N/A

Step 1 – Describe the NQTL's requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical

Mental Health/Substance Use Disorder

Pharmacy POS:

According to Kaiser's Evidence of Coverage, Services are identified as Experimental or Investigational and are excluded if any of the following is true about the Service:

- They cannot be legally marketed in the United States without the approval of the U.S. Food and Drug Administration (FDA), and the FDA has not granted this approval.
- They are the subject of a current new drug or new device application on file with the FDA.

They are provided as part of a Phase I, Phase II, or Phase IV clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Services.

- They are provided pursuant to a written protocol or other document that lists an evaluation of the Services' safety, toxicity, or efficacy as among its objectives.
- They are subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research concerning the safety, toxicity, or efficacy of Services.
- They are provided pursuant to informed consent documents that describe the Services as experimental or investigational, or in other terms that indicate that the Services are being evaluated for their safety, toxicity, or efficacy.
- The prevailing opinion among experts as expressed in the published authoritative medical or scientific literature is that:
 - Use of the Services should be substantially confined to research settings, or
 - Further research is necessary to determine the safety, toxicity, or efficacy of the Services. In making determinations whether a Service is experimental or investigational, the following sources of information will be relied upon exclusively:

This exclusion does not apply to Services that we cover under "Services Provided in Connection with Clinical Trials" in the "Benefits" section of this EOC.

Pharmacy POS:

According to Kaiser's Evidence of Coverage, Services are identified as Experimental or Investigational and are excluded if any of the following is true about the Service:

- They cannot be legally marketed in the United States without the approval of the U.S. Food and Drug Administration (FDA), and the FDA has not granted this approval.
- They are the subject of a current new drug or new device application on file with the FDA.

They are provided as part of a Phase I, Phase II, or Phase IV clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Services.

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 - Use of the Services should be substantially confined to research settings, or
 - Further research is necessary to determine the safety, toxicity, or efficacy of the Services. In making determinations whether a Service is experimental or investigational, the following sources of information will be relied upon exclusively:

This exclusion does not apply to Services that we cover under "Services Provided in Connection with Clinical Trials" in the "Benefits" section of this EOC.

Medical/Surgical

The plan requires any experimental or investigational treatment for either behavioral health or medical/surgical to be reviewed by utilization management to determine if the treatment is medically necessary under all benefit classifications.

Pharmacy PPO:

The Experimental and Investigational NQTL is defined as the internal processes of review of prescribed drugs to determine whether they meet the criteria for the plan's coverage exclusion for Experimental and Investigational prescription drugs.

Prescriptions for drugs that are determined to be Experimental or Investigational are not covered by MedImpact's pharmacy benefit.

Requests for experimental or investigational medications will be considered in the context of the plan's coverage documentation.

Off-label uses are also excluded from coverage unless such off-label use is supported by standard drug compendia or otherwise supported by the medical evidence. Off-label Use means use of an FDA-approved medication that has been prescribed by a provider for treatment of a condition or disease other than for an indication specifically designated in the product's FDA-approved labeling.

Mental Health/Substance Use Disorder

The plan requires any experimental or investigational treatment for either behavioral health or medical/surgical to be reviewed by utilization management to determine if the treatment is medically necessary under all benefit classifications.

Pharmacy PPO:

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

The Experimental and Investigational NQTL is defined as the internal processes of review of prescribed drugs to determine whether they meet the criteria for the plan's coverage exclusion for Experimental and Investigational prescription drugs.

Prescriptions for drugs that are determined to be Experimental or Investigational are not covered by MedImpact's pharmacy benefit.

Requests for experimental or investigational medications will be considered in the context of the plan's coverage documentation.

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Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical

Pharmacy POS:

The key factors in applying this NQTL are to assure patient safety and effectiveness of treatment.

Pharmacy PPO:

Experimental or Investigational services include a treatment, procedure, equipment, medication,

Mental Health/Substance Use Disorder

Pharmacy POS:

The key factors in applying this NQTL are to assure patient safety and effectiveness of treatment.

Pharmacy PPO:

Medical/Surgical

medication usage, medical device, or supply that meets one or more of the following criteria:

1. A medication or device which cannot be lawfully marketed without the approval of the United States Food and Drug Administration (FDA) and has not been granted such approval on the date the service or treatment is provided.
2. The treatment or service is subject to oversight by an Institutional Review Board.
3. Sufficient scientific evidence has failed to demonstrate that the requested service is effective in clinical diagnosis, evaluation, management, or treatment of the condition for which the service was requested.
4. The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety, or efficacy.
5. Evaluation of existing scientific evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.

If prescribed for an off-label use, clinical reviewers must find support in at least one source of compendia.

1. A request for off-label use can be denied only after the reviewers failed to find support in at least 2 sources of compendia.
2. If the reviewer was not able to find support after checking two different sources of compendia, the burden is placed on the provider to submit evidence of support.

Mental Health/Substance Use Disorder

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

Experimental or Investigational services include a treatment, procedure, equipment, medication, medication usage, medical device, or supply that meets one or more of the following criteria:

1. A medication or device which cannot be lawfully marketed without the approval of the United States Food and Drug Administration (FDA) and has not been granted such approval on the date the service or treatment is provided.
2. The treatment or service is subject to oversight by an Institutional Review Board.
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2. If the reviewer was not able to find support after checking two different sources of compendia, the burden is placed on the provider to submit evidence of support.

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical

Mental Health/Substance Use Disorder

Pharmacy POS:

Criteria and standards for evaluating medical necessity for experimental and investigational treatments are:

1. Current practice within Kaiser GA Standard of Care.
2. Known standards of care have been exhausted.
3. Food and Drug Administration Approval
4. Treatment safety: patient administered, or provider administered; qualifications and credentials of treating providers.
5. Treatment provider recommendation.

To support decision making in new technologies in care delivery, Kaiser national has an Interregional New Technologies Committee (INTC) charged with monitoring and evaluating new and new applications of existing medical and behavioral technologies with the overall objective of improving health outcomes for members.

These technologies include devices and procedures. The INTC evaluates the medical appropriateness of these technologies based on demonstrated published evidence of safety, efficacy, and comparative utility. The INTC informally tracks and analyzes emerging technologies as evidence on their safety and efficacy becomes available. The INTC is composed of physicians and non-physicians from the different regions and Program Offices within the Kaiser Permanente Medical Care Program. The members of the INTC include:

- physicians at the senior administrative level
- health plan/hospital senior managers
- attorneys at the Senior Counsel level
- a consulting medical ethicist
- a consulting behavioral specialist

Full-time staff support to the INTC includes coordinating literature searches, gathering data and information from a wide variety of sources, analyzing data, preparing evidence tables, coordinating INTC meetings, and writing minutes. Staff consult internal PMG clinical experts on every technology discussed by the INTC.

A determination by the INTC that there is “insufficient” evidence to support a particular treatment or device does not mean that the treatment or device is not medically appropriate to be provided to a particular patient, based on the clinical judgment of the treating physician in the context of treating an individual patient.

Pharmacy POS:

Criteria and standards for evaluating medical necessity for experimental and investigational treatments are:

1. Current practice within Kaiser GA Standard of Care.
2. Known standards of care have been exhausted.
3. Food and Drug Administration Approval
4. Treatment safety: patient administered, or provider administered; qualifications and credentials of treating providers.
5. Treatment provider recommendation.

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A determination by the INTC that there is “insufficient” evidence to support a particular treatment or device does not mean that the treatment or device is not medically appropriate to be provided to a particular patient, based on the clinical judgment of the treating physician in the context of treating an individual patient.

Medical/Surgical

Mental Health/Substance Use Disorder

Evaluation of new pharmaceuticals and new indications for existing pharmaceuticals for coverage under the pharmacy benefit is under the purview of the RFTC (Regional Formulary and Therapeutics Committee). In rare situations, RFTC will evaluate devices used to administer pharmaceuticals for coverage under the pharmacy benefit.

Recommendations related to new technology are then reviewed locally by the KP Georgia Regional Benefits Committee (RBC) regarding the potential inclusion in benefit packages and evaluation of the recommendations in the context of local market forces, and development of processes for local medical management and administration.

Pharmacy PPO:

Evidentiary standards and sources applied by the Plan are:

1. A medication or device which cannot be lawfully marketed without the approval of the United States Food and Drug Administration (FDA) and has not been granted such approval on the date the service or treatment is provided.

- a. Evidentiary standard: FDA approval
- b. Source: FDA approved prescribing information or package labeling

2. The treatment or service is subject to oversight by an Institutional Review Board (IRB).

- a. Evidentiary standard: oversight by an IRB, pursuant to FDA definitions and guidance for IRBs
- b. Source: IRB protocols

3. Sufficient scientific evidence has failed to demonstrate that the requested service is effective in clinical diagnosis, evaluation, management, or treatment of the condition for which the service was requested.

- a. Evidentiary standard: sufficiency of the scientific evidence as determined by the Pharmacist in Charge or Supervisor of PA/UM Programs, with oversight by the Manager and/or Director of PA/UM Programs, pursuant to their clinical expertise and professional judgment.
- b. Sources: all relevant evidence submitted by the prescriber are considered, including scientific evidence includes, but is not limited to, reports and articles published in authoritative, peer-reviewed medical and scientific literature, and

Evaluation of new pharmaceuticals and new indications for existing pharmaceuticals for coverage under the pharmacy benefit is under the purview of the RFTC (Regional Formulary and Therapeutics Committee). In rare situations, RFTC will evaluate devices used to administer pharmaceuticals for coverage under the pharmacy benefit.

Recommendations related to new technology are then reviewed locally by the KP Georgia Regional Benefits Committee (RBC) regarding the potential inclusion in benefit packages and evaluation of the recommendations in the context of local market forces, and development of processes for local medical management and administration.

Pharmacy PPO:

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

Evidentiary standards and sources applied by the Plan are:

1. A medication or device which cannot be lawfully marketed without the approval of the United States Food and Drug Administration (FDA) and has not been granted such approval on the date the service or treatment is provided.

- a. Evidentiary standard: FDA approval
- b. Source: FDA approved prescribing information or package labeling

2. The treatment or service is subject to oversight by an Institutional Review Board (IRB).

- a. Evidentiary standard: oversight by an IRB, pursuant to FDA definitions and guidance for IRBs
- b. Source: IRB protocols

3. Sufficient scientific evidence has failed to demonstrate that the requested service is effective in clinical diagnosis, evaluation, management, or treatment of the condition for which the service was requested.

- a. Evidentiary standard: sufficiency of the scientific evidence as determined by the Pharmacist in Charge or Supervisor of PA/UM Programs, with oversight by the Manager and/or Director of PA/UM Programs, pursuant to their clinical expertise and professional judgment.

Medical/Surgical

assessments and coverage recommendations published by established and recognized medical efficacy review organizations.

4. The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety, or efficacy.

a. Evidentiary standard: existence of ongoing clinical trials

b. Source: FDA registry of clinical trials

5. Evaluation of existing scientific evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.

a. Evidentiary standard: relative effectiveness of the evaluated drug as determined by the Pharmacist in Charge or Supervisor of PA/UM Programs, with oversight by the Manager and/or Director of PA/UM Programs, pursuant to their clinical expertise and professional judgment.

b. Sources: all relevant evidence submitted by the prescriber are considered, including scientific evidence includes, but is not limited to, reports and articles published in authoritative, peer-reviewed medical and scientific literature, and assessments and coverage recommendations published by established and recognized medical efficacy review organizations.

If a drug is prescribed for an off-label use, clinical reviewers must find support in at least one source of compendia. Recognized compendia are:

- a. DRUGDEX Information System
- b. American Hospital Formulary Service Drug Information (AHFS-DI),
- c. Lexi-Drugs
- d. National Comprehensive Cancer Network (NCCN)
- e. Clinical Pharmacology

Mental Health/Substance Use Disorder

b. Sources: all relevant evidence submitted by the prescriber are considered, including scientific evidence includes, but is not limited to, reports and articles published in authoritative, peer-reviewed medical and scientific literature, and assessments and coverage recommendations published by established and recognized medical efficacy review organizations.

4. The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety, or efficacy.

a. Evidentiary standard: existence of ongoing clinical trials

b. Source: FDA registry of clinical trials

5. Evaluation of existing scientific evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.

a. Evidentiary standard: relative effectiveness of the evaluated drug as determined by the Pharmacist in Charge or Supervisor of PA/UM Programs, with oversight by the Manager and/or Director of PA/UM Programs, pursuant to their clinical expertise and professional judgment.

b. Sources: all relevant evidence submitted by the prescriber are considered, including scientific evidence includes, but is not limited to, reports and articles published in authoritative, peer-reviewed medical and scientific literature, and assessments and coverage recommendations published by established and recognized medical efficacy review organizations.

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- e. Clinical Pharmacology

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Pharmacy POS:</u> The plan uses the same definition and factors and standards for UM evaluation of experimental and investigational requests for coverage. Each request is reviewed by a utilization management physician. The physician reviews the record including provider recommendations, past treatments, and application of standard of care. If these factors are met, further evaluation includes FDA approval status, evaluation recommendations by the Interregional New Technologies committee, potential benefits of care, and safety of administration. The credentialed level of review (physician) is the same for both medical/surgical or behavioral health.</p> <p>Treatments that are not FDA approved or are without clinical provider recommendation are denied for both medical/surgical and behavioral health.</p> <p>Medically indicated treatments that have FDA approval but are outside standard of care at Kaiser are reviewed for safety of administration and potential benefit for both medical/surgical and behavioral health.</p> <p>New technology reviews are prioritized in accordance with the professional judgment of the INTC committee members often based on relative impact on all Health Plan membership. Committee membership includes physicians and non-physicians from different regions and Program Offices within the KP Medical Care Program. When a new medical technology or procedure needs review, our Inter-regional New Technology Committee (INTC) examines and evaluates data from government agencies, medical experts, medical journals, and medical specialty societies. Recommendations from this inter-regional committee then are passed onto the local committee(s). The committee reviews the national recommendations to see how they apply to local medical</p>	<p><u>Pharmacy POS:</u> The plan uses the same definition and factors and standards for UM evaluation of experimental and investigational requests for coverage. Each request is reviewed by a utilization management physician. The physician reviews the record including provider recommendations, past treatments, and application of standard of care. If these factors are met, further evaluation includes FDA approval status, evaluation recommendations by the Interregional New Technologies committee, potential benefits of care, and safety of administration. The credentialed level of review (physician) is the same for both medical/surgical or behavioral health.</p> <p>Treatments that are not FDA approved or are without clinical provider recommendation are denied for both medical/surgical and behavioral health.</p> <p>Medically indicated treatments that have FDA approval but are outside standard of care at Kaiser are reviewed for safety of administration and potential benefit for both medical/surgical and behavioral health.</p> <p>New technology reviews are prioritized in accordance with the professional judgment of the INTC committee members often based on relative impact on all Health Plan membership. Committee membership includes physicians and non-physicians from different regions and Program Offices within the KP Medical Care Program. When a new medical technology or procedure needs review, our Inter-regional New Technology Committee (INTC) examines and evaluates data from government agencies, medical experts, medical journals, and medical specialty societies. Recommendations from this inter-regional committee then are passed onto the local committee(s). The committee reviews the national recommendations to see how they apply to local medical</p>

Medical/Surgical

practices. Once this review takes place, the committee makes recommendations for the new technology or procedure to become a covered benefit. In addition, the committee communicates practice guidelines to network providers and related health care providers. If the committee's recommendation is accepted, the new technology is added to the covered benefits, either immediately or when this contract renews.

Members of the RNTG provide our GA Permanente practitioners a rapid, evidence-based response to new technology questions via "Technology on Tap", a staff messaging process available through KP Health Connect. The assessments provide guidance related to new and existing medical technology to ensure that physicians of GA Permanente are providing consistent state-of-the art care that is supported with medical and scientific evidence.

Benefit Exceptions and Member Appeals

Each region has a process in place to manage benefit exceptions and member appeals. Those situations involving new medical technologies are always managed through the local new technology committee, with assistance from and regular communication occurring with INTC staff. Because each patient is evaluated individually regarding the medical appropriateness of any given medical intervention, situations will arise where a given patient presents either a unique opportunity to benefit from an "experimental" technology or proves to be an inappropriate candidate for an accepted form of medical technology. INTC staff can arrange for expert review of individual cases by ad-hoc panels of experts to help determine if such a situation exists. Regional ethics committees are another means of evaluating such cases, and finally, outside, third party ombudsman review provides a source of dispute resolution for such cases. By tracking and documenting the resolution of these cases, a database of similar situations is available to the regions for future use. This information adds to the overall knowledge base about any given medical technology.

Pharmacy PPO:

A request for off-label use can be denied only after the reviewers failed to find support in at least 2 sources of compendia. If the reviewer was not able to find support after checking two different sources of compendia, the

Mental Health/Substance Use Disorder

practices. Once this review takes place, the committee makes recommendations for the new technology or procedure to become a covered benefit. In addition, the committee communicates practice guidelines to network providers and related health care providers. If the committee's recommendation is accepted, the new technology is added to the covered benefits, either immediately or when this contract renews.

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Pharmacy PPO:

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

Medical/Surgical

burden is placed on the provider to submit evidence of support. If time allows, the reviewer will outreach to request submission of literature support.

A finding that the literature supports the prescribed use requires at least 2 peer-reviewed journal articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses for humans as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal. When evaluating this literature, reviewers will consider (among other things) the following:

- a. Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients.
- b. Whether the study is appropriate to address the clinical question. The contractor will consider:
 - i. Whether the experimental design, in light of the drugs and conditions under investigation, is appropriate to address the investigative question. (For example, in some clinical studies, it may be unnecessary or not feasible to use randomization, double blind trials, placebos, or crossover.).
 - ii. Those non-randomized clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs; and,
 - iii. That case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.
- c. For cancer treatment drugs, whether the clinical characteristics of the beneficiary and the cancer are adequately represented in the published evidence.
- d. For cancer treatment drugs, whether the administered chemotherapy regimen is adequately represented in the published evidence.

The reviewer may also consider therapy recommendations listed in guidelines issued by leading nationally recognized associations and agencies. The

Mental Health/Substance Use Disorder

A request for off-label use can be denied only after the reviewers failed to find support in at least 2 sources of compendia. If the reviewer was not able to find support after checking two different sources of compendia, the burden is placed on the provider to submit evidence of support. If time allows, the reviewer will outreach to request submission of literature support.

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- a. Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients.
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 - ii. Those non-randomized clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs; and,
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- c. For cancer treatment drugs, whether the clinical characteristics of the beneficiary and the cancer are adequately represented in the published evidence.
- d. For cancer treatment drugs, whether the administered chemotherapy regimen is adequately represented in the published evidence.

Medical/Surgical	Mental Health/Substance Use Disorder
<p>reviewer will be looking for recommended regimens based on the patient’s diagnosis and clinical characteristics. In addition, the reviewer will consider the strength of the rating for the particular treatment, should that be available. The reviewer may also accept an orphan drug status in compendia for off-label review.</p> <p>If no compelling evidence is found to support the request, but it is believed to be clinically necessary, the case can be sent to a physician specialist for review. The physician will issue a medical opinion as to whether the request is medically necessary.</p>	<p>The reviewer may also consider therapy recommendations listed in guidelines issued by leading nationally recognized associations and agencies. The reviewer will be looking for recommended regimens based on the patient’s diagnosis and clinical characteristics. In addition, the reviewer will consider the strength of the rating for the particular treatment, should that be available. The reviewer may also accept an orphan drug status in compendia for off-label review.</p> <p>If no compelling evidence is found to support the request, but it is believed to be clinically necessary, the case can be sent to a physician specialist for review. The physician will issue a medical opinion as to whether the request is medically necessary.</p>

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Pharmacy POS:</u> Kaiser Permanente Georgia evaluates annually the application of medical necessity criteria in utilization management decision making with health care professionals, staff, physician, and non-physicians for both medical/surgical and mental health/substance use disorder benefits and services. this annual review provides insight into the consistency of determinations for all areas utilizing medical necessity criteria in determining authorization of services and treatments.</p> <p><u>Pharmacy PPO:</u> Coverage denials are not specifically coded to identify denials for E/I drugs or indications. A request for an E/I drug would generally be denied with the notation “coverage criteria not met.” Moreover, denials based on E/I determinations are relatively rare, especially for MH/SUD drugs, and would not provide a sufficient sample</p>	<p><u>Pharmacy POS:</u> Kaiser Permanente Georgia evaluates annually the application of medical necessity criteria in utilization management decision making with health care professionals, staff, physician, and non-physicians for both medical/surgical and mental health/substance use disorder benefits and services. this annual review provides insight into the consistency of determinations for all areas utilizing medical necessity criteria in determining authorization of services and treatments.</p> <p><u>Pharmacy PPO:</u> All drugs (medical, mental health, and substance use disorder) are treated equally and follow the same process as outlined under Med/Surg.</p> <p>Coverage denials are not specifically coded to identify denials for E/I drugs or indications. A request for an E/I drug would generally be denied with the notation</p>

Medical/Surgical

Mental Health/Substance Use Disorder

size for a meaningful comparison to E/I determinations for M/S drugs.

“coverage criteria not met.” Moreover, denials based on E/I determinations are relatively rare, especially for MH/SUD drugs, and would not provide a sufficient sample size for a meaningful comparison to E/I determinations for M/S drugs.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Pharmacy POS:

The plan concludes based on the rate of denials for behavioral health services for experimental or investigational services in and the reliability rating for Utilization Management physicians across behavioral health and medical/surgical in the application of medical necessity that we do not find a disparity toward behavioral health services for exclusions for experimental or investigational service requests.

Pharmacy PPO:

- Experimental or Investigational medications are not covered by MedImpact’s pharmacy benefit.
- The factors, evidentiary standards, and sources used to determine whether a requested drug is E/I are the same for both M/S and MH/SUD drugs.
- The processes and staff used to make E/I determinations are the same for both M/S and MH/SUD drugs.
- E/I denials are relatively rare, especially for MH/SUD drugs, though current data do not permit such denials to be distinguished from other denials where the coverage criteria were not met.
- For all the processes, strategies, evidentiary standards, and other factors used to apply E/I exclusions for prescription drugs are the same, as written and in operation, for both M/S and MH/SUD drugs, and do not differ based on the indication or diagnosis being treated. Therefore, by definition, these processes, strategies, evidentiary standards, and other factors comply with mental health and substance use disorder parity requirements.

Kaiser Permanente Insurance Company (KPIC) Georgia

Non-Quantitative Treatment Limits (NQTL)



NQTL: Medical Necessity

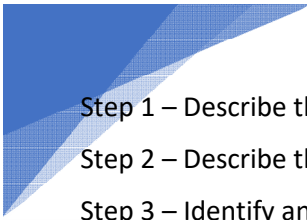
Preferred Provider Organization (PPO) and Point-of-Service (POS) Plans

Last Reviewed: December 20, 2023



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Benefits		Classifications					
Is NQTL applied to Medical/Surgical benefits?	Is NQTL applied to Mental Health/Substance Use Disorder benefits?	Is NQTL applied to In Network Inpatient classification?	Is NQTL applied to Out of Network Inpatient classification?	Is NQTL applied to In Network Outpatient classification?	Is NQTL applied to Out of Network Outpatient classification?	Is NQTL applied to Emergency classification?	Is NQTL applied to Prescription classification?
Yes	Yes	Yes	Yes	Yes	Yes	No	Yes

Benefit Classification 1: Inpatient – In Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage POS:</u> N/A	<u>Permanente Advantage POS:</u> N/A
<u>Permanente Advantage PPO:</u> <ul style="list-style-type: none"> Inpatient Medical / Surgical Hospital Care Inpatient Medically Necessary Bariatric Surgery (Morbid Obesity Services) Inpatient Infertility Services Inpatient Rehabilitation and Habilitation Services Skilled Nursing Facility Inpatient Transplant Services 	<u>Permanente Advantage PPO:</u> <ul style="list-style-type: none"> Inpatient Behavioral Health (BH)/Mental Health (MH) Hospital Care Inpatient Substance Use Disorder (SUD) Services

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage PPO</u> <u>Medically Necessary</u> means the service that, in the judgement of KPIC are: <ol style="list-style-type: none"> Essential for the diagnosis and treatment of Covered Person’s injury or sickness; In accord with generally accepted medical practice and professional recognized standards in the community; Appropriate with regard to standards of medical care; Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms; 	<u>Permanente Advantage PPO</u> <u>Medically Necessary</u> means the service that, in the judgement of KPIC are: <ol style="list-style-type: none"> Essential for the diagnosis and treatment of Covered Person’s injury or sickness; In accord with generally accepted medical practice and professional recognized standards in the community; Appropriate with regard to standards of medical care; Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;

Medical/Surgical

5. Not provided solely for the convenience of the covered person or the convenience of the healthcare provider or facility;
6. Not primarily custodial care; and
7. Provided at the most appropriate supply, level and facility.
When applied to confinement in a hospital or other facility, this test means the Covered Person needs to be confined to as an inpatient due to the nature of the services rendered or due to the Covered Person's condition and that the Covered Person cannot receive safe and adequate care through outpatient treatment.

The fact that a physician may prescribe, authorize, or direct a service, does not in itself make it Medically Necessary or covered by the Group Policy

Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person's health care needs; and (3) manages Your plan of care. Precertification/Precertified means the required assessment of the necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review Program. If the Medical Review Program determines that the care is not Medically Necessary, Precertification will be denied.

A Covered Person must provide all necessary information to the Medical Review Program in order for it to make its determination. This means the Covered Person may be required to:

1. Obtain a second opinion from a Physician selected from a panel of three or more Physicians designated by the Medical Review Program. If the Covered Person is required to obtain a second medical opinion, it will be provided at no charge to the Covered Person;
2. Participate in the Medical Review Program's case management, Hospital discharge planning and long term case management programs; and/or
3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the requested treatment or service. If the Covered Person or the Covered Person's provider does not provide the necessary information or will not release necessary information, Precertification will be denied.

Permanente Advantage utilizes the same Medical Necessity Review procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. Permanente Advantage applies relevant Utilization Management (UM) criteria to make medical necessity decisions and the relevant UM criteria is applied to MH/SUD and M/S in the exact same manner. The Medical Necessity NQTL does not apply to the Emergency Services benefit because all emergency services are automatically

Mental Health/Substance Use Disorder

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Medical/Surgical

covered for all plans. UM adopts and utilizes nationally developed clinical criteria approved by the Utilization and Quality Management Committee. Permanente Advantage utilizes evidence-based criteria/guidelines, such as American Society of Addiction Medicine (ASAM) for SUD, Milliman Care Guidelines (MCG™) for Med/Surg and MH and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. Medical Necessity decisions are based on sound clinical evidence to make utilization decisions and specifies procedures for appropriately applying the criteria. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Medical Necessity cases are reviewed and processed within the regulatory turnaround times.

Qualifications/Training:

Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing medical necessity reviews are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. If any of the attributes indicate that the UM criteria are not appropriate, the case is referred to the UM Physician Reviewer for discussion, and final decision. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

The scope of the Utilization Management Program includes oversight, review, approval, and adoption annually, of the evidenced based criteria to make medical necessity determinations, with involvement of the appropriate and credentialed practitioners. Currently, Permanente Advantage does not modify or revise any nationally developed and recognized treatment guidelines approved and adopted. We apply medical necessity criteria to subclassification and/or subclassification of benefits that require medical necessity review.

Mental Health/Substance Use Disorder

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Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage PPO</u></p> <p>Factors</p> <p>Variability and/or lack of adherence to criteria Provider discretion and variation in determining medical necessity Clinical effectiveness of the treatment or service Appropriate level of care Severity or chronicity of medical surgical (M/S) or Mental Health (MH) / Substance Use Disorder (SUD) conditions</p> <p>Sources</p> <p>Internal quality audits National Accreditation standards Electronic medical record Internal and external medical necessity requirements Certification of Insurance</p>	<p><u>Permanente Advantage PPO</u></p> <p>Factors</p> <p>Variability and/or lack of adherence to criteria Provider discretion and variation in determining medical necessity Clinical effectiveness of the treatment or service Appropriate level of care Severity or chronicity of medical surgical (M/S) or Mental Health (MH) / Substance Use Disorder (SUD) conditions</p> <p>Sources</p> <p>Internal quality audits National Accreditation standards Electronic medical record Internal and external medical necessity requirements Certification of Insurance</p>

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage PPO</u></p> <p>The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as American Society of Addiction Medicine (ASAM) for SUD, Milliman Care Guidelines (MCG™) for M/S along with MH and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. This standard applies to the following factors:</p> <p>1. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity:</p>	<p><u>Permanente Advantage PPO</u></p> <p>The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as American Society of Addiction Medicine (ASAM) for SUD, Milliman Care Guidelines (MCG™) for M/S along with MH and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. This standard applies to the following factors:</p> <p>1. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity:</p>

Medical/Surgical

Mental Health/Substance Use Disorder

<p>a. ASAM criteria developed to replace the 40-50 criteria sets of criteria used, proactively offer clinically sound alternatives to proprietary and variable criteria used by payers who funded or managed care. Coalition of National Clinical Criteria continues to work towards a national set of criteria (ASAM) accepted by providers, payers, managed care, and policy makers to reduce variability and/or adherence to standards of care.</p> <p>b. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards.</p> <p>c. WPATH Standards of Care are international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health, including gender dysphoria.</p> <p>2. Effectiveness of the treatment or service:</p> <p>a. ASAM criteria encourages moving from seeing diagnosis as sufficient justification for treatment, vs a treatment that is holistic and address multiple needs. Treatment tailored to needs of individual, guided by individual treatment plan in consultation with patient contributes to a significantly to treatment outcomes.</p> <p>b. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes.</p> <p>c. WPATH clinical guidance for health professionals to assist TGD people, including gender dysphoria with safe and effective pathways to achieving lasting personal comfort with their gendered selves, with the aim of optimizing their overall health, psychological well-being, and self-fulfillment.</p> <p>3. Appropriate level of care:</p> <p>a. ASAM describes treatment as a continuum of care marked by 4 broad levels of care and an early intervention level. Diagnostic admission criteria for levels of care ensures appropriate level of care at admission. Levels of care 0.5 (early intervention) through 4 (medically managed intensive inpatient services). Movement through any level of service(s) the patient's progress in all six dimensions is assessed at regular intervals.</p> <p>b. MCG care guidelines offer evidence-based criteria, goals, and optimal care pathways to move the patient through the continuum of care. Clinical indications for admission or procedure, continued stay, extended stay, goal length of stay, readmission risk, and discharge planning. Transitions of care guidelines address transitions between care settings. MCG behavioral health level of care comparison charts address 5</p>	<p>a. ASAM criteria developed to replace the 40-50 criteria sets of criteria used, proactively offer clinically sound alternatives to proprietary and variable criteria used by payers who funded or managed care. Coalition of National Clinical Criteria continues to work towards a national set of criteria (ASAM) accepted by providers, payers, managed care, and policy makers to reduce variability and/or adherence to standards of care.</p> <p>b. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards.</p> <p>c. WPATH Standards of Care are international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health, including gender dysphoria.</p> <p>2. Effectiveness of the treatment or service:</p> <p>a. ASAM criteria encourages moving from seeing diagnosis as sufficient justification for treatment, vs a treatment that is holistic and address multiple needs. Treatment tailored to needs of individual, guided by individual treatment plan in consultation with patient contributes to a significantly to treatment outcomes.</p> <p>b. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes.</p> <p>c. WPATH clinical guidance for health professionals to assist TGD people, including gender dysphoria with safe and effective pathways to achieving lasting personal comfort with their gendered selves, with the aim of optimizing their overall health, psychological well-being, and self-fulfillment.</p> <p>3. Appropriate level of care:</p> <p>a. ASAM describes treatment as a continuum of care marked by 4 broad levels of care and an early intervention level. Diagnostic admission criteria for levels of care ensures appropriate level of care at admission. Levels of care 0.5 (early intervention) through 4 (medically managed intensive inpatient services). Movement through any level of service(s) the patient's progress in all six dimensions is assessed at regular intervals.</p> <p>b. MCG care guidelines offer evidence-based criteria, goals, and optimal care pathways to move the patient through the continuum of care. Clinical indications for admission or procedure, continued stay, extended stay, goal length of stay, readmission risk, and discharge planning. Transitions of care guidelines address transitions between care settings. MCG behavioral health level of care comparison charts address 5</p>
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Medical/Surgical

Mental Health/Substance Use Disorder

levels of care; inpatient, residential, partial hospital, intensive outpatient, and outpatient care.

4. Severity or chronicity of the M/S, MH/BH/SUD conditions:
 - a. ASAM addresses co-occurring and complexity capability, recognizing that co-occurring mental health is an expectation, not an exception. This has been incorporated into the ASAM patient placement criteria utilized. Matrix is available for matching severity and level of function with type and intensity of service.
 - b. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.
 - c. WPATH Standards of Care incorporate the evaluation of coexisting mental health concerns as one of the steps in the assessment and referral process: assess, diagnose, and discuss treatment options for coexisting mental health concerns.
5. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, provider discretion and variation in determining medical necessity, effectiveness of the treatment or service, appropriate level of care and severity or chronicity of the M/S, MH/SUD conditions.

levels of care; inpatient, residential, partial hospital, intensive outpatient, and outpatient care.

4. Severity or chronicity of the M/S, MH/BH/SUD conditions:
 - a. ASAM addresses co-occurring and complexity capability, recognizing that co-occurring mental health is an expectation, not an exception. This has been incorporated into the ASAM patient placement criteria utilized. Matrix is available for matching severity and level of function with type and intensity of service.
 - b. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.
 - c. WPATH Standards of Care incorporate the evaluation of coexisting mental health concerns as one of the steps in the assessment and referral process: assess, diagnose, and discuss treatment options for coexisting mental health concerns.
5. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, provider discretion and variation in determining medical necessity, effectiveness of the treatment or service, appropriate level of care and severity or chronicity of the M/S, MH/SUD conditions.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO

1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of Medically Necessary indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, concluding comparable.

Permanente Advantage PPO

1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of Medically Necessary indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, concluding comparable.

Medical/Surgical	Mental Health/Substance Use Disorder
<ol style="list-style-type: none"> Market analysis of comparable Plans identified 100% of plans require medical necessity review for all Inpatient services for MH/SUD and M/S, excluding services covered under the Newborns' and Mothers' Health Protection Act of 1996, which is consistent with the KPIC plans. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024. Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization Management and Quality Management (UM/QM) minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the UM/QM Committee. Exhibits # 1, #4 	<ol style="list-style-type: none"> Market analysis of comparable Plans identified 100% of plans require medical necessity review for all Inpatient services for MH/SUD and M/S, excluding services covered under the Newborns' and Mothers' Health Protection Act of 1996, which is consistent with the KPIC plans. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024. Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization Management and Quality Management (UM/QM) minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the UM/QM Committee. Exhibits # 1, #4

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage PPO</u></p> <ol style="list-style-type: none"> Permanente Advantage utilizes the same medical necessity review procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how the member can file for an appeal. Medical Necessity requests are reviewed and processed within the regulatory turnaround times. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were 	<p><u>Permanente Advantage PPO</u></p> <ol style="list-style-type: none"> Permanente Advantage utilizes the same medical necessity review procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how the member can file for an appeal. Medical Necessity requests are reviewed and processed within the regulatory turnaround times. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were

Medical/Surgical	Mental Health/Substance Use Disorder
<p>completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.</p> <p>3. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.</p> <p>4. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6</p> <p>5. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.</p>	<p>completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.</p> <p>3. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.</p> <p>4. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6</p> <p>5. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.</p>

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Permanente Advantage PPO

Permanente Advantage's market analysis for the Kaiser Permanente Insurance Company (KPIC) Plans confirmed all comparable plans require Medical Necessity Review for all In Network Inpatient services for MH/SUD and M/S. No Medical Necessity Review of emergency services is required. The URAC audit of Utilization Management (UM) policies, procedures, as well as clinical chart review of denial and appeal charts, concluded Permanente Advantage met the URAC accreditation standards and were consistent and comparable as written and in operation for MH/SUD and M/S. Internal audits and inter-rater testing confirmed the competency of selection and utilization of the Medical Necessity criteria for services requiring Medical Necessity Review, as written and in operation; the caveat being that ASAM criteria is utilized for SUD, MCG is utilized for MH and M/S and WPATH Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. Permanente Advantage concludes that as written and in operation, the UM policies, process, factors, and evidentiary standards used to develop and apply Medical Necessity NQTL for all MH/SUD In Network Inpatient services is comparable and no more stringent than M/S for the KPIC plans, and therefore are compliant with the final regulation of the Mental Health Parity and Addiction Equity Act.

Benefit Classification 2: Inpatient – Out-of-Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage POS:</u> <ul style="list-style-type: none"> Inpatient Medical / Surgical Hospital Care 	<u>Permanente Advantage POS:</u>

Medical/Surgical

- Skilled Nursing Facility

Permanente Advantage PPO:

- Inpatient Medical / Surgical Hospital Care
- Inpatient Medically Necessary Bariatric Surgery (Morbid Obesity Services)
- Inpatient Infertility Services
- Inpatient Rehabilitation and Habilitation Services
- Skilled Nursing Facility
- Inpatient Transplant Services

Mental Health/Substance Use Disorder

- Inpatient Behavioral Health (BH)/Mental Health (MH) Hospital Care
- Inpatient Substance Use Disorder (SUD) Services

Permanente Advantage PPO:

- Inpatient Behavioral Health (BH)/Mental Health (MH) Hospital Care
- Inpatient Substance Use Disorder (SUD) Services

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO & POS

Medically Necessary means the service that, in the judgement of KPIC are:

1. Essential for the diagnosis and treatment of Covered Person’s injury or sickness;
2. In accord with generally accepted medical practice and professional recognized standards in the community;
3. Appropriate with regard to standards of medical care;
4. Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;
5. Not provided solely for the convenience of the covered person or the convenience of the healthcare provider or facility;
6. Not primarily custodial care; and
7. Provided at the most appropriate supply, level and facility.

When applied to confinement in a hospital or other facility, this test means the Covered Person needs to be confined to as an inpatient due to the nature of the services rendered or due to the Covered Person’s condition and that the Covered Person cannot receive safe and adequate care through outpatient treatment.

The fact that a physician may prescribe, authorize, or direct a service, does not in itself make it Medically Necessary or covered by the Group Policy

Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person’s health care needs; and (3) manages Your plan of care.

Precertification/Precertified means the required assessment of

Permanente Advantage PPO & POS

Medically Necessary means the service that, in the judgement of KPIC are:

1. Essential for the diagnosis and treatment of Covered Person’s injury or sickness;
2. In accord with generally accepted medical practice and professional recognized standards in the community;
3. Appropriate with regard to standards of medical care;
4. Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;
5. Not provided solely for the convenience of the covered person or the convenience of the healthcare provider or facility;
6. Not primarily custodial care; and
7. Provided at the most appropriate supply, level and facility.

When applied to confinement in a hospital or other facility, this test means the Covered Person needs to be confined to as an inpatient due to the nature of the services rendered or due to the Covered Person’s condition and that the Covered Person cannot receive safe and adequate care through outpatient treatment.

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Precertification/Precertified means the required assessment of

Medical/Surgical

the necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review Program. If the Medical Review Program determines that the care is not Medically Necessary, Precertification will be denied.

A Covered Person must provide all necessary information to the Medical Review Program in order for it to make its determination. This means the Covered Person may be required to:

1. Obtain a second opinion from a Physician selected from a panel of three or more Physicians designated by the Medical Review Program. If the Covered Person is required to obtain a second medical opinion, it will be provided at no charge to the Covered Person;
2. Participate in the Medical Review Program's case management, Hospital discharge planning and long term case management programs; and/or
3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the requested treatment or service. If the Covered Person or the Covered Person's provider does not provide the necessary information or will not release necessary information, Precertification will be denied.

Permanente Advantage utilizes the same Medical Necessity Review procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. Permanente Advantage applies relevant Utilization Management (UM) criteria to make medical necessity decisions and the relevant UM criteria is applied to MH/SUD and M/S 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 approved by the Utilization and Quality Management Committee. Permanente Advantage utilizes evidence-based criteria/guidelines, such as American Society of Addiction Medicine (ASAM) for SUD, Milliman Care Guidelines (MCG™) for Med/Surg and MH and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. Medical Necessity decisions are based on sound clinical evidence to make utilization decisions and specifies procedures for appropriately applying the criteria. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Medical Necessity cases are reviewed and processed within the regulatory turnaround times.

Mental Health/Substance Use Disorder

the necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review Program. If the Medical Review Program determines that the care is not Medically Necessary, Precertification will be denied.

A Covered Person must provide all necessary information to the Medical Review Program in order for it to make its determination. This means the Covered Person may be required to:

1. Obtain a second opinion from a Physician selected from a panel of three or more Physicians designated by the Medical Review Program. If the Covered Person is required to obtain a second medical opinion, it will be provided at no charge to the Covered Person;
2. Participate in the Medical Review Program's case management, Hospital discharge planning and long term case management programs; and/or
3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the requested treatment or service. If the Covered Person or the Covered Person's provider does not provide the necessary information or will not release necessary information, Precertification will be denied.

Permanente Advantage utilizes the same Medical Necessity Review procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. Permanente Advantage applies relevant Utilization Management (UM) criteria to make medical necessity decisions and the relevant UM criteria is applied to MH/SUD and M/S 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 approved by the Utilization and Quality Management Committee. Permanente Advantage utilizes evidence-based criteria/guidelines, such as American Society of Addiction Medicine (ASAM) for SUD, Milliman Care Guidelines (MCG™) for Med/Surg and MH and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. Medical Necessity decisions are based on sound clinical evidence to make utilization decisions and specifies procedures for appropriately applying the criteria. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Medical Necessity cases are reviewed and processed within the regulatory turnaround times.

Medical/Surgical

Mental Health/Substance Use Disorder

Qualifications/Training:

Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing medical necessity reviews are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. If any of the attributes indicate that the UM criteria are not appropriate, the case is referred to the UM Physician Reviewer for discussion, and final decision. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

The scope of the Utilization Management Program includes oversight, review, approval, and adoption annually, of the evidenced based criteria to make medical necessity determinations, with involvement of the appropriate and credentialed practitioners. Currently, Permanente Advantage does not modify or revise any nationally developed and recognized treatment guidelines approved and adopted. We apply medical necessity criteria to subclassification and/or sub-classification of benefits that require medical necessity review.

Qualifications/Training:

Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing medical necessity reviews are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. If any of the attributes indicate that the UM criteria are not appropriate, the case is referred to the UM Physician Reviewer for discussion, and final decision. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

The scope of the Utilization Management Program includes oversight, review, approval, and adoption annually, of the evidenced based criteria to make medical necessity determinations, with involvement of the appropriate and credentialed practitioners. Currently, Permanente Advantage does not modify or revise any nationally developed and recognized treatment guidelines approved and adopted. We apply medical necessity criteria to subclassification and/or sub-classification of benefits that require medical necessity review.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO & POS

Factors

Variability and/or lack of adherence to criteria
Provider discretion and variation in determining medical necessity
Clinical effectiveness of the treatment or service
Appropriate level of care
Severity or chronicity of medical surgical (M/S) or Mental Health (MH) / Substance Use Disorder (SUD) conditions

Sources

Internal quality audits
National Accreditation standards
Electronic medical record
Internal and external medical necessity requirements
Certification of Insurance

Permanente Advantage PPO & POS

Factors

Variability and/or lack of adherence to criteria
Provider discretion and variation in determining medical necessity
Clinical effectiveness of the treatment or service
Appropriate level of care
Severity or chronicity of medical surgical (M/S) or Mental Health (MH) / Substance Use Disorder (SUD) conditions

Sources

Internal quality audits
National Accreditation standards
Electronic medical record
Internal and external medical necessity requirements
Certification of Insurance

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage PPO & POS</u></p> <p>The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as American Society of Addiction Medicine (ASAM) for SUD, Milliman Care Guidelines (MCG™) for M/S along with MH and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. This standard applies to the following factors:</p> <ol style="list-style-type: none">1. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity:<ol style="list-style-type: none">a. ASAM criteria developed to replace the 40-50 criteria sets of criteria used, proactively offer clinically sound alternatives to proprietary and variable criteria used by payers who funded or managed care. Coalition of National Clinical Criteria continues to work towards a national set of criteria (ASAM) accepted by providers, payers, managed care, and policy makers to reduce variability and/or adherence to standards of care.b. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards.c. WPATH Standards of Care are international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health, including gender dysphoria.2. Effectiveness of the treatment or service:<ol style="list-style-type: none">a. ASAM criteria encourages moving from seeing diagnosis as sufficient justification for treatment, vs a treatment that is	<p><u>Permanente Advantage PPO & POS</u></p> <p>The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as American Society of Addiction Medicine (ASAM) for SUD, Milliman Care Guidelines (MCG™) for M/S along with MH and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. This standard applies to the following factors:</p> <ol style="list-style-type: none">1. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity:<ol style="list-style-type: none">a. ASAM criteria developed to replace the 40-50 criteria sets of criteria used, proactively offer clinically sound alternatives to proprietary and variable criteria used by payers who funded or managed care. Coalition of National Clinical Criteria continues to work towards a national set of criteria (ASAM) accepted by providers, payers, managed care, and policy makers to reduce variability and/or adherence to standards of care.b. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards.c. WPATH Standards of Care are international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health, including gender dysphoria.2. Effectiveness of the treatment or service:<ol style="list-style-type: none">a. ASAM criteria encourages moving from seeing diagnosis as sufficient justification for treatment, vs a treatment that is

Medical/Surgical

holistic and address multiple needs. Treatment tailored to needs of individual, guided by individual treatment plan in consultation with patient contributes to a significantly to treatment outcomes.

b. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes.

c. WPATH clinical guidance for health professionals to assist TGD people, including gender dysphoria with safe and effective pathways to achieving lasting personal comfort with their gendered selves, with the aim of optimizing their overall health, psychological well-being, and self-fulfillment.

3. Appropriate level of care:

a. ASAM describes treatment as a continuum of care marked by 4 broad levels of care and an early intervention level. Diagnostic admission criteria for levels of care ensures appropriate level of care at admission. Levels of care 0.5 (early intervention) through 4 (medically managed intensive inpatient services). Movement through any level of service(s) the patient's progress in all six dimensions is assessed at regular intervals.

b. MCG care guidelines offer evidence-based criteria, goals, and optimal care pathways to move the patient through the continuum of care. Clinical indications for admission or procedure, continued stay, extended stay, goal length of stay, readmission risk, and discharge planning. Transitions of care guidelines address transitions between care settings. MCG behavioral health level of care comparison charts address 5 levels of care; inpatient, residential, partial hospital, intensive outpatient, and outpatient care.

4. Severity or chronicity of the M/S, MH/BH/SUD conditions:

a. ASAM addresses co-occurring and complexity capability, recognizing that co-occurring mental health is an expectation, not an exception. This has been incorporated into the ASAM patient placement criteria utilized. Matrix is available for matching severity and level of function with type and intensity of service.

b. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.

c. WPATH Standards of Care incorporate the evaluation of coexisting mental health concerns as one of the steps in the assessment and referral process: assess, diagnose, and discuss treatment options for coexisting mental health concerns.

5. Health plan accreditation standards for quality assurance.

URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles

Mental Health/Substance Use Disorder

holistic and address multiple needs. Treatment tailored to needs of individual, guided by individual treatment plan in consultation with patient contributes to a significantly to treatment outcomes.

b. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes.

c. WPATH clinical guidance for health professionals to assist TGD people, including gender dysphoria with safe and effective pathways to achieving lasting personal comfort with their gendered selves, with the aim of optimizing their overall health, psychological well-being, and self-fulfillment.

3. Appropriate level of care:

a. ASAM describes treatment as a continuum of care marked by 4 broad levels of care and an early intervention level. Diagnostic admission criteria for levels of care ensures appropriate level of care at admission. Levels of care 0.5 (early intervention) through 4 (medically managed intensive inpatient services). Movement through any level of service(s) the patient's progress in all six dimensions is assessed at regular intervals.

b. MCG care guidelines offer evidence-based criteria, goals, and optimal care pathways to move the patient through the continuum of care. Clinical indications for admission or procedure, continued stay, extended stay, goal length of stay, readmission risk, and discharge planning. Transitions of care guidelines address transitions between care settings. MCG behavioral health level of care comparison charts address 5 levels of care; inpatient, residential, partial hospital, intensive outpatient, and outpatient care.

4. Severity or chronicity of the M/S, MH/BH/SUD conditions:

a. ASAM addresses co-occurring and complexity capability, recognizing that co-occurring mental health is an expectation, not an exception. This has been incorporated into the ASAM patient placement criteria utilized. Matrix is available for matching severity and level of function with type and intensity of service.

b. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.

c. WPATH Standards of Care incorporate the evaluation of coexisting mental health concerns as one of the steps in the assessment and referral process: assess, diagnose, and discuss treatment options for coexisting mental health concerns.

5. Health plan accreditation standards for quality assurance.

URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles

Medical/Surgical

Mental Health/Substance Use Disorder

into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, provider discretion and variation in determining medical necessity, effectiveness of the treatment or service, appropriate level of care and severity or chronicity of the M/S, MH/SUD conditions.

into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, provider discretion and variation in determining medical necessity, effectiveness of the treatment or service, appropriate level of care and severity or chronicity of the M/S, MH/SUD conditions.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO & POS

1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of Medically Necessary indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, concluding comparable.
2. Market analysis of comparable Plans identified 100% of plans require medical necessity review for all Inpatient services for MH/SUD and M/S, excluding services covered under the Newborns' and Mothers' Health Protection Act of 1996, which is consistent with the KPIC plans.
3. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.
4. Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization Management and Quality Management (UM/QM) minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the UM/QM Committee. Exhibits # 1, #4

Permanente Advantage PPO & POS

1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of Medically Necessary indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, concluding comparable.
2. Market analysis of comparable Plans identified 100% of plans require medical necessity review for all Inpatient services for MH/SUD and M/S, excluding services covered under the Newborns' and Mothers' Health Protection Act of 1996, which is consistent with the KPIC plans.
3. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.
4. Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization Management and Quality Management (UM/QM) minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the UM/QM Committee. Exhibits # 1, #4

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage PPO & POS</u> <ol style="list-style-type: none">1. Permanente Advantage utilizes the same medical necessity review procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how the member can file for an appeal. Medical Necessity requests are reviewed and processed within the regulatory turnaround times.2. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.3. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.4. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #65. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.	<u>Permanente Advantage PPO & POS</u> <ol style="list-style-type: none">1. Permanente Advantage utilizes the same medical necessity review procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how the member can file for an appeal. Medical Necessity requests are reviewed and processed within the regulatory turnaround times.2. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.3. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.4. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #65. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Permanente Advantage PPO & POS

Permanente Advantage's market analysis for the Kaiser Permanente Insurance Company (KPIC) Plans confirmed all comparable plans require Medical Necessity Review for all Out of Network Inpatient services for MH/SUD and M/S. No Medical Necessity Review of emergency services is required. The URAC audit of Utilization Management (UM) policies, procedures, as well as clinical chart review of denial and appeal charts, concluded Permanente Advantage met the URAC accreditation standards and were consistent and comparable as written and in operation for MH/SUD and M/S. Internal audits and inter-rater testing confirmed the competency of selection and utilization of the Medical Necessity criteria for services requiring Medical Necessity Review, as written and in operation; the caveat being that ASAM criteria is utilized for SUD, MCG is utilized for MH and M/S and WPATH Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. Permanente Advantage concludes that as written and in operation, the UM policies, process, factors, and evidentiary standards used to develop and apply Medical Necessity NQTL for all MH/SUD Out of Network Inpatient services is comparable and no more stringent than M/S for the KPIC plans, and therefore are compliant with the final regulation of the Mental Health Parity and Addiction Equity Act.

Benefit Classification 3: Outpatient – In Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage POS:</u> N/A</p> <p><u>Permanente Advantage PPO:</u></p> <ul style="list-style-type: none"> Genetic Laboratory Services High Tech Radiology Services (e.g., MRI's, CTs, PET, Myelogram and Nuclear Medicine scans) Chemotherapy, Radiation, and Infusion Therapy Outpatient Surgery (includes Facility and Professional Charges) Hospital Outpatient (includes Facility and Professional Charges) Medically Necessary Non-Emergency Ambulance Clinical Trials Medically Necessary Dental Services Medically Necessary Durable Medical Equipment (DME) Medically Necessary Pediatric Hearing Aid(s) and services for children through age 18 Home Health Care Hospice Care Outpatient Infertility Services Outpatient Bariatric Surgery (Morbid Obesity Services) Office / Outpatient Administered Drugs Supplies Supplements Prosthetic Devices (External) and Orthotics (P&O) Prosthetic (Internally Implanted) Reconstructive Surgery Rehabilitation Services and Habilitative Services <ul style="list-style-type: none"> Speech Therapy 	<p><u>Permanente Advantage POS:</u> N/A</p> <p><u>Permanente Advantage PPO:</u></p> <ul style="list-style-type: none"> Autism Spectrum Disorder Services <ul style="list-style-type: none"> Applied Behavior Analysis Program (Limited to Children through age 20) Speech Therapy (Limited to Children through age 20) Physical and Occupational Therapy (Limited to Children through age 20): Clinical Trials

Medical/Surgical

- Physical and Occupational Therapy
- Pulmonary Therapy (in-home only)
- Cognitive Therapy for Traumatic Brain Injury
- Multi-disciplinary Rehabilitation
- Outpatient Transplant Services

Mental Health/Substance Use Disorder

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO

Medically Necessary means the service that, in the judgement of KPIC are:

1. Essential for the diagnosis and treatment of Covered Person’s injury or sickness;
2. In accord with generally accepted medical practice and professional recognized standards in the community;
3. Appropriate with regard to standards of medical care;
4. Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;
5. Not provided solely for the convenience of the covered person or the convenience of the healthcare provider or facility;
6. Not primarily custodial care; and
7. Provided at the most appropriate supply, level and facility.

When applied to confinement in a hospital or other facility, this test means the Covered Person needs to be confined to as an inpatient due to the nature of the services rendered or due to the Covered Person’s condition and that the Covered Person cannot receive safe and adequate care through outpatient treatment.

The fact that a physician may prescribe, authorize, or direct a service, does not in itself make it Medically Necessary or covered by the Group Policy

Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person’s health care needs; and (3) manages Your plan of care.

Precertification/Precertified means the required assessment of the necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review Program. If the Medical Review Program determines that the care is not Medically Necessary, Precertification will be denied.

Permanente Advantage PPO

Medically Necessary means the service that, in the judgement of KPIC are:

1. Essential for the diagnosis and treatment of Covered Person’s injury or sickness;
2. In accord with generally accepted medical practice and professional recognized standards in the community;
3. Appropriate with regard to standards of medical care;
4. Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;
5. Not provided solely for the convenience of the covered person or the convenience of the healthcare provider or facility;
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Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person’s health care needs; and (3) manages Your plan of care.

Precertification/Precertified means the required assessment of the necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review Program. If the Medical Review Program determines that the care is not Medically Necessary, Precertification will be denied.

Medical/Surgical

A Covered Person must provide all necessary information to the Medical Review Program in order for it to make its determination. This means the Covered Person may be required to:

1. Obtain a second opinion from a Physician selected from a panel of three or more Physicians designated by the Medical Review Program. If the Covered Person is required to obtain a second medical opinion, it will be provided at no charge to the Covered Person;
2. Participate in the Medical Review Program's case management, Hospital discharge planning and long term case management programs; and/or
3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the requested treatment or service. If the Covered Person or the Covered Person's provider does not provide the necessary information or will not release necessary information, Precertification will be denied.

Permanente Advantage utilizes the same Medical Necessity Review procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. Permanente Advantage applies relevant Utilization Management (UM) criteria to make medical necessity decisions and the relevant UM criteria is applied to MH/SUD and M/S 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 approved by the Utilization and Quality Management Committee. Permanente Advantage utilizes evidence-based criteria/guidelines, such as American Society of Addiction Medicine (ASAM) for SUD, Milliman Care Guidelines (MCG™) for Med/Surg and MH and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. Medical Necessity decisions are based on sound clinical evidence to make utilization decisions and specifies procedures for appropriately applying the criteria. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Medical Necessity cases are reviewed and processed within the regulatory turnaround times.

Qualifications/Training:

Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff

Mental Health/Substance Use Disorder

A Covered Person must provide all necessary information to the Medical Review Program in order for it to make its determination. This means the Covered Person may be required to:

1. Obtain a second opinion from a Physician selected from a panel of three or more Physicians designated by the Medical Review Program. If the Covered Person is required to obtain a second medical opinion, it will be provided at no charge to the Covered Person;
2. Participate in the Medical Review Program's case management, Hospital discharge planning and long term case management programs; and/or
3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the requested treatment or service. If the Covered Person or the Covered Person's provider does not provide the necessary information or will not release necessary information, Precertification will be denied.

Permanente Advantage utilizes the same Medical Necessity Review procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. Permanente Advantage applies relevant Utilization Management (UM) criteria to make medical necessity decisions and the relevant UM criteria is applied to MH/SUD and M/S 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 approved by the Utilization and Quality Management Committee. Permanente Advantage utilizes evidence-based criteria/guidelines, such as American Society of Addiction Medicine (ASAM) for SUD, Milliman Care Guidelines (MCG™) for Med/Surg and MH and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. Medical Necessity decisions are based on sound clinical evidence to make utilization decisions and specifies procedures for appropriately applying the criteria. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Medical Necessity cases are reviewed and processed within the regulatory turnaround times.

Qualifications/Training:

Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff

Medical/Surgical

members responsible for processing medical necessity reviews are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. If any of the attributes indicate that the UM criteria are not appropriate, the case is referred to the UM Physician Reviewer for discussion, and final decision. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

The scope of the Utilization Management Program includes oversight, review, approval, and adoption annually, of the evidenced based criteria to make medical necessity determinations, with involvement of the appropriate and credentialed practitioners. Currently, Permanente Advantage does not modify or revise any nationally developed and recognized treatment guidelines approved and adopted. We apply medical necessity criteria to subclassification and/or sub-classification of benefits that require medical necessity review.

Mental Health/Substance Use Disorder

members responsible for processing medical necessity reviews are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. If any of the attributes indicate that the UM criteria are not appropriate, the case is referred to the UM Physician Reviewer for discussion, and final decision. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

The scope of the Utilization Management Program includes oversight, review, approval, and adoption annually, of the evidenced based criteria to make medical necessity determinations, with involvement of the appropriate and credentialed practitioners. Currently, Permanente Advantage does not modify or revise any nationally developed and recognized treatment guidelines approved and adopted. We apply medical necessity criteria to subclassification and/or sub-classification of benefits that require medical necessity review.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical

Permanente Advantage PPO

Factors

Variability and/or lack of adherence to criteria
Provider discretion and variation in determining medical necessity
Clinical effectiveness of the treatment or service
Severity or chronicity of medical surgical (M/S) or Mental Health (MH) / Substance Use Disorder (SUD) conditions

Sources

Internal quality audits
National Accreditation standards
Electronic medical record
Internal and external medical necessity requirements
Certification of Insurance

Mental Health/Substance Use Disorder

Permanente Advantage PPO

Factors

Variability and/or lack of adherence to criteria
Provider discretion and variation in determining medical necessity
Clinical effectiveness of the treatment or service
Severity or chronicity of medical surgical (M/S) or Mental Health (MH) / Substance Use Disorder (SUD) conditions

Sources

Internal quality audits
National Accreditation standards
Electronic medical record
Internal and external medical necessity requirements
Certification of Insurance

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage PPO</u></p> <p>The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as American Society of Addiction Medicine (ASAM) for SUD, Milliman Care Guidelines (MCG™) for M/S along with MH and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. This standard applies to the following factors:</p> <ol style="list-style-type: none"> 1. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity: <ol style="list-style-type: none"> a. ASAM criteria developed to replace the 40-50 criteria sets of criteria used, proactively offer clinically sound alternatives to proprietary and variable criteria used by payers who funded or managed care. Coalition of National Clinical Criteria continues to work towards a national set of criteria (ASAM) accepted by providers, payers, managed care, and policy makers to reduce variability and/or adherence to standards of care. b. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards. c. WPATH Standards of Care are international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health, including gender dysphoria. 2. Effectiveness of the treatment or service: <ol style="list-style-type: none"> a. ASAM criteria encourages moving from seeing diagnosis as sufficient justification for treatment, vs a treatment that is holistic and address multiple needs. Treatment tailored to needs of individual, guided by individual treatment plan in consultation with patient contributes to a significantly to treatment outcomes. b. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of 	<p><u>Permanente Advantage PPO</u></p> <p>The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as American Society of Addiction Medicine (ASAM) for SUD, Milliman Care Guidelines (MCG™) for M/S along with MH and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. This standard applies to the following factors:</p> <ol style="list-style-type: none"> 1. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity: <ol style="list-style-type: none"> a. ASAM criteria developed to replace the 40-50 criteria sets of criteria used, proactively offer clinically sound alternatives to proprietary and variable criteria used by payers who funded or managed care. Coalition of National Clinical Criteria continues to work towards a national set of criteria (ASAM) accepted by providers, payers, managed care, and policy makers to reduce variability and/or adherence to standards of care. b. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards. c. WPATH Standards of Care are international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health, including gender dysphoria. 2. Effectiveness of the treatment or service: <ol style="list-style-type: none"> a. ASAM criteria encourages moving from seeing diagnosis as sufficient justification for treatment, vs a treatment that is holistic and address multiple needs. Treatment tailored to needs of individual, guided by individual treatment plan in consultation with patient contributes to a significantly to treatment outcomes. b. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of

Medical/Surgical

Mental Health/Substance Use Disorder

care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes.

c. WPATH clinical guidance for health professionals to assist TGD people, including gender dysphoria with safe and effective pathways to achieving lasting personal comfort with their gendered selves, with the aim of optimizing their overall health, psychological well-being, and self-fulfillment.

3. Severity or chronicity of the M/S, MH/BH/SUD conditions:

a. ASAM addresses co-occurring and complexity capability, recognizing that co-occurring mental health is an expectation, not an exception. This has been incorporated into the ASAM patient placement criteria utilized. Matrix is available for matching severity and level of function with type and intensity of service.

b. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.

c. WPATH Standards of Care incorporate the evaluation of coexisting mental health concerns as one of the steps in the assessment and referral process: assess, diagnose, and discuss treatment options for coexisting mental health concerns.

4. Health plan accreditation standards for quality assurance.

URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, provider discretion and variation in determining medical necessity, effectiveness of the treatment or service and severity or chronicity of the M/S, MH/SUD conditions.

care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes.

c. WPATH clinical guidance for health professionals to assist TGD people, including gender dysphoria with safe and effective pathways to achieving lasting personal comfort with their gendered selves, with the aim of optimizing their overall health, psychological well-being, and self-fulfillment.

3. Severity or chronicity of the M/S, MH/BH/SUD conditions:

a. ASAM addresses co-occurring and complexity capability, recognizing that co-occurring mental health is an expectation, not an exception. This has been incorporated into the ASAM patient placement criteria utilized. Matrix is available for matching severity and level of function with type and intensity of service.

b. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.

c. WPATH Standards of Care incorporate the evaluation of coexisting mental health concerns as one of the steps in the assessment and referral process: assess, diagnose, and discuss treatment options for coexisting mental health concerns.

4. Health plan accreditation standards for quality assurance.

URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, provider discretion and variation in determining medical necessity, effectiveness of the treatment or service and severity or chronicity of the M/S, MH/SUD conditions.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO

Permanente Advantage PPO

Medical/Surgical

Mental Health/Substance Use Disorder

1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of Medically Necessary indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, concluding comparable.
2. Market analysis of comparable Plans identified 100% of plans require medical necessity review for selected M/S Outpatient services which is comparable with KPIC M/S medical necessity reviews. Additionally, comparable Plans identified 33% require medical necessity review for Outpatient MH/SUD Intensive Outpatient Program (IOP) and 100% for Partial Hospitalization Programs (PHP) services, wherein KPIC plans do not require medical necessity review for IOP or PHP.
3. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.
4. Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization Management and Quality Management (UM/QM) minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may different, but they go through the same approval process at the UM/QM Committee. Exhibits # 1, #4

1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of Medically Necessary indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, concluding comparable.
2. Market analysis of comparable Plans identified 100% of plans require medical necessity review for selected M/S Outpatient services which is comparable with KPIC M/S medical necessity reviews. Additionally, comparable Plans identified 33% require medical necessity review for Outpatient MH/SUD Intensive Outpatient Program (IOP) and 100% for Partial Hospitalization Programs (PHP) services, wherein KPIC plans do not require medical necessity review for IOP or PHP.
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4. Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization Management and Quality Management (UM/QM) minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may different, but they go through the same approval process at the UM/QM Committee. Exhibits # 1, #4

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO

1. Permanente Advantage utilizes the same medical necessity review procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both

Permanente Advantage PPO

1. Permanente Advantage utilizes the same medical necessity review procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both

Medical/Surgical

verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how the member can file for an appeal. Medical Necessity requests are reviewed and processed within the regulatory turnaround times.

2. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.
3. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.
4. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6
5. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.

Mental Health/Substance Use Disorder

verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how the member can file for an appeal. Medical Necessity requests are reviewed and processed within the regulatory turnaround times.

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Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Permanente Advantage PPO

Permanente Advantage's market analysis for the KPIC Plans confirmed all comparable plans require Medical Necessity Review for selected In Network Outpatient M/S services, yet KPIC plans were less restrictive, not requiring Medical Necessity Review of Outpatient MH/SUD: Partial Hospitalization or Intensive Outpatient Programs. No Medical Necessity Review of emergency services is required. The URAC internal audit of Utilization Management policies, procedures, and clinical chart review of denial and appeal charts concluded Permanente Advantage met the URAC accreditation standards and were consistent and comparable as written and in operation for MH/SUD and M/S. Internal audits and inter-rater testing confirmed the competency of selection and utilization of the Medical Necessity criteria for services requiring Medical Necessity Review, as written and in operation; the caveat being that ASAM criteria is utilized for SUD, MCG is utilized for MH and M/S and WPATH Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. Permanente Advantage concludes that as written and in operation, the UM policies, process, factors, and evidentiary standards used to develop and apply Medical Necessity NQTL for all In Network MH/SUD Outpatient services is comparable and no more stringent than M/S for the KPIC Plans, and therefore are compliant with the final regulation of the Mental Health Parity and Addiction Equity Act.

Benefit Classification 4: Outpatient – Out-of-Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage POS:</u></p> <ul style="list-style-type: none"> Genetic Laboratory Services High Tech Radiology Services (e.g., MRI's, CTs, PET, Myelogram and Nuclear Medicine scans) Chemotherapy, Radiation, and Infusion Therapy Outpatient Surgery (includes Facility and Professional Charges) Hospital Outpatient (includes Facility and Professional Charges) Clinical Trials Medically Necessary Durable Medical Equipment (DME) Medically Necessary Pediatric Hearing Aid(s) and services for children through age 18 Home Health Care Hospice Care Office / Outpatient Administered Drugs Supplies Supplements Prosthetic Devices (External) and Orthotics (P&O) Prosthetic (Internally Implanted) Rehabilitation Services <ul style="list-style-type: none"> Speech Therapy Physical and Occupational Therapy <p><u>Permanente Advantage PPO:</u></p> <ul style="list-style-type: none"> Genetic Laboratory Services High Tech Radiology Services (e.g., MRI's, CTs, PET, Myelogram and Nuclear Medicine scans): Chemotherapy, Radiation, and Infusion Therapy Outpatient Surgery (includes Facility and Professional Charges) Hospital Outpatient (includes Facility and Professional Charges) Medically Necessary Non-Emergency Ambulance Clinical Trials Medically Necessary Dental Services Medically Necessary Durable Medical Equipment (DME) Medically Necessary Pediatric Hearing Aid(s) and services for children through age 18 Home Health Care Hospice Care Outpatient Infertility Services Outpatient Bariatric Surgery (Morbid Obesity Services) Office / Outpatient Administered Drugs Supplies Supplements Prosthetic Devices (External) and Orthotics (P&O) Prosthetic (Internally Implanted) 	<p><u>Permanente Advantage POS:</u></p> <ul style="list-style-type: none"> Autism Spectrum Disorder Services <ul style="list-style-type: none"> Applied Behavior Analysis Program (Limited to Children through age 20) Speech Therapy (Limited to Children through age 20) Physical and Occupational Therapy (Limited to Children through age 20) Clinical Trials <p><u>Permanente Advantage PPO:</u></p> <ul style="list-style-type: none"> Autism Spectrum Disorder Services <ul style="list-style-type: none"> Applied Behavior Analysis Program (Limited to Children through age 20) Speech Therapy (Limited to Children through age 20) Physical and Occupational Therapy (Limited to Children through age 20) Clinical Trials

Medical/Surgical

- Reconstructive Surgery
- Rehabilitation Services and Habilitative Services
 - Speech Therapy
 - Physical and Occupational Therapy
 - Pulmonary Therapy (in-home only)
 - Cognitive Therapy for Traumatic Brain Injury
 - Multi-disciplinary Rehabilitation
- Outpatient Transplant Services

Mental Health/Substance Use Disorder

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO & POS

Medically Necessary means the service that, in the judgement of KPIC are:

1. Essential for the diagnosis and treatment of Covered Person’s injury or sickness;
2. In accord with generally accepted medical practice and professional recognized standards in the community;
3. Appropriate with regard to standards of medical care;
4. Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;
5. Not provided solely for the convenience of the covered person or the convenience of the healthcare provider or facility;
6. Not primarily custodial care; and
7. Provided at the most appropriate supply, level and facility.

When applied to confinement in a hospital or other facility, this test means the Covered Person needs to be confined to as an inpatient due to the nature of the services rendered or due to the Covered Person’s condition and that the Covered Person cannot receive safe and adequate care through outpatient treatment.

The fact that a physician may prescribe, authorize, or direct a service, does not in itself make it Medically Necessary or covered by the Group Policy

Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person’s health care needs; and (3) manages Your plan of care.

Precertification/Precertified means the required assessment of the necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review

Permanente Advantage PPO & POS

Medically Necessary means the service that, in the judgement of KPIC are:

1. Essential for the diagnosis and treatment of Covered Person’s injury or sickness;
2. In accord with generally accepted medical practice and professional recognized standards in the community;
3. Appropriate with regard to standards of medical care;
4. Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;
5. Not provided solely for the convenience of the covered person or the convenience of the healthcare provider or facility;
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Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person’s health care needs; and (3) manages Your plan of care.

Precertification/Precertified means the required assessment of the necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review

Medical/Surgical

Program. If the Medical Review Program determines that the care is not Medically Necessary, Precertification will be denied.

A Covered Person must provide all necessary information to the Medical Review Program in order for it to make its determination. This means the Covered Person may be required to:

1. Obtain a second opinion from a Physician selected from a panel of three or more Physicians designated by the Medical Review Program. If the Covered Person is required to obtain a second medical opinion, it will be provided at no charge to the Covered Person;
2. Participate in the Medical Review Program's case management, Hospital discharge planning and long term case management programs; and/or
3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the requested treatment or service. If the Covered Person or the Covered Person's provider does not provide the necessary information or will not release necessary information, Precertification will be denied.

Permanente Advantage utilizes the same Medical Necessity Review procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. Permanente Advantage applies relevant Utilization Management (UM) criteria to make medical necessity decisions and the relevant UM criteria is applied to MH/SUD and M/S 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 approved by the Utilization and Quality Management Committee. Permanente Advantage utilizes evidence-based criteria/guidelines, such as American Society of Addiction Medicine (ASAM) for SUD, Milliman Care Guidelines (MCG™) for Med/Surg and MH and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. Medical Necessity decisions are based on sound clinical evidence to make utilization decisions and specifies procedures for appropriately applying the criteria. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Medical Necessity cases are reviewed and processed within the regulatory turnaround times.

Qualifications/Training:

Mental Health/Substance Use Disorder

Program. If the Medical Review Program determines that the care is not Medically Necessary, Precertification will be denied.

A Covered Person must provide all necessary information to the Medical Review Program in order for it to make its determination. This means the Covered Person may be required to:

1. Obtain a second opinion from a Physician selected from a panel of three or more Physicians designated by the Medical Review Program. If the Covered Person is required to obtain a second medical opinion, it will be provided at no charge to the Covered Person;
2. Participate in the Medical Review Program's case management, Hospital discharge planning and long term case management programs; and/or
3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the requested treatment or service. If the Covered Person or the Covered Person's provider does not provide the necessary information or will not release necessary information, Precertification will be denied.

Permanente Advantage utilizes the same Medical Necessity Review procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. Permanente Advantage applies relevant Utilization Management (UM) criteria to make medical necessity decisions and the relevant UM criteria is applied to MH/SUD and M/S 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 approved by the Utilization and Quality Management Committee. Permanente Advantage utilizes evidence-based criteria/guidelines, such as American Society of Addiction Medicine (ASAM) for SUD, Milliman Care Guidelines (MCG™) for Med/Surg and MH and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. Medical Necessity decisions are based on sound clinical evidence to make utilization decisions and specifies procedures for appropriately applying the criteria. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Medical Necessity cases are reviewed and processed within the regulatory turnaround times.

Qualifications/Training:

Medical/Surgical

Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing medical necessity reviews are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. If any of the attributes indicate that the UM criteria are not appropriate, the case is referred to the UM Physician Reviewer for discussion, and final decision. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

The scope of the Utilization Management Program includes oversight, review, approval, and adoption annually, of the evidenced based criteria to make medical necessity determinations, with involvement of the appropriate and credentialed practitioners. Currently, Permanente Advantage does not modify or revise any nationally developed and recognized treatment guidelines approved and adopted. We apply medical necessity criteria to subclassification and/or subclassification of benefits that require medical necessity review.

Mental Health/Substance Use Disorder

Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing medical necessity reviews are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. If any of the attributes indicate that the UM criteria are not appropriate, the case is referred to the UM Physician Reviewer for discussion, and final decision. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

The scope of the Utilization Management Program includes oversight, review, approval, and adoption annually, of the evidenced based criteria to make medical necessity determinations, with involvement of the appropriate and credentialed practitioners. Currently, Permanente Advantage does not modify or revise any nationally developed and recognized treatment guidelines approved and adopted. We apply medical necessity criteria to subclassification and/or subclassification of benefits that require medical necessity review.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical

Permanente Advantage PPO & POS

Factors

Variability and/or lack of adherence to criteria
Provider discretion and variation in determining medical necessity
Clinical effectiveness of the treatment or service
Severity or chronicity of medical surgical (M/S) or Mental Health (MH) / Substance Use Disorder (SUD) conditions

Sources

Internal quality audits
National Accreditation standards
Electronic medical record
Internal and external medical necessity requirements
Certification of Insurance

Mental Health/Substance Use Disorder

Permanente Advantage PPO & POS

Factors

Variability and/or lack of adherence to criteria
Provider discretion and variation in determining medical necessity
Clinical effectiveness of the treatment or service
Severity or chronicity of medical surgical (M/S) or Mental Health (MH) / Substance Use Disorder (SUD) conditions

Sources

Internal quality audits
National Accreditation standards
Electronic medical record
Internal and external medical necessity requirements
Certification of Insurance

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor

identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage PPO & POS</u></p> <p>The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as American Society of Addiction Medicine (ASAM) for SUD, Milliman Care Guidelines (MCG™) for M/S along with MH and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. This standard applies to the following factors:</p> <ol style="list-style-type: none"> 1. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity: <ol style="list-style-type: none"> a. ASAM criteria developed to replace the 40-50 criteria sets of criteria used, proactively offer clinically sound alternatives to proprietary and variable criteria used by payers who funded or managed care. Coalition of National Clinical Criteria continues to work towards a national set of criteria (ASAM) accepted by providers, payers, managed care, and policy makers to reduce variability and/or adherence to standards of care. b. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards. c. WPATH Standards of Care are international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health, including gender dysphoria. 2. Effectiveness of the treatment or service: <ol style="list-style-type: none"> a. ASAM criteria encourages moving from seeing diagnosis as sufficient justification for treatment, vs a treatment that is holistic and address multiple needs. Treatment tailored to needs of individual, guided by individual treatment plan in consultation with patient contributes to a significantly to treatment outcomes. 	<p><u>Permanente Advantage PPO & POS</u></p> <p>The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as American Society of Addiction Medicine (ASAM) for SUD, Milliman Care Guidelines (MCG™) for M/S along with MH and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. This standard applies to the following factors:</p> <ol style="list-style-type: none"> 1. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity: <ol style="list-style-type: none"> a. ASAM criteria developed to replace the 40-50 criteria sets of criteria used, proactively offer clinically sound alternatives to proprietary and variable criteria used by payers who funded or managed care. Coalition of National Clinical Criteria continues to work towards a national set of criteria (ASAM) accepted by providers, payers, managed care, and policy makers to reduce variability and/or adherence to standards of care. b. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards. c. WPATH Standards of Care are international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health, including gender dysphoria. 2. Effectiveness of the treatment or service: <ol style="list-style-type: none"> a. ASAM criteria encourages moving from seeing diagnosis as sufficient justification for treatment, vs a treatment that is holistic and address multiple needs. Treatment tailored to needs of individual, guided by individual treatment plan in consultation with patient contributes to a significantly to treatment outcomes.

Medical/Surgical

Mental Health/Substance Use Disorder

- b. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes.
- c. WPATH clinical guidance for health professionals to assist TGD people, including gender dysphoria with safe and effective pathways to achieving lasting personal comfort with their gendered selves, with the aim of optimizing their overall health, psychological well-being, and self-fulfillment.
- 3. Severity or chronicity of the M/S, MH/BH/SUD conditions:
 - a. ASAM addresses co-occurring and complexity capability, recognizing that co-occurring mental health is an expectation, not an exception. This has been incorporated into the ASAM patient placement criteria utilized. Matrix is available for matching severity and level of function with type and intensity of service.
 - b. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.
 - c. WPATH Standards of Care incorporate the evaluation of coexisting mental health concerns as one of the steps in the assessment and referral process: assess, diagnose, and discuss treatment options for coexisting mental health concerns.
- 4. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, provider discretion and variation in determining medical necessity, effectiveness of the treatment or service and severity or chronicity of the M/S, MH/SUD conditions.

- b. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes.
- c. WPATH clinical guidance for health professionals to assist TGD people, including gender dysphoria with safe and effective pathways to achieving lasting personal comfort with their gendered selves, with the aim of optimizing their overall health, psychological well-being, and self-fulfillment.
- 3. Severity or chronicity of the M/S, MH/BH/SUD conditions:
 - a. ASAM addresses co-occurring and complexity capability, recognizing that co-occurring mental health is an expectation, not an exception. This has been incorporated into the ASAM patient placement criteria utilized. Matrix is available for matching severity and level of function with type and intensity of service.
 - b. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.
 - c. WPATH Standards of Care incorporate the evaluation of coexisting mental health concerns as one of the steps in the assessment and referral process: assess, diagnose, and discuss treatment options for coexisting mental health concerns.
- 4. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, provider discretion and variation in determining medical necessity, effectiveness of the treatment or service and severity or chronicity of the M/S, MH/SUD conditions.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO & POS

1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of Medically Necessary indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, concluding comparable.
2. Market analysis of comparable Plans identified 100% of plans require medical necessity review for selected M/S Outpatient services which is comparable with KPIC M/S medical necessity reviews. Additionally, comparable Plans identified 33% require medical necessity review for Outpatient MH/SUD Intensive Outpatient Program (IOP) and 100% for Partial Hospitalization Programs (PHP) services, wherein KPIC plans do not require medical necessity review for IOP or PHP.
3. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.
4. Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization Management and Quality Management (UM/QM) minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may different, but they go through the same approval process at the UM/QM Committee. Exhibits # 1, #4

Permanente Advantage PPO & POS

1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of Medically Necessary indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, concluding comparable.
2. Market analysis of comparable Plans identified 100% of plans require medical necessity review for selected M/S Outpatient services which is comparable with KPIC M/S medical necessity reviews. Additionally, comparable Plans identified 33% require medical necessity review for Outpatient MH/SUD Intensive Outpatient Program (IOP) and 100% for Partial Hospitalization Programs (PHP) services, wherein KPIC plans do not require medical necessity review for IOP or PHP.
3. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.
4. Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization Management and Quality Management (UM/QM) minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may different, but they go through the same approval process at the UM/QM Committee. Exhibits # 1, #4

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO & POS

1. Permanente Advantage utilizes the same medical necessity review procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided

Permanente Advantage PPO & POS

1. Permanente Advantage utilizes the same medical necessity review procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided

Medical/Surgical

to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how the member can file for an appeal. Medical Necessity requests are reviewed and processed within the regulatory turnaround times.

2. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.
3. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.
4. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6
5. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.

Mental Health/Substance Use Disorder

to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how the member can file for an appeal. Medical Necessity requests are reviewed and processed within the regulatory turnaround times.

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Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Permanente Advantage PPO & POS

Permanente Advantage's market analysis for the KPIC Plans confirmed all comparable plans require Medical Necessity Review for selected Out of Network Outpatient M/S services, yet KPIC plans were less restrictive, not requiring Medical Necessity Review of Outpatient MH/SUD: Partial Hospitalization or Intensive Outpatient Programs. No Medical Necessity Review of emergency services is required. The URAC audit of Permanente Advantage's Utilization Management (UM) policies, procedures, and clinical chart review of denial and appeal charts concluded Permanente Advantage met the URAC accreditation standards and were consistent and comparable as written and in operation for MH/SUD and M/S. Internal audits and inter-rater testing confirmed the competency of selection and utilization of the Medical Necessity criteria for services requiring Medical Necessity Review, as written and in operation; the caveat being that ASAM criteria is utilized for SUD, MCG is utilized for MH and M/S and WPATH Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. Permanente Advantage concludes that as written and in operation, the UM policies, process, factors, and evidentiary standards used to develop and apply Medical Necessity NQTL for all Out of Network MH/SUD Outpatient services is comparable and no more stringent than M/S for the KPIC plans, and therefore are compliant with the final regulation of the Mental Health Parity and Addiction Equity Act.

Benefit Classification 5: Emergency Services

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – Pre-certification is not required for Emergency Services	N/A – Pre-certification is not required for Emergency Services

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – Pre-certification is not required for Emergency Services	N/A – Pre-certification is not required for Emergency Services

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – Pre-certification is not required for Emergency Services	N/A – Pre-certification is not required for Emergency Services

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – Pre-certification is not required for Emergency Services	N/A – Pre-certification is not required for Emergency Services

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – Pre-certification is not required for Emergency Services	N/A – Pre-certification is not required for Emergency Services

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – Pre-certification is not required for Emergency Services	N/A – Pre-certification is not required for Emergency Services

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion
N/A – Pre-certification is not required for Emergency Services

Benefit Classification 6: Pharmacy Services

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
Pharmacy POS & PPO Prescription drugs (self-administered)	Pharmacy POS & PPO Prescription drugs (self-administered)

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>POS Pharmacy</u> Criteria-based consultation (CBC) drugs are drugs for which therapeutic alternatives or approved generic equivalent(s) are available. For a CBC drug to be authorized for coverage on the prescription drug benefit, its use must meet defined medical necessity criteria.</p> <p><u>PPO Pharmacy</u> The Medical Necessity NQTL analyzes the factors, sources, and evidentiary standards applied by the plan to create the criteria or guidelines used to perform benefit authorizations. Medical necessity is defined as health care and services that are necessary to address:</p> <ol style="list-style-type: none">1. The prevention, diagnosis, and treatment of a patient’s disease, condition, and/or disorder that result in health impairments and/or disability.2. The ability for a patient to achieve age-appropriate growth and development.3. The ability for a patient to attain, maintain, or regain functional capacity. <p>MedImpact (PBM) does not make determinations of Medical Necessity in the state of Colorado. The treating physician makes a medical necessity determination that the prescribed medication is indicated for the patient’s clinical diagnosis. A MedImpact physician or pharmacist performs benefit authorizations using clinical judgment to determine whether the plan coverage rules are met for the prescribed drug.</p>	<p><u>POS Pharmacy</u> Criteria-based consultation (CBC) drugs are drugs for which therapeutic alternatives or approved generic equivalent(s) are available. For a CBC drug to be authorized for coverage on the prescription drug benefit, its use must meet defined medical necessity criteria.</p> <p><u>PPO Pharmacy</u> The Medical Necessity NQTL analyzes the factors, sources, and evidentiary standards applied by the plan to create the criteria or guidelines used to perform benefit authorizations. Medical necessity is defined as health care and services that are necessary to address:</p> <ol style="list-style-type: none">1. The prevention, diagnosis, and treatment of a patient’s disease, condition, and/or disorder that result in health impairments and/or disability.2. The ability for a patient to achieve age-appropriate growth and development.3. The ability for a patient to attain, maintain, or regain functional capacity. <p>MedImpact (PBM) does not make determinations of Medical Necessity in the state of Colorado. The treating physician makes a medical necessity determination that the prescribed medication is indicated for the patient’s clinical diagnosis. A MedImpact physician or pharmacist performs benefit authorizations using clinical judgment to determine whether the plan coverage rules are met for the prescribed drug.</p>

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
<u>POS Pharmacy</u>	<u>POS Pharmacy</u>

Medical/Surgical

Mental Health/Substance Use Disorder

The use of Criteria Based Consultation drugs may be restricted to one or more specialty groups. This restriction may be due to:

- Potential for significant safety concerns.
- High potential for adverse effects.
- High cost-to-benefit ratio in conjunction with other clinical concerns.
- High potential for abuse

PPO Pharmacy

Medical necessity guidelines are developed for all drugs that are subject to formulary limits, including Prior Authorization, Step Therapy, Quantity Limits, and Age Limits.

Factors for determining which drugs to subject to PA and Step Therapy are set forth in the PA and Step Therapy NQTL analyses. Quantity Limits and Age Limits are developed in accordance with FDA approval and product labeling.

The use of Criteria Based Consultation drugs may be restricted to one or more specialty groups. This restriction may be due to:

- Potential for significant safety concerns.
- High potential for adverse effects.
- High cost-to-benefit ratio in conjunction with other clinical concerns.
- High potential for abuse

PPO Pharmacy

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

Medical necessity guidelines are developed for all drugs that are subject to formulary limits, including Prior Authorization, Step Therapy, Quantity Limits, and Age Limits.

Factors for determining which drugs to subject to PA and Step Therapy are set forth in the PA and Step Therapy NQTL analyses. Quantity Limits and Age Limits are developed in accordance with FDA approval and product labeling.

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical

Mental Health/Substance Use Disorder

POS Pharmacy:

The RFTC uses both internal and external resources, including Specialty Department input, Food and Drug Administration recommendations, and clinical trials published in the medical literature to guide them in the creation of prescribing criteria.

PPO Pharmacy:

Medical necessity guidelines are developed for all drugs that are subject to PA.

POS Pharmacy:

The RFTC uses both internal and external resources, including Specialty Department input, Food and Drug Administration recommendations, and clinical trials published in the medical literature to guide them in the creation of prescribing criteria.

PPO Pharmacy:

Medical/Surgical

Sources consulted by MedImpact for the development of each PA guideline include:

- FDA approval
- Peer-reviewed medical literature, where at least 2 peer-reviewed journal articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses for humans as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal. When evaluating this literature, reviewers will consider (among other things) the following:
 - (1) Whether the clinical characteristics of the beneficiary and the cancer are adequately represented in the published evidence.
 - (2) Whether the administered chemotherapy regimen is adequately represented in the published evidence.
 - (3) Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients.
 - (4) Whether the study is appropriate to address the clinical question. The contractor will consider:
 - (5) Whether the experimental design, in light of the drugs and conditions under investigation, is appropriate to address the investigative question. (For example, in some clinical studies, it may be unnecessary or not feasible to use randomization, double blind trials, placebos, or crossover.).
 - (a) That non-randomized clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs; and
 - (b) That case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.
- Therapy recommendations listed in guidelines issued by leading nationally recognized associations and agencies, such as the CDC (Centers for Disease Control and Prevention), the AASLD (American Association for the Study of Liver Diseases) or IDSA guidelines (Infectious Diseases Society of America). The reviewer will be looking for recommended regimens based on the patient's diagnosis and clinical characteristics. In

Mental Health/Substance Use Disorder

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

Medical necessity guidelines are developed for all drugs that are subject to PA.

Sources consulted by MedImpact for the development of each PA guideline include:

- FDA approval
- Peer-reviewed medical literature, where at least 2 peer-reviewed journal articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses for humans as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal. When evaluating this literature, reviewers will consider (among other things) the following:
 - (1) Whether the clinical characteristics of the beneficiary and the cancer are adequately represented in the published evidence.
 - (2) Whether the administered chemotherapy regimen is adequately represented in the published evidence.
 - (3) Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients.
 - (4) Whether the study is appropriate to address the clinical question. The contractor will consider:
 - (5) Whether the experimental design, in light of the drugs and conditions under investigation, is appropriate to address the investigative question. (For example, in some clinical studies, it may be unnecessary or not feasible to use randomization, double blind trials, placebos, or crossover.).
 - (a) That non-randomized clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs; and
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- Therapy recommendations listed in guidelines issued by leading nationally recognized associations and agencies, such as the CDC (Centers for Disease Control and Prevention), the

Medical/Surgical	Mental Health/Substance Use Disorder
<p>addition, the reviewer will consider the strength of the rating for the particular treatment, should that be available.</p> <ul style="list-style-type: none"> • Drug compendia in common use, including: <ol style="list-style-type: none"> (1) American Hospital Formulary Service-Drug Information (AHFS-DI) (2) Clinical Pharmacology (3) National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium (4) TruvenHealth Analytics Micromedex DrugDex (5) Wolters Kluwer Lexi-Drugs • Other authoritative medical sources. • Expert opinion where necessary 	<p>AASLD (American Association for the Study of Liver Diseases) or IDSA guidelines (Infectious Diseases Society of America). The reviewer will be looking for recommended regimens based on the patient's diagnosis and clinical characteristics. In addition, the reviewer will consider the strength of the rating for the particular treatment, should that be available.</p> <ul style="list-style-type: none"> • Drug compendia in common use, including: <ol style="list-style-type: none"> (1) American Hospital Formulary Service-Drug Information (AHFS-DI) (2) Clinical Pharmacology (3) National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium (4) TruvenHealth Analytics Micromedex DrugDex (5) Wolters Kluwer Lexi-Drugs • Other authoritative medical sources. • Expert opinion where necessary

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>POS Pharmacy</u></p> <p>A pharmacist 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. Once the review has been completed the drug is then added for use as medical necessity criteria for either behavioral/medical surgical drugs. Criteria are reviewed at least annually or when changes are made, and previous criteria are archived.</p> <p><u>PPO Pharmacy</u></p>	<p><u>POS Pharmacy</u></p> <p>A pharmacist 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. Once the review has been completed the drug is then added for use as medical necessity criteria for either behavioral/medical surgical drugs. Criteria are reviewed at least annually or when changes are made, and previous criteria are archived.</p> <p><u>PPO Pharmacy</u></p>

Medical/Surgical

The MedImpact PA guideline development process follows the following steps:

- (1) A PA guideline is developed whenever it is determined that a new drug or drug class is appropriate to subject to PA. The need for a proposed PA guideline is agreed upon by the Medical Director, the Director of Drug Information, and the Director of Formulary Administration and Strategy and is reflective of a comprehensive review of drug safety, cost, and disease management strategy.
- (2) Clinical criteria recommendations are developed by a designated Drug Information Pharmacist using an evidence-based process taking into consideration published peer reviewed medical literature and national treatment guidelines whenever available.
- (3) If a guideline appears to be controversial or is deemed to need specialized input, independent expert medical specialty reviewer input is routinely requested
- (4) After internal and independent external (if necessary) review is complete, the guideline is presented to the MedImpact P&T Committee in conjunction with the presentation of the medication or medication class monograph for final approval.
- (5) PA Guidelines are developed by a designated Clinical PA Pharmacist according to clinical criteria approved at the quarterly P&T Committee meeting.
 - a. An interim PA per label (e.g., FDA approved indication, dosing limits, etc.) may be applied and developed at drug launch prior to the P&T Committee meeting upon approval by the P&T chairman and co-chairperson or their designee. The MedImpact P&T Committee is chaired by the VP/ Medical Director of MedImpact or, in cases of unavailability, a qualified physician committee member as his/her designee. The Director of Drug Information serves as Co-Chairperson of the Committee.

The duties of Co-Chair may be delegated to the Manager of Drug Information. The P&T Committee is comprised of at least ten, but not more than fifteen voting members, all of whom are healthcare professionals with unrestricted licenses to practice in their professions in a state or territory of the United States, and whose training and expertise materially contributes to the goals of the P&T Committee; all of whom are physicians or pharmacists, and a majority of whom are actively practicing in their

Mental Health/Substance Use Disorder

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

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Medical/Surgical

Mental Health/Substance Use Disorder

professions. A maximum of two MedImpact employees may be voting members. The P&T Committee includes at least one actively practicing physician and at least one actively practicing pharmacist who are experts, defined as a person who has training and/or ongoing clinical practice experience, in the care of the elderly or disabled persons and who are not employees of MedImpact. The P&T Committee includes at least one: (a) licensed psychiatrist, or (b) licensed physician who is an expert, defined as a person who has training and/or ongoing clinical practice experience, in the treatment of substance abuse disorders.

Sources consulted by MedImpact for the development of each PA guideline include:

- FDA approval
- Peer-reviewed medical literature, where at least 2 peer-reviewed journal articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses for humans as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal. When evaluating this literature, reviewers will consider (among other things) the following:
 - (1) Whether the clinical characteristics of the beneficiary and the cancer are adequately represented in the published evidence.

territory of the United States, and whose training and expertise materially contributes to the goals of the P&T Committee; all of whom are physicians or pharmacists, and a majority of whom are actively practicing in their professions. A maximum of two MedImpact employees may be voting members. The P&T Committee includes at least one actively practicing physician and at least one actively practicing pharmacist who are experts, defined as a person who has training and/or ongoing clinical practice experience, in the care of the elderly or disabled persons and who are not employees of MedImpact. The P&T Committee includes at least one: (a) licensed psychiatrist, or (b) licensed physician who is an expert, defined as a person who has training and/or ongoing clinical practice experience, in the treatment of substance abuse disorders.

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 - (1) Whether the clinical characteristics of the beneficiary and the cancer are adequately represented in the published evidence.

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical

Mental Health/Substance Use Disorder

POS Pharmacy

POS Pharmacy

Medical/Surgical

The Criteria Based Consultation (CBC) medications for both medical/surgical and mental health/SUD where found it follow the same regional treatment guidelines that are informed by published clinical evidence. To ensure criteria are used correctly and consistently CBC medication are reviewed, at random as a part of the Inter-Rater Reliability (IRR) annual process.

PPO Pharmacy

The comparative analysis conducted included review of the medical necessity review process for medications included within the formulary that contain a prior authorization parameter. MedImpact utilizes the same processes for application of Medical Necessity criteria, PA, and other forms of Utilization Management (UM) for both MH/SUD and M/S prescription drug benefits. All processes rely on evidence-based clinical guidelines to determine whether the requested medication is medically necessary. The same methodology is utilized to develop prior authorization criteria and utilization management parameters. Thus, the NQTLs that are in place with respect to medical necessity criteria for MH/SUD benefits are the same and applied no more stringently than those applied to M/S benefits. Inter-rater reliability (IRR) is conducted to determine whether PA guidelines are being applied consistently by all reviewers.

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Mental Health/Substance Use Disorder

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PPO Pharmacy

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Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

POS Pharmacy

In review of the parity analysis above there appears to be a comparable development process and operational implementation of medical necessity criteria for both medical/surgical and behavioral health drugs.

Summary Conclusion

PPO Pharmacy

The processes, strategies, evidentiary standards, and other factors used to develop PA guidelines for prescription drugs are the same, as written and in operation, for both M/S and MH/SUD drugs, and do not differ based on the indication or diagnosis being treated. Therefore, by definition, these processes, strategies, evidentiary standards, and other factors comply with mental health and substance use disorder parity requirements.

Kaiser Permanente Insurance Company (KPIC) Georgia Region

Non-Quantitative Treatment Limits (NQTL)



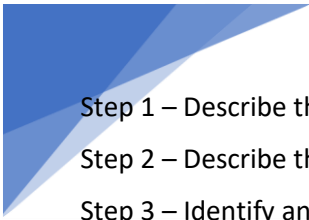
NQTL: Network Provider Reimbursement Rates (PPO/POS)

Last Reviewed: May 12, 2023



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Benefits		Classifications					
Is NQTL applied to Medical/Surgical benefits?	Is NQTL applied to Mental Health/Substance Use Disorder benefits?	Is NQTL applied to In Network Inpatient classification ?	Is NQTL applied to Out of Network Inpatient classification ?	Is NQTL applied to In Network Outpatient classification ?	Is NQTL applied to Out of Network Outpatient classification ?	Is NQTL applied to Emergency classification ?	Is NQTL applied to Prescription classification ?
Y	Y	Y	Y	Y	Y	Y	y

Benefit Classification 1: Inpatient – In Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
<p>PPO</p> <ul style="list-style-type: none"> INPATIENT SERVICES <ul style="list-style-type: none"> Hospital (includes Facility and Professional Charges) Maternity Services (includes Facility and Professional Charges) REHABILITATION SERVICES AND HABILITATIVE SERVICES <ul style="list-style-type: none"> Inpatient <ul style="list-style-type: none"> Multi-disciplinary Rehabilitation in a Comprehensive Rehabilitation Facility Skilled Nursing Facility Transplants <p>POS N/A</p>	<p>PPO</p> <ul style="list-style-type: none"> MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES <ul style="list-style-type: none"> Inpatient <ul style="list-style-type: none"> Hospital (includes Facility and Professional Charges) <p>POS N/A</p>

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
Kaiser Permanente Insurance Company (KPIC) offers the Dual Choice Plan in Georgia. This plan is composed of an In-Network PPO plan and Out-of-Network PPO plan. The Preferred Provider Organization (PPO) In-Network plan is	Kaiser Permanente Insurance Company (KPIC) offers the Dual Choice Plan in Georgia. This plan is composed of an In-Network PPO plan and Out-of-Network PPO plan. The Preferred Provider Organization (PPO) In-Network plan is

Medical/Surgical

comprised of Kaiser Providers and Contracted Providers and also offers the Private Health Care System (PHCS) network. The Out-of-Network PPO allows members to access any licensed health care provider in the United States. The type of plan or network that the member elects for their medical care has different member cost-share. Kaiser Permanente administers both PPO plans. “Our goal at Kaiser Permanente Insurance Company (KPIC) is to offer affordable care to all Members through the provider networks.”

Reimbursement for In Network PHCS:

KPIC partners with Provider Network, MultiPlan/ Private Health Care System (PHCS) to apply the pricing to be used for the Provider Network Reimbursement for medical care services received by members accessing the KPIC PPO. KPIC ensures that the financial requirements and treatment limitations on mental health or substance use disorder benefits they provide are no more restrictive than those on medical or surgical benefits.

Treatment limitations may be quantitative treatment limitations (QTLs) which are numerical in nature (such as visit limits) or non-quantitative treatment limitations (NQTLs), which are non-numerical limits on the scope or duration of benefits for treatment. NQTLs are processes, strategies, standards, or other criteria that limit the scope or duration of benefits for services provided under the plan. Examples of NQTLs include, but are not limited to, medical management standards limiting benefits based on medical necessity, and network admission standards such as credentialing or reimbursement rates.

The law does not prohibit the use of NQTLs as long as they are not applied more stringently to MH/SUD benefits as compared to Medical/Surgical benefits. Disparate results do not necessarily indicate a violation of the MHPAEA, so long as comparable processes are followed. MultiPlan, on behalf of itself and its subsidiaries (collectively “MultiPlan”) is neither a health care provider nor an insurance company, and does not reimburse physicians, hospitals, or other healthcare providers for their services. MultiPlan does not pay claims, determine eligibility, or make benefit determinations; those responsibilities lie with KPIC.

The Federal regulations prohibiting the imposition of a discriminatory NQTL for MH/SUD services does not directly apply to MultiPlan. However, KPIC purchased access to MultiPlan’s Negotiation Services, as defined below, may require information from MultiPlan to assist with their compliance of these federal requirements. MultiPlan’s services include access to both MH/SUD and Medical/Surgical providers. This comparative analysis is specific to MultiPlan’s Negotiation

Mental Health/Substance Use Disorder

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Medical/Surgical

Services, including an analysis of MultiPlan's Financial Negotiation Services and Clinical Negotiation Services.

Please note that although the regulation refers to the parity of "reimbursement," this document will discuss the parity of the amount negotiated with providers, as described below, since MultiPlan does not "reimburse" providers. MultiPlan has adopted the six-step analysis outlined by the Kennedy Forum for conducting a comparative analysis.

MultiPlan offers two types of negotiation services which may be accessed jointly or individually by KPIC: (i) Financial Negotiation Services, and (ii) Clinical Negotiation Services (collectively "Negotiation Services"). A more detailed description of each service is provided below. Negotiation Services offered to KPIC were identified as NQTLs requiring a comparative analysis to ensure that the processes are applied no more stringently to MH/SUD providers than Medical/Surgical providers.

MultiPlan utilizes a standard set of criteria for Financial Negotiation Services and Clinical Negotiation Services as part of the Negotiation Services and does not differentiate in the application of those criteria based on whether the provider is a MH/SUD provider or a Medical/Surgical provider. Negotiations Services with MH/SUD providers are managed in the same fashion, using the same contract documents, rate methodologies, and processes as all other providers.

As supported by this comparative analysis, MultiPlan does not establish NQTLs on, or implied through, relationships with providers, as written and/or in operation, that are applied more stringently to MH/SUD services than those applicable to Medical/Surgical services. MultiPlan's policies, processes, and operational implementation of such processes are not designed to restrict access to, or discriminate against, specific provider types or services, including but not limited to, MH/SUD providers. All policies and processes are implemented to apply equally regardless of provider type.

FINANCIAL NEGOTIATION SERVICES

MultiPlan's Financial Negotiation Services provides KPIC with access to negotiated reductions on claims for health care services rendered to KPIC members by out-of-network health care providers ("Financial Negotiation Services"). A provider may be considered "out-of-network" if the provider has not contractually agreed to participate in a MultiPlan network and/or a KPIC network. Financial Negotiation Services by MultiPlan may be initiated before or after the services are rendered, but typically occur prior to payment for such health care services. As part of Financial Negotiation Services, MultiPlan utilizes prevailing market reimbursement amounts to negotiate reductions with out-of-network providers, and in exchange, the out-of-network providers agree not to balance

Mental Health/Substance Use Disorder

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Medical/Surgical

bill KPIC members for the difference between the agreed upon negotiated reduction and the provider's billed charges.

Financial Negotiation Services apply to both MH/SUD and Medical/Surgical providers. MultiPlan Financial Negotiation Services with out-of-network health care providers are based on comprehensive financial benchmarks, including publicly-available claim pricing data, MultiPlan's provider network performance with like claims, and MultiPlan's proprietary commercial benchmarks which are based on the amounts generally accepted by providers as payment in full ("MultiPlan's Proprietary Valuation Tool").

NEGOTIATION SERVICES

Similar to MultiPlan's Financial Negotiation Services:

- take place after services have been rendered but prior to payment to providers for the services
- result in written agreements with providers where each agreement specifies reimbursement for an individual claim
- consider prevailing market reimbursement amounts when negotiating with providers
- include language in the agreements to help protect the KPIC's members from balance billing
- follow the same processes to seek agreement with MH/SUD providers and Medical/Surgical providers.

Negotiation Services differ from Financial Negotiation Services in that Negotiations involve an enhanced discussion between MultiPlan and the provider regarding potential billing waste, abuse or errors identified on the individual claims. Negotiations attempt to correct for potential billing waste, abuse or errors, negotiations are pursued with providers that have a MultiPlan network contract (where the contract allows) as well as out-of-network providers.

MultiPlan identifies billing issues on claims using a proprietary claims analytic system that evaluates the claims against industry-standard medical coding rules and clinical guidelines. The system then scores the claims to determine which claims should be resolved through Financial Negotiations versus Clinical Negotiations. The scoring process takes into account charges associated with the billing issues, confidence in the accuracy of the issues on the specific claim, and historical experience with the providers. A portion of the claims selected for Negotiations may be reviewed by certified medical coders, nurses and/or physicians to further evaluate the applicability of the system-identified issues. After analysis and expert evaluation of the claims, Negotiations are completed by negotiators who are specially trained in billing waste, abuse, and errors.

Mental Health/Substance Use Disorder

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Medical/Surgical

Mental Health/Substance Use Disorder

Reimbursement for In Network PHCS Contracted Providers:

KPIC partners with Provider Network, MultiPlan/ Private Health Care System (PHCS) to apply the pricing to be used for the Provider Network Reimbursement for medical care services received by members that are accessing the KPIC POS. KPIC ensures that the financial requirements and treatment limitations on mental health or substance use disorder benefits they provide are no more restrictive than those on medical or surgical benefits.

Treatment limitations may be quantitative treatment limitations (QTLs) which are numerical in nature (such as visit limits) or non-quantitative treatment limitations (NQTLs), which are non-numerical limits on the scope or duration of benefits for treatment. NQTLs are processes, strategies, standards, or other criteria that limit the scope or duration of benefits for services provided under the plan. Examples of NQTLs include, but are not limited to, medical management standards limiting benefits based on medical necessity, and network admission standards such as credentialing or reimbursement rates.

Disparate results do not necessarily indicate a violation of the MHPAEA, so long as comparable processes are followed. MultiPlan, on behalf of itself and its subsidiaries (collectively “MultiPlan”) is neither a health care provider nor an insurance company, and does not reimburse physicians, hospitals, or other healthcare providers for their services. MultiPlan does not pay claims, determine eligibility, or make benefit determinations; those responsibilities KPIC.

The Federal regulations prohibiting the imposition of a discriminatory NQTL for MH/SUD services does not directly apply to MultiPlan. However, KPIC purchased access to MultiPlan’s Negotiation Services, as defined below, may require information from MultiPlan to assist with their compliance of these federal requirements. MultiPlan’s services include access to both MH/SUD and Medical/Surgical providers. This comparative analysis is specific to MultiPlan’s Negotiation Services, including an analysis of MultiPlan’s Financial Negotiation Services and Clinical Negotiation Services.

Please note that although the regulation refers to the parity of “reimbursement,” this document will discuss the parity of the amount negotiated with providers, as described below, since MultiPlan does not “reimburse” providers. MultiPlan has adopted the six-step analysis outlined by the Kennedy Forum for conducting a comparative analysis.

MultiPlan offers two types of negotiation services which may be accessed jointly or individually by KPIC: (i) Financial Negotiation Services, and (ii) Clinical Negotiation Services (collectively “Negotiation Services”). A more detailed description of each service is provided below. Negotiation Services offered to KPIC

Reimbursement for In Network PHCS Contracted Providers:

KPIC partners with Provider Network, MultiPlan/ Private Health Care System (PHCS) to apply the pricing to be used for the Provider Network Reimbursement for medical care services received by members that are accessing the KPIC POS. KPIC ensures that the financial requirements and treatment limitations on mental health or substance use disorder benefits they provide are no more restrictive than those on medical or surgical benefits.

Treatment limitations may be quantitative treatment limitations (QTLs) which are numerical in nature (such as visit limits) or non-quantitative treatment limitations (NQTLs), which are non-numerical limits on the scope or duration of benefits for treatment. NQTLs are processes, strategies, standards, or other criteria that limit the scope or duration of benefits for services provided under the plan. Examples of NQTLs include, but are not limited to, medical management standards limiting benefits based on medical necessity, and network admission standards such as credentialing or reimbursement rates.

Disparate results do not necessarily indicate a violation of the MHPAEA, so long as comparable processes are followed. MultiPlan, on behalf of itself and its subsidiaries (collectively “MultiPlan”) is neither a health care provider nor an insurance company, and does not reimburse physicians, hospitals, or other healthcare providers for their services. MultiPlan does not pay claims, determine eligibility, or make benefit determinations; those responsibilities KPIC.

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Please note that although the regulation refers to the parity of “reimbursement,” this document will discuss the parity of the amount negotiated with providers, as described below, since MultiPlan does not “reimburse” providers. MultiPlan has adopted the six-step analysis outlined by the Kennedy Forum for conducting a comparative analysis.

MultiPlan offers two types of negotiation services which may be accessed jointly or individually by KPIC: (i) Financial Negotiation Services, and (ii) Clinical Negotiation Services (collectively “Negotiation Services”). A more detailed description of each service is provided below. Negotiation Services offered to KPIC

Medical/Surgical

were identified as NQTLs requiring a comparative analysis to ensure that the processes are applied no more stringently to MH/SUD providers than Medical/Surgical providers.

MultiPlan utilizes a standard set of criteria for Financial Negotiation Services and Clinical Negotiation Services as part of the Negotiation Services and does not differentiate in the application of those criteria based on whether the provider is a MH/SUD provider or a Medical/Surgical provider. Negotiations Services with MH/SUD providers are managed in the same fashion, using the same contract documents, rate methodologies, and processes as all other providers.

As supported by this comparative analysis, MultiPlan does not establish NQTLs on, or implied through, relationships with providers, as written and/or in operation, that are applied more stringently to MH/SUD services than those applicable to Medical/Surgical services. MultiPlan's policies, processes, and operational implementation of such processes are not designed to restrict access to, or discriminate against, specific provider types or services, including but not limited to, MH/SUD providers. All policies and processes are implemented to apply equally regardless of provider type.

FINANCIAL NEGOTIATION SERVICES

MultiPlan's Financial Negotiation Services provides KPIC with access to negotiated reductions on claims for health care services rendered to KPIC members by out-of-network health care providers ("Financial Negotiation Services"). A provider may be considered "out-of-network" if the provider has not contractually agreed to participate in a MultiPlan network and/or a KPIC network. Financial Negotiation Services by MultiPlan may be initiated before or after the services are rendered, but typically occur prior to payment for such health care services. As part of Financial Negotiation Services, MultiPlan utilizes prevailing market reimbursement amounts to negotiate reductions with out-of-network providers, and in exchange, the out-of-network providers agree not to balance bill KPIC members for the difference between the agreed upon negotiated reduction and the provider's billed charges.

Financial Negotiation Services apply to both MH/SUD and Medical/Surgical providers. MultiPlan Financial Negotiation Services with out-of-network health care providers are based on comprehensive financial benchmarks, including publicly-available claim pricing data, MultiPlan's provider network performance with like claims, and MultiPlan's proprietary commercial benchmarks which are based on the amounts generally accepted by providers as payment in full ("MultiPlan's Proprietary Valuation Tool").

NEGOTIATION SERVICES

Similar to MultiPlan's Financial Negotiation Services:

Mental Health/Substance Use Disorder

were identified as NQTLs requiring a comparative analysis to ensure that the processes are applied no more stringently to MH/SUD providers than Medical/Surgical providers.

MultiPlan utilizes a standard set of criteria for Financial Negotiation Services and Clinical Negotiation Services as part of the Negotiation Services and does not differentiate in the application of those criteria based on whether the provider is a MH/SUD provider or a Medical/Surgical provider. Negotiations Services with MH/SUD providers are managed in the same fashion, using the same contract documents, rate methodologies, and processes as all other providers.

As supported by this comparative analysis, MultiPlan does not establish NQTLs on, or implied through, relationships with providers, as written and/or in operation, that are applied more stringently to MH/SUD services than those applicable to Medical/Surgical services. MultiPlan's policies, processes, and operational implementation of such processes are not designed to restrict access to, or discriminate against, specific provider types or services, including but not limited to, MH/SUD providers. All policies and processes are implemented to apply equally regardless of provider type.

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NEGOTIATION SERVICES

Similar to MultiPlan's Financial Negotiation Services:

Medical/Surgical

- take place after services have been rendered but prior to payment to providers for the services
- result in written agreements with providers where each agreement specifies reimbursement for an individual claim
- consider prevailing market reimbursement amounts when negotiating with providers
- include language in the agreements to help protect the KPIC's members from balance billing
- follow the same processes to seek agreement with MH/SUD providers and Medical/Surgical providers.

Negotiation Services differ from Financial Negotiation Services in that Negotiations involve an enhanced discussion between MultiPlan and the provider regarding potential billing waste, abuse or errors identified on the individual claims. Negotiations attempt to correct for potential billing waste, abuse or errors, negotiations are pursued with providers that have a MultiPlan network contract (where the contract allows) as well as out-of-network providers.

MultiPlan identifies billing issues on claims using a proprietary claims analytic system that evaluates the claims against industry-standard medical coding rules and clinical guidelines. The system then scores the claims to determine which claims should be resolved through Financial Negotiations versus Clinical Negotiations. The scoring process takes into account charges associated with the billing issues, confidence in the accuracy of the issues on the specific claim, and historical experience with the providers. A portion of the claims selected for Negotiations may be reviewed by certified medical coders, nurses and/or physicians to further evaluate the applicability of the system-identified issues. After analysis and expert evaluation of the claims, Negotiations are completed by negotiators who are specially trained in billing waste, abuse, and errors.

Mental Health/Substance Use Disorder

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Negotiation Services differ from Financial Negotiation Services in that Negotiations involve an enhanced discussion between MultiPlan and the provider regarding potential billing waste, abuse or errors identified on the individual claims. Negotiations attempt to correct for potential billing waste, abuse or errors, negotiations are pursued with providers that have a MultiPlan network contract (where the contract allows) as well as out-of-network providers.

MultiPlan identifies billing issues on claims using a proprietary claims analytic system that evaluates the claims against industry-standard medical coding rules and clinical guidelines. The system then scores the claims to determine which claims should be resolved through Financial Negotiations versus Clinical Negotiations. The scoring process takes into account charges associated with the billing issues, confidence in the accuracy of the issues on the specific claim, and historical experience with the providers. A portion of the claims selected for Negotiations may be reviewed by certified medical coders, nurses and/or physicians to further evaluate the applicability of the system-identified issues. After analysis and expert evaluation of the claims, Negotiations are completed by negotiators who are specially trained in billing waste, abuse, and errors.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical

FACTORS USED IN NEGOTIATION SERVICES:

Financial Negotiation Services and Clinical Negotiation Services have been established by MultiPlan to ensure that: (i) KPIC and their members have access to the greatest possible discount for health care services rendered to members which is based on

Mental Health/Substance Use Disorder

FACTORS USED IN NEGOTIATION SERVICES:

Financial Negotiation Services and Clinical Negotiation Services have been established by MultiPlan to ensure that: (i) KPIC and their members have access to the greatest possible discount for health care services rendered to members which is based on

Medical/Surgical

prevailing market reimbursement data, while also offering members protection against balance billing for the difference between the agreed upon negotiated reduction and the provider's billed charges; (ii) MultiPlan applies consistent negotiation processes and standards throughout the organization when negotiating with MH/SUD and Medical/Surgical provider types for reductions on out of network health care services; and (iii) the negotiated discounts offered to, and agreed upon by, out of network providers are offered, processed, and managed in the same manner for MH/SUD providers as for all other provider types.

"FINANCIAL NEGOTIATION SERVICES FACTORS" CONSIDERED FOR OUT-OF-NETWORK CLAIMS

As introduced above, the primary goal of Financial Negotiation Services is to provide the greatest possible savings to KPIC members, which is agreed upon by the out-of-network provider, using a number of informational statistics and criteria as a baseline for negotiations ("Financial Negotiation Services Factors"). The grid below identifies the Financial Negotiation Services Factors used when negotiating a discount for health care services with an out-of-network provider on behalf of KPIC who purchased access to Financial Negotiation Services.

Financial Negotiation may vary depending on whether the negotiation is for a single case (i.e., single patient for specific date of service) or whether the provider agreed to a more global approach to a negotiated discount. The same process is used to negotiate with both MH/SUD and Medical/Surgical providers, even though outcomes may differ.

Factor	Description	Outpatient (Physician) Services	Outpatient (Facility) Services	Inpatient Services	Emergency Services
Allowed Amount	KPIC may identify an Allowed Amount which Negotiation Services must negotiate below in order for KPIC to elect to access the negotiated discount. The negotiated amount may differ from claim to claim, but the process produces the same target discount amount in the same market, and KPIC determines if they will access the negotiated amount, based on their Allowed Amount determination.	✓	✓	✓	✓
Medicare Reimbursement Benchmark	The negotiation system captures Medicare rates for billed services which are used as a reference point for negotiations to compare billed charges to Medicare reimbursement. This information may be used in discussion or as a basis to generate an offer to a provider.	✓	✓	✓	✓
MultiPlan's Proprietary Valuation Tool	The negotiation system captures the value established by MultiPlan's Proprietary Valuation Tool which is used as a reference point for negotiations with a provider.	✓	✓	✓	✓
Negotiation Agreement	An agreement with a provider for an agreed upon rate for a claim. Financial Negotiation agreements may be for (i) a single case agreement; (ii) all claims submitted for KPIC and all patients; or (iii) all claims associated with a specific KPIC patient.	✓	✓	✓	✓

CLINICAL NEGOTIATION SERVICES FACTORS" CONSIDERED

Mental Health/Substance Use Disorder

prevailing market reimbursement data, while also offering members protection against balance billing for the difference between the agreed upon negotiated reduction and the provider's billed charges; (ii) MultiPlan applies consistent negotiation processes and standards throughout the organization when negotiating with MH/SUD and Medical/Surgical provider types for reductions on out of network health care services; and (iii) the negotiated discounts offered to, and agreed upon by, out of network providers are offered, processed, and managed in the same manner for MH/SUD providers as for all other provider types.

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Financial Negotiation may vary depending on whether the negotiation is for a single case (i.e., single patient for specific date of service) or whether the provider agreed to a more global approach to a negotiated discount. The same process is used to negotiate with both MH/SUD and Medical/Surgical providers, even though outcomes may differ.

Factor	Description	Outpatient (Physician) Services	Outpatient (Facility) Services	Inpatient Services	Emergency Services
Allowed Amount	KPIC may identify an Allowed Amount which Negotiation Services must negotiate below in order for KPIC to elect to access the negotiated discount. The negotiated amount may differ from claim to claim, but the process produces the same target discount amount in the same market, and KPIC determines if they will access the negotiated amount, based on their Allowed Amount determination.	✓	✓	✓	✓
Medicare Reimbursement Benchmark	The negotiation system captures Medicare rates for billed services which are used as a reference point for negotiations to compare billed charges to Medicare reimbursement. This information may be used in discussion or as a basis to generate an offer to a provider.	✓	✓	✓	✓
MultiPlan's Proprietary Valuation Tool	The negotiation system captures the value established by MultiPlan's Proprietary Valuation Tool which is used as a reference point for negotiations with a provider.	✓	✓	✓	✓
Negotiation Agreement	An agreement with a provider for an agreed upon rate for a claim. Financial Negotiation agreements may be for (i) a single case agreement; (ii) all claims submitted for KPIC and all patients; or (iii) all claims associated with a specific KPIC patient.	✓	✓	✓	✓

CLINICAL NEGOTIATION SERVICES FACTORS" CONSIDERED

Medical/Surgical

Clinical Negotiation Services start with an automated computer analysis of claims used to identify potential billing waste, abuse, or errors. The analysis relies upon industry-standard medical coding rules and clinical guidelines that are publicly available and sponsored by well-recognized entities such as Medicare and the American Medical Association. Sources for Reimbursement Methodologies include:

- CMS Physician pricing guidelines
- CMS HCPCS pricing guidelines
- CMS DRG classification

When applicable, the analysis may also incorporate billing rules and guidelines utilized by KPIC. Common issues identified during the automated analysis include:

- billing a procedure that is inconsistent with the place of service (e.g., billing for a hospital emergency room visit in a doctor's office)
- billing both a component procedure and a more comprehensive procedure that includes the component (e.g., billing an EKG and a cardiac stress test that includes an EKG)
- billing an incorrect number of services (e.g., can only bill one service per day when the service is defined as a per diem service)
- billing for incompatible procedures (repair an organ and remove an organ)

Note that MultiPlan does not create its own billing rules and guidelines. Instead, MultiPlan identifies billing waste, abuse, and errors based on the rules and guidelines published by reputable health care entities. MultiPlan also does not authorize services, deny services, perform utilization review, or determine the necessity of services. MultiPlan's claims analysis focuses on the correctness of the procedure, diagnosis, and other codes reported on claims.

The grid below identifies the Clinical Negotiation Services Factors used by MultiPlan when reviewing and negotiating MultiPlan network claims and out-of-network claims with providers on behalf of KPIC.

Mental Health/Substance Use Disorder

Clinical Negotiation Services start with an automated computer analysis of claims used to identify potential billing waste, abuse, or errors. The analysis relies upon industry-standard medical coding rules and clinical guidelines that are publicly available and sponsored by well-recognized entities such as Medicare and the American Medical Association. Sources for Reimbursement Methodologies include:

- CMS Physician pricing guidelines
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When applicable, the analysis may also incorporate billing rules and guidelines utilized by KPIC. Common issues identified during the automated analysis include:

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- billing an incorrect number of services (e.g., can only bill one service per day when the service is defined as a per diem service)
- billing for incompatible procedures (repair an organ and remove an organ)

Note that MultiPlan does not create its own billing rules and guidelines. Instead, MultiPlan identifies billing waste, abuse, and errors based on the rules and guidelines published by reputable health care entities. MultiPlan also does not authorize services, deny services, perform utilization review, or determine the necessity of services. MultiPlan's claims analysis focuses on the correctness of the procedure, diagnosis, and other codes reported on claims.

The grid below identifies the Clinical Negotiation Services Factors used by MultiPlan when reviewing and negotiating MultiPlan network claims and out-of-network claims with providers on behalf of KPIC.

Medical/Surgical

Mental Health/Substance Use Disorder

Factor	Description	Outpatient (Professional) Services	Outpatient (Facility) Services	Inpatient Services	Emergency Services	Factor	Description	Outpatient (Professional) Services	Outpatient (Facility) Services	Inpatient Services	Emergency Services
Billing waste, abuse, and errors analysis	Automated computerized analysis of claims data to identify potential billing situations that conflict with industry-standard coding rules and clinical guidelines. Expert review may occur on a portion of the claims to validate applicability of issues on the claims.	✓	✓	✓	✓	Billing waste, abuse, and errors analysis	Automated computerized analysis of claims data to identify potential billing situations that conflict with industry-standard coding rules and clinical guidelines. Expert review may occur on a portion of the claims to validate applicability of issues on the claims.	✓	✓	✓	✓
Allowed Amount	KPIC may identify an Allowed Amount which Negotiation Services must negotiate below in order for KPIC to elect to access the Negotiation Services agreement.	✓	✓	✓	✓	Allowed Amount	KPIC may identify an Allowed Amount which Negotiation Services must negotiate below in order for KPIC to elect to access the Negotiation Services agreement.	✓	✓	✓	✓
Medicare Reimbursement Benchmark	The negotiation system captures Medicare rates for billed services which are used as a reference point for negotiations to compare billed charges to Medicare reimbursement.	✓	✓	✓	✓	Medicare Reimbursement Benchmark	The negotiation system captures Medicare rates for billed services which are used as a reference point for negotiations to compare billed charges to Medicare reimbursement.	✓	✓	✓	✓
MultiPlan's Proprietary Valuation Tool	The negotiation system captures the value established by MultiPlan's Proprietary Valuation Tool which is used as a reference point for negotiations with a provider.	✓	✓	✓	✓	MultiPlan's Proprietary Valuation Tool	The negotiation system captures the value established by MultiPlan's Proprietary Valuation Tool which is used as a reference point for negotiations with a provider.	✓	✓	✓	✓
Negotiation Agreement	An agreement with a provider for an agreed upon rate for a claim. KPIC Negotiation agreements are for a single case agreement only.	✓	✓	✓	✓	Negotiation Agreement	An agreement with a provider for an agreed upon rate for a claim. KPIC Negotiation agreements are for a single case agreement only.	✓	✓	✓	✓

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical

Mental Health/Substance Use Disorder

MultiPlan's established proprietary processes and policies, industry-standard analytics, and guidelines, as well as certain state and federal requirements, are used to formulate the criteria that establish the Negotiation Services Factors. These evidentiary standards support MultiPlan's determinations of what constitutes an effective Negotiation Services program.

EVIDENTIARY STANDARDS FOR EACH FACTOR CONSIDERED WHEN ESTABLISHING FINANCIAL NEGOTIATION SERVICES FACTORS

The evidentiary standards for the Financial Negotiation Services Factors used in developing the processes for the review and negotiation of out-of-network MH/SUD and Medical/Surgical claims submitted to MultiPlan by Clients are detailed below:

MultiPlan's established proprietary processes and policies, industry-standard analytics, and guidelines, as well as certain state and federal requirements, are used to formulate the criteria that establish the Negotiation Services Factors. These evidentiary standards support MultiPlan's determinations of what constitutes an effective Negotiation Services program.

EVIDENTIARY STANDARDS FOR EACH FACTOR CONSIDERED WHEN ESTABLISHING FINANCIAL NEGOTIATION SERVICES FACTORS

The evidentiary standards for the Financial Negotiation Services Factors used in developing the processes for the review and negotiation of out-of-network MH/SUD and Medical/Surgical claims submitted to MultiPlan by Clients are detailed below:

Medical/Surgical

Mental Health/Substance Use Disorder

Factor	Evidentiary Standard	MH Providers	SUD Providers	Medical Surgical Providers
Allowed Amount	1. KPIC's vendor (First Health) -Defined (Usual and Customary amount may vary depending on source used by Client). MultiPlan does not establish	✓	✓	✓
Medicare Reimbursement Benchmark	1. Reimbursement methods and rates published by CMS 2. Publicly available fee schedules published by CMS	✓	✓	✓
MultiPlan's Proprietary Valuation Tool	1. Relative Value Units (RVU) 2. Geographic Practice Cost Indices (GPCI) 3. Publicly Available Data Sets	✓	✓	✓
Negotiation Agreement	1. The creation, negotiation criteria, processing and application of the Financial Negotiation agreements are standardized to ensure a consistent process.	✓	✓	✓

EVIDENTIARY STANDARDS FOR EACH FACTOR CONSIDERED WHEN ESTABLISHING CLINICAL NEGOTIATION SERVICES FACTORS

The evidentiary standards for the Clinical Negotiation Services Factors used in developing the processes for the review and negotiation of MultiPlan network and out-of-network Medical/Surgical and MH/SUD claims submitted to MultiPlan by Clients are detailed below:

Factor	Evidentiary Standard	MH Providers	SUD Providers	Medical Surgical Providers
Billing waste, abuse, and errors analysis	1. CPT coding guidelines published by the American Medical Association 2. National Correct Coding Initiative (NCCI) publicly available data files and manuals 3. Outpatient Code Editor (OCE) publicly available data files and manuals for outpatient facility services 4. Resource-Based Relative Value Scale (RBRVS) publicly available data files and manuals for professional reimbursement 5. HCPCS coding guidelines published by the American Hospital Association 6. Health care billing instructions published by the National Uniform Billing Committee for facility billing 7. Standards and guidelines published by coding organizations (e.g. AAPC, American Health Information Management Association (AHIMA)) 8. Standards and guidelines published by Professional Medical Associations (e.g., American Society of Anesthesiologists) 9. State regulations related to state-specific workers' compensation programs 10. KPIC's policies regarding reimbursement guidelines (applies only to specific KPIC claims) 11. Provider-Specific – When industry standards are not met, indicates if the provider is a statistical outlier for frequency of billing inaccuracy	✓	✓	✓
Allowed Amount	1. KPIC's vendor (Fair Health) Defined (Usual and Customary amount may vary depending on source used by Client). MultiPlan does not have establish this target value.	✓	✓	✓
Medicare Benchmark	1. Reimbursement methods and rates published by CMS 2. Publicly available fee schedules published by CMS	✓	✓	✓
MultiPlan's Proprietary Valuation Tool	1. Relative Value Units (RVU) 2. Geographic Practice Cost Indices (GPCI) 3. Publicly Available Data Sets	✓	✓	✓
Negotiation Agreement	1. The creation, negotiation criteria, processing, and application of the Clinical Negotiation agreements are standardized to ensure a consistent process.	✓	✓	✓

Factor	Evidentiary Standard	MH Providers	SUD Providers	Medical Surgical Providers
Allowed Amount	1. KPIC's vendor (First Health) -Defined (Usual and Customary amount may vary depending on source used by Client). MultiPlan does not establish	✓	✓	✓
Medicare Reimbursement Benchmark	1. Reimbursement methods and rates published by CMS 2. Publicly available fee schedules published by CMS	✓	✓	✓
MultiPlan's Proprietary Valuation Tool	1. Relative Value Units (RVU) 2. Geographic Practice Cost Indices (GPCI) 3. Publicly Available Data Sets	✓	✓	✓
Negotiation Agreement	1. The creation, negotiation criteria, processing and application of the Financial Negotiation agreements are standardized to ensure a consistent process.	✓	✓	✓

EVIDENTIARY STANDARDS FOR EACH FACTOR CONSIDERED WHEN ESTABLISHING CLINICAL NEGOTIATION SERVICES FACTORS

The evidentiary standards for the Clinical Negotiation Services Factors used in developing the processes for the review and negotiation of MultiPlan network and out-of-network Medical/Surgical and MH/SUD claims submitted to MultiPlan by Clients are detailed below:

Factor	Evidentiary Standard	MH Providers	SUD Providers	Medical Surgical Providers
Billing waste, abuse, and errors analysis	1. CPT coding guidelines published by the American Medical Association 2. National Correct Coding Initiative (NCCI) publicly available data files and manuals 3. Outpatient Code Editor (OCE) publicly available data files and manuals for outpatient facility services 4. Resource-Based Relative Value Scale (RBRVS) publicly available data files and manuals for professional reimbursement 5. HCPCS coding guidelines published by the American Hospital Association 6. Health care billing instructions published by the National Uniform Billing Committee for facility billing 7. Standards and guidelines published by coding organizations (e.g. AAPC, American Health Information Management Association (AHIMA)) 8. Standards and guidelines published by Professional Medical Associations (e.g., American Society of Anesthesiologists) 9. State regulations related to state-specific workers' compensation programs 10. KPIC's policies regarding reimbursement guidelines (applies only to specific KPIC claims) 11. Provider-Specific – When industry standards are not met, indicates if the provider is a statistical outlier for frequency of billing inaccuracy	✓	✓	✓
Allowed Amount	1. KPIC's vendor (Fair Health) Defined (Usual and Customary amount may vary depending on source used by Client). MultiPlan does not have establish this target value.	✓	✓	✓
Medicare Benchmark	1. Reimbursement methods and rates published by CMS 2. Publicly available fee schedules published by CMS	✓	✓	✓
MultiPlan's Proprietary Valuation Tool	1. Relative Value Units (RVU) 2. Geographic Practice Cost Indices (GPCI) 3. Publicly Available Data Sets	✓	✓	✓
Negotiation Agreement	1. The creation, negotiation criteria, processing, and application of the Clinical Negotiation agreements are standardized to ensure a consistent process.	✓	✓	✓

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical

Mental Health/Substance Use Disorder

WRITTEN POLICY AND PROCESS COMPARATIVE ANALYSIS:

This section includes the comparative analysis of MultiPlan's Negotiation Services processes to ensure that MultiPlan processes are applied no more stringently to MH/SUD providers than they would be to Medical/Surgical service providers. A summary of processes as outlined in MultiPlan proprietary policies and procedures is included.

DESCRIPTION OF THE NEGOTIATION SERVICES NQTL PROCESSES

KPIC will determine what types of claims should be considered (i.e., practitioner and/or facility), and may also establish a minimum claim threshold amount before a claim will be eligible for Negotiation Services (e.g., review claims over \$1,000.00 only). Once claim eligibility is established per the KPIC's criteria, MultiPlan will verify the provider's information to confirm whether the MH/SUD or Medical/Surgical provider has made a request not to be contacted or has a history of unsuccessful negotiations, in which case the claim will be returned to KPIC without MultiPlan attempting to conduct a Financial Negotiation. For those claims deemed eligible for Financial Negotiation Services, MultiPlan will contact the provider to attempt to negotiate.

A similar claim eligibility process is followed for KPIC Clinical Negotiation Services as it relates to claim thresholds only, but eligibility is not limited based on KPIC defined claim type (i.e., practitioner or facility). However, using the Waste and Abuse Review Factors described in the table above, the claim may also be reviewed to determine whether industry standard billing and coding practices were followed. If there is evidence of waste/abuse, then the claim becomes a Clinical Negotiation Services claim and Clinical negotiations are attempted. All providers for Clinical Negotiation Services are contacted due to the identified irregularities in the claim. KPIC purchased access to both Financial Negotiation Services and Clinical Negotiation Services, unsuccessful Clinical Negotiations may be forwarded to Financial Negotiations Services if the provider has an existing Financial Negotiation Agreement.

Once MultiPlan contacts the provider to attempt a financial or clinical negotiation, the negotiation generally ends in the three possible outcomes: (1) signed agreement with a negotiated amount; (2) no agreement is reached by time frame allowed by KPIC to obtain an agreement; or (3) no agreement is reached because the provider has not agreed to terms consistent with negotiation criteria established by KPIC. The same process is used to negotiate with both MH/SUD and Medical/Surgical providers, even though outcomes may differ. MultiPlan does not apply processes more stringently to MH/SUD providers that it does for Medical/Surgical providers.

NEGOTIATION SERVICES NQTL POLICY AUDIT RESULTS

WRITTEN POLICY AND PROCESS COMPARATIVE ANALYSIS:

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NEGOTIATION SERVICES NQTL POLICY AUDIT RESULTS

Medical/Surgical

The Negotiation Services policies and procedures are applied consistently for all claims and all provider types, which includes both MH/SUD and Medical/Surgical providers. Specific exceptions may be applied for a particular provider type (professional or facility); however, those exceptions are applied consistently for the applicable provider type (e.g., modifiers such as multiple procedures, bi-lateral, assistant surgeon, co-surgeon, and anesthesia that are applicable to professional providers but are not applicable to facility providers).

The previous subsections include a general overview of the content of the policies reviewed to ensure consistent application to all providers, MH/SUD or Medical/Surgical, equally. Therefore, the chart below includes an analysis of the content to support the findings of an internal review of MultiPlan's written policies.

POLICY	POLICY CONTENTS	APPLICABILITY		
		MH/SUD		MEDICAL/
		PROVIDERS	PROVIDERS	PROVIDERS
Negotiation Services Agreements Policy	1. Written agreement between MultiPlan and out-of-network providers for a predetermined discount amount. 2. Ambulatory Surgical Centers are eligible for a single case agreement but not for a global negotiated agreement.	V	V	V
Assistant Surgeon and Co-Surgeon Claims Policy	1. Reduction in negotiated amount based on industry standard practices for Assistant Surgeons and Co-Surgeons.	N/A	N/A	V
Unsuccessful Negotiation History Provider Policy	1. A provider with a history of unsuccessful negotiations may prefer not be contacted to negotiate a reduction in billed charges.	V	V	V
Patient Benefits Policy	1. During negotiations, if a provider requests a copy of the patient's benefit plan, MultiPlan may request such information from KPIC or refer the provider to the insurer for benefit information. KPIC is responsible for benefit requirements, benefit determinations, and payment for healthcare services.	V	V	V
Stop Negotiation Policies	1. Negotiations for claims submitted with eligible charges that exceed KPIC's Allowed Amount or payor liability, as determined by benefit plan design, may be discontinued. MultiPlan does not determine the Allowed Amount or make benefit determinations. The same Allowed Amount for KPIC is used for both MH/SUD claims and Medical/Surgical claims.	V	V	V
Claim Negotiation Timelines Policy	1. Time frame established for contacting a provider after receipt of claim. 2. Automated reminders are sent on the specific dates following the initial contact. 3. Negotiations must close by KPIC's claim due date identified on each claim, unless an extension is granted by the KPIC due to potential for high likelihood of a successful negotiation identified by MultiPlan.	V	V	V
Multiple Bilateral Surgery Claims Guide Policy	1. Claims with surgical modifiers 50 and 51 require industry-standard reductions for procedures performed at the same time that share resources or are on identical opposing structures.	N/A	N/A	V
Anesthesia Claims Policy	1. Claims with modifiers QK, QX, or QY require minimum reductions for anesthesiology services provided that (a) more than 1 anesthesia procedure is performed, (b) they are performed by a CRNA, or (c) they are directed by an anesthesiologist to a CRNA.	N/A	N/A	V

Mental Health/Substance Use Disorder

The Negotiation Services policies and procedures are applied consistently for all claims and all provider types, which includes both MH/SUD and Medical/Surgical providers. Specific exceptions may be applied for a particular provider type (professional or facility); however, those exceptions are applied consistently for the applicable provider type (e.g., modifiers such as multiple procedures, bi-lateral, assistant surgeon, co-surgeon, and anesthesia that are applicable to professional providers but are not applicable to facility providers).

The previous subsections include a general overview of the content of the policies reviewed to ensure consistent application to all providers, MH/SUD or Medical/Surgical, equally. Therefore, the chart below includes an analysis of the content to support the findings of an internal review of MultiPlan's written policies.

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Stop Negotiation Policies	1. Negotiations for claims submitted with eligible charges that exceed KPIC's Allowed Amount or payor liability, as determined by benefit plan design, may be discontinued. MultiPlan does not determine the Allowed Amount or make benefit determinations. The same Allowed Amount for KPIC is used for both MH/SUD claims and Medical/Surgical claims.	V	V	V
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Anesthesia Claims Policy	1. Claims with modifiers QK, QX, or QY require minimum reductions for anesthesiology services provided that (a) more than 1 anesthesia procedure is performed, (b) they are performed by a CRNA, or (c) they are directed by an anesthesiologist to a CRNA.	N/A	N/A	V

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

OPERATIONAL IMPLEMENTATION OF PROCESSES AND STRATEGIES COMPARATIVE ANALYSIS:

The grid below shows the percentage of claims that resulted in invalid, successful, and unsuccessful negotiations. These categories are defined as follows:

1. Invalid – A negotiation attempt could not be made due to claim-specific circumstances, including but not limited to the following: provider received reimbursement prior to negotiation attempt; KPIC already initiated direct negotiation with the provider; or the Allowed Amount was too low to attempt negotiation. Specific to mental health claims, for example, it is common that out-of-network mental health claims are paid to the provider by the member at the time the service is provided (i.e., up front) eliminating the opportunity for negotiation.
2. Successful – A successful negotiation is reached via an agreement with the provider.
3. Unsuccessful – Negotiation attempt was unsuccessful with provider.

For Financial Negotiations Services, 33.5% of MH/SUD claims and 52.37% of Medical/Surgical claims were determined to be invalid. These percentages are comparable given that MH/SUD claims were lower in volume. MultiPlan does not have responsibility for claims that are not submitted for negotiation. A higher percentage of claims were successfully negotiated for MH/SUD claims (34.72%) as compared to Medical/Surgical claims (26.25%); however, the Medical/Surgical claims were significantly higher volume. Financial Negotiation Services received approximately 99 times more Medical/Surgical claims than MH/SUD in 2022. The percentage of successfully negotiated claims volume is within an acceptable standard deviation of 10%.

For Clinical Negotiations Services, 24.25% of MH/SUD claims and 33.45% of Medical/Surgical claims were determined to be invalid. These percentages are comparable with a standard deviation of less than 1%. Medical/Surgical claims are successfully negotiated at a rate of 33.26%, which is higher than the percentage of the successfully negotiated MH/SUD claims at 24.25%. This variance of 9.51% is likely due to the lower volume of MH/SUD claims selected for Clinical Negotiation Services for the reasons noted earlier (higher volume of MH/SUD claims that are paid up front and are never routed to MultiPlan for negotiation attempts). Claims with unsuccessful clinical negotiations are returned to KPIC for repricing (or another MultiPlan product offering if purchased by KPIC), and therefore, MultiPlan Negotiation Services policies no longer apply. A slightly higher percentage of unsuccessful clinical negotiations does not imply a disparity in application of Multiplan's Clinical Negotiation Services processes.

OPERATIONAL IMPLEMENTATION OF PROCESSES AND STRATEGIES COMPARATIVE ANALYSIS:

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Medical/Surgical

Mental Health/Substance Use Disorder

MH/SUD providers are treated equally and do not have different criteria or processes.

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State specific detail can be found on Appendix A, attached hereto.

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NEGOTIATION TYPE	CATEGORY	OUTCOME REASON	CLAIMS	% CLAIMS
FINANCIAL	MH/SUD	Invalid	614,214	33.55%
		Successful	635,648	33.26%
		Unsuccessful	580,910	31.73%
	MH/SUD Total		1,830,772	1.16% of Total
	MEDICAL/ SURGICAL	Invalid	81,735,997	52.37%
		Successful	40,967,900	26.25%
		Unsuccessful	33,367,30	21.38%
	MEDICAL/ SURGICAL Total		156,071,213	98.84% of Total
CLINICAL	MH/SUD	Invalid	2,621	24.52%
		Successful	2,539	23.75%
		Unsuccessful	5,529	51.73%
	MH/SUD Total		10,689	0.54% of Total
	MEDICAL/ SURGICAL	Invalid	656,520	33.45%
		Successful	652,850	33.26%
		Unsuccessful	653,562	33.30%
	MEDICAL/ SURGICAL Total		1,962,932	99.46% of Total
Grand Total			159,875,606	100.00%

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	MH/SUD Total		10,689	0.54% of Total
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		Successful	652,850	33.26%
		Unsuccessful	653,562	33.30%
	MEDICAL/ SURGICAL Total		1,962,932	99.46% of Total
Grand Total		159,875,606	100.00%	

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

FINDINGS/COMPLIANCE DETERMINATION:

MultiPlan applies the criteria for Negotiation Services in the same manner to both MH/SUD and Medical/Surgical providers, and all aspects of the Negotiation Services process are subject to MultiPlan's policies and procedures. At no time have NQTLs been established or implied through MultiPlan's Financial Negotiation Services and Clinical Negotiation Services that are applied more stringently to MH/SUD providers than those applicable to Medical/Surgical providers.

The same set of policies and procedures are utilized for all providers, whether MH/SUD or Medical/Surgical, when initiating and providing Negotiation Services. The same staff members work with MH/SUD and Medical/Surgical providers when initiating a financial or clinical negotiation with a provider. No criteria are applied more stringently to MH/SUD than to Medical/Surgical providers.

MultiPlan Negotiation Services standards, as well as certain state and federally defined criteria, have been used to define the evidentiary standards used in this analysis. Review of the standards and reporting of the negotiation results from the last calendar year, as well as a comparison of historical negotiation practices provides evidentiary support that MultiPlan is not applying policies and procedures more stringently to MH/SUD than to Medical/Surgical providers.

In 2022, MH/SUD claims accounted for 1.16% of the Financial Negotiations Services and 0.54% of the Clinical Negotiations Services for MultiPlan's total Negotiation Services claims. This low volume of MH/SUD claims compared to the Medical/Surgical claims received likely accounts for the slight deviation in the number of successful negotiations as it relates to MH/SUD claims. Due to the low volume of claims submitted for MH/SUD claims, and the results being within an acceptable standard deviation, MultiPlan concludes that Negotiation Services processes for both Financial Negotiation Services and Clinical Negotiation Services, as applied

Summary Conclusion

in writing and operation, are not applied more stringently to MH/SUD claims than that of Medical/Surgical Claims even with slightly disparate results.

Benefit Classification 2: Inpatient – Out-of-Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>PPO</u></p> <ul style="list-style-type: none"> INPATIENT SERVICES <ul style="list-style-type: none"> Hospital (includes Facility and Professional Charges) Maternity Services (includes Facility and Professional Charges) REHABILITATION SERVICES AND HABILITATIVE SERVICES <ul style="list-style-type: none"> Multi-disciplinary Rehabilitation in a Comprehensive Rehabilitation Facility Skilled Nursing Facility Transplants <p><u>POS</u></p> <ul style="list-style-type: none"> Maternity inpatient hospital Services Hospital Inpatient Care <ul style="list-style-type: none"> Inpatient hospital (including medical detoxification) Physician/Professional charges Skilled Nursing Facility Care <ul style="list-style-type: none"> Room and board, skilled nursing Services (including Physician/Professional charges) Transplants 	<p><u>PPO</u></p> <ul style="list-style-type: none"> MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES <ul style="list-style-type: none"> Hospital (includes Facility and Professional Charges) <p><u>POS</u></p> <ul style="list-style-type: none"> Inpatient Mental Health <ul style="list-style-type: none"> Inpatient mental health facility Physician/Professional charges Inpatient Chemical Dependency Treatment <ul style="list-style-type: none"> Inpatient treatment Physician/Professional charges

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>PPO Out of Network Reimbursement:</u></p> <p>Usual, Customary, and Reasonable (UCR) refers to a methodology used by a health plan to determine the reasonable</p>	<p><u>PPO Out of Network Reimbursement:</u></p> <p>Usual, Customary, and Reasonable (UCR) refers to a methodology used by a health plan to determine the reasonable</p>

Medical/Surgical

value of services to compensate a provider where there is no agreement as to price between the plan and the provider. UCR reimbursement methodology is used for Out of Network professional and/or ancillary services, this reimbursement is commonly used for the out-of-network PPO. For facilities, if the service is Institutional and HB 888 and HR 133 do not apply, Institutional services are reimbursed at 100% of billed charges minus the member cost share.

Kaiser Permanente Insurance Companies' (KPIC) use of UCR is relatively limited given that KPIC plans in Georgia (GA) use the Private Healthcare System (PHCS) provider network contract for access of medical care for professional and ancillary services such as physicians, laboratory, radiology, etc.

In addition, with limited exceptions discussed below, the Federal No Surprises Act now requires that many payors adjudicate emergency and "surprise" claims based on the "Qualifying Payment Amount (QPA)," which generally represents the payor's median contract rate for the service in the relevant geography. In some jurisdictions, this has further limited the potential need for plans to employ a UCR method to adjudicate emergency and "surprise" claims. In other jurisdictions, existing state law requires payment of emergency and "surprise" claims based on specific methodologies, such as HB 888 in Georgia. A number of these state methodologies will continue to apply following enactment of the No Surprises Act.

We note that a UCR method is only applied where there is no agreement as to pricing, and when no other law or regulation requires payment in a particular manner such as HB 888 in Georgia or Federal mandate HR 133 for Inpatient Professional claims only. In many circumstances, KPIC has mechanisms in place to arrive at an agreement as to price. In general, KPIC employs a payment "hierarchy" that first pays under a direct contract or a PHCS contract if one is in place. If there is no contract, KPIC may then send the claim for fee negotiation and potential execution of a letter of agreement or may utilize a partner rental network to price the claim.

What are the required qualifications/training for persons who create and implement the UCR process?

KPIC's UCR methodology was created and is maintained by Fair Health and Multiplan.

Mental Health/Substance Use Disorder

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What are the required qualifications/training for persons who create and implement the UCR process?

KPIC's UCR methodology was created and is maintained by Fair Health and Multiplan.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
<p>(a) The Usual, Customary and Reasonable Charge (UCR):</p> <p>(i) the charge generally made by a Physician or other supplier of services, medicines, or supplies; or</p> <p>(ii) the general level of charge made by Physicians or other suppliers within an area in which the charge is incurred for a Covered Service comparable in severity and nature to the Injury of Sickness being treated. The general level of charges is determined in accordance with schedules on file with the authorized Claims Administrator. For charges not listed in the schedules. If the Maximum Allowable Charge is the UCR, the Covered Person will be responsible for payment to a Non-Participating Provider of any amount in excess of the UCR when the UCR is less than the actual billed charges.</p> <p>Only Non-PAR professional services are priced with UCR. Factors include:</p> <ol style="list-style-type: none"> 1) Source UCR benchmark vendor (FairHealth/Multiplan) 2) Vendor methodology in compiling the data 3) KPIC selection of UCR percentile 4) KPIC application of UCR standard <p>Sources:</p> <ol style="list-style-type: none"> 1) KPIC's own internal procedure document," KPIC Pricing Hierarchy". 2) Correspondence between Fair Health and KPIC, quotation from Fair Health: "Fair Health does not prescribe, recommend or suggest any particular value or standard, nor determine applicability of UCR. FAIR Health's benchmarks are created by CPT, HCPC and ICD-10 procedure and revenue codes. To create benchmark values, FAIR Health applies the same methodology, geographical standards, and procedures to MH/SUD codes that we do to any other codes, including medical and surgical codes". <p>In fact, in many cases, the same code is used for a service, whether it is associated with a Med/Surg or MH/SUD diagnosis, in which case we will provide one set of benchmark values for that code. In the relatively rare cases where a service code is specific to MH/SUD, the methodologies used are the same and are applied no more stringently than for Med/Surg codes."</p>	<p>(a) The Usual, Customary and Reasonable Charge (UCR):</p> <p>(i) the charge generally made by a Physician or other supplier of services, medicines, or supplies; or</p> <p>(ii) the general level of charge made by Physicians or other suppliers within an area in which the charge is incurred for a Covered Service comparable in severity and nature to the Injury of Sickness being treated. The general level of charges is determined in accordance with schedules on file with the authorized Claims Administrator. For charges not listed in the schedules. If the Maximum Allowable Charge is the UCR, the Covered Person will be responsible for payment to a Non-Participating Provider of any amount in excess of the UCR when the UCR is less than the actual billed charges.</p> <p>Only Non-PAR professional services are priced with UCR. Factors include:</p> <ol style="list-style-type: none"> 1) Source UCR benchmark vendor (FairHealth/Multiplan) 2) Vendor methodology in compiling the data 3) KPIC selection of UCR percentile 4) KPIC application of UCR standard <p>Sources:</p> <ol style="list-style-type: none"> 1) KPIC's own internal procedure document," KPIC Pricing Hierarchy". 2) Correspondence between Fair Health and KPIC, quotation from Fair Health: "Fair Health does not prescribe, recommend or suggest any particular value or standard, nor determine applicability of UCR. FAIR Health's benchmarks are created by CPT, HCPC and ICD-10 procedure and revenue codes. To create benchmark values, FAIR Health applies the same methodology, geographical standards, and procedures to MH/SUD codes that we do to any other codes, including medical and surgical codes". <p>In fact, in many cases, the same code is used for a service, whether it is associated with a Med/Surg or MH/SUD diagnosis, in which case we will provide one set of benchmark values for that code. In the relatively rare cases where a service code is specific to MH/SUD, the methodologies used are the same and are applied no more stringently than for Med/Surg codes."</p>

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
<p>The basis of the evidentiary standard are:</p> <p>1) Confirmation from Fair Health that all methodologies used in compiling benchmark data are equivalent between MH/SUD and Med/Surg.</p> <p>2) KPIC's documented procedure for determination of UCR; a single procedure exists for out-of-network payments that applies to both MH/SUD and Med/Surg with no distinction between the two. KPIC's selection of a benchmark vendor, selection of benchmark percentile, and methodology for applying the benchmark for UCR purposes are equivalent for professional and ancillary services are applied to MH/SUD and Med/Surg. Analysis indicates that there is no difference.</p>	<p>The basis of the evidentiary standard are:</p> <p>1) Confirmation from Fair Health that all methodologies used in compiling benchmark data are equivalent between MH/SUD and Med/Surg.</p> <p>2) KPIC's documented procedure for determination of UCR; a single procedure exists for out-of-network payments that applies to both MH/SUD and Med/Surg with no distinction between the two. KPIC's selection of a benchmark vendor, selection of benchmark percentile, and methodology for applying the benchmark for UCR purposes are equivalent for professional and ancillary services are applied to MH/SUD and Med/Surg. Analysis indicates that there is no difference.</p>

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
<p>Analysis indicates that as described in writing by Fair Health, no distinction exists in the Fair Health methodology for compiling MH/SUD benchmark or Med/Surg benchmarks. In addition, analysis of KPIC's written documentation of the UCR practice of using Fair Health 80th percentile for out of network providers that are rendering professional and/or ancillary services indicates that there is no distinction between MH/SUD and Med/Surg. All factors are one and the same for MH/SUD and Med/Surg. Analysis indicates that there is no difference.</p>	<p>Analysis indicates that as described in writing by Fair Health, no distinction exists in the Fair Health methodology for compiling MH/SUD benchmark or Med/Surg benchmarks. In addition, analysis of KPIC's written documentation of the UCR practice of using Fair Health 80th percentile for out of network providers that are rendering professional and/or ancillary services indicates that there is no distinction between MH/SUD and Med/Surg. All factors are one and the same for MH/SUD and Med/Surg. Analysis indicates that there is no difference.</p>

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
Analysis confirmed that in operational practice, the four factors for UCR (selection of a benchmark vendor, vendor methodology in compiling benchmarks, KPIC's selection of 80 th percentile, and KPIC's application of the benchmark) are applied uniformly between MH/SUD and Med/Surg. Analysis indicates that there is no difference.	Analysis confirmed that in operational practice, the four factors for UCR (selection of a benchmark vendor, vendor methodology in compiling benchmarks, KPIC's selection of 80 th percentile, and KPIC's application of the benchmark) are applied uniformly between MH/SUD and Med/Surg. Analysis indicates that there is no difference.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion
Because KPIC's UCR methodology for MH/SUD benefits and Med/Surg benefits rendered by professional and/or ancillary are one and the same (both set at the 80 th percentile of billed charges for the service/geography in question, based on benchmarks from Fair Health), and because Fair Health applies the exact same methodology to MH/SUD and Med/Surg services when compiling its benchmarks, no additional analysis is needed to confirm compliance.

Benefit Classification 3: Outpatient – In Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
<p>PPO</p> <ul style="list-style-type: none"> Outpatient Services <ul style="list-style-type: none"> Primary Care Specialty Care Telemedicine and Telehealth Visits <ul style="list-style-type: none"> Primary Care Specialty Care Injection Visits (other than Immunization) including Allergy Injection <ul style="list-style-type: none"> Primary Care Specialty Care Allergy Testing (performed in Office Setting or Outpatient Hospital Setting) Allergy Serum Genetic Laboratory Services 	<p>PPO</p> <ul style="list-style-type: none"> Outpatient Services <ul style="list-style-type: none"> Integrated Behavioral Health Consultation AUTISM SPECTRUM DISORDER SERVICES <ul style="list-style-type: none"> Applied Behavior Analysis Program (Limited to Children through age 20) Speech Therapy (Limited to Children through age 20) Physical and Occupational Therapy (Limited to Children through age 20) CLINICAL TRIALS MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES <ul style="list-style-type: none"> Individual visits Group visits

Medical/Surgical

- Radiology Services other than High Tech Radiology Services
- High Tech Radiology Services (e.g., MRI's, CTs, PET, Myelogram and Nuclear Medicine scans)
- Chemotherapy, Radiation and Infusion Therapy
- Chiropractic Care (spinal manipulation only)
- Outpatient Surgery (includes Facility and Professional Charges)
- Hospital Outpatient (includes Facility and Professional Charges)
- AMBULANCE SERVICES
 - Ambulance (per trip)
 - Non-Emergency Ambulance (per trip)
- AUTISM SPECTRUM DISORDER SERVICES
 - CLINICAL TRIALS
- DENTAL SERVICES
 - Accidental injury to teeth
 - Treatment of TMJ and CMJ
- Dialysis
- DURABLE MEDICAL EQUIPMENT (DME)
 - Durable Medical Equipment (DME)
 - Ultraviolet Light Therapy System (Light box) for Psoriasis and Atopic Dermatitis
- HEARING SERVICES
 - Hearing exams and tests
 - Pediatric Hearing Aid(s) and services for children through age 18
- Home Health Care
- Hospice
- Infertility Services
- PREVENTIVE VISITS AND SERVICES
 - Primary Care Visit
 - Specialty Care Visit
 - Well Child Exams (through age 5)
 - Well Child Exams (age 6 through 21)
 - Screenings
 - Health Promotion
 - Disease Prevention
 - Other Covered Preventive Care:
 - Routine Adult Physical Exams
 - Preventive Care DME
 - Blood Pressure Monitors for Hypertension
 - Preventive Care Labs and Screening
 - Prostate specific antigen (PSA) test
 - Tobacco Cessation Drugs for Pregnant Women
 - Iron Deficiency Anemia Screening for Pregnant Woman
- PROSTHETIC DEVICES AND ORTHOTICS
 - Prosthetic Devices (External) and Orthotics (P&O)

Mental Health/Substance Use Disorder

- Medication visit
- Partial Hospitalization
- Intensive Outpatient Therapy Programs
- Neurophysiological and psychological testing
- Electroconvulsive treatment

Medical/Surgical	Mental Health/Substance Use Disorder
<ul style="list-style-type: none"> ○ Internally Implanted Prosthetics • REHABILITATION SERVICES AND HABILITATIVE SERVICES <ul style="list-style-type: none"> ○ Speech Therapy ○ Physical and Occupational Therapy ○ Pulmonary Therapy ○ Cardiac Rehabilitation ○ Cognitive Therapy for Traumatic Brain Injury ○ Multi-disciplinary Rehabilitation • RECONSTRUCTIVE SURGERY • Urgent Care • VISION SERVICES <ul style="list-style-type: none"> ○ Adult Routine Eye Exam: <ul style="list-style-type: none"> ▪ Pediatric Routine Eye Exam (Children through age 18) <p><u>POS</u> N/A</p>	<p><u>POS</u> N/A</p>

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
<p>Kaiser Permanente Insurance Company (KPIC) offers the Dual Choice Plan in Georgia. This plan is composed of an In-Network PPO plan and Out-of-Network PPO plan. The Preferred Provider Organization (PPO) In-Network plan is comprised of Kaiser Providers and Contracted Providers and also offers the Private Health Care System (PHCS) network. The Out-of-Network PPO allows members to access any licensed health care provider in the United States. The type of plan or network that the member elects for their medical care has different member cost-share. Kaiser Permanente administers both PPO plans. “Our goal at Kaiser Permanente Insurance Company (KPIC) is to offer affordable care to all Members through the provider networks.”</p> <p><u>Reimbursement for In Network PHCS:</u> KPIC partners with Provider Network, MultiPlan/ Private Health Care System (PHCS) to apply the pricing to be used for the Provider Network Reimbursement for medical care services received by members accessing the KPIC PPO. KPIC ensures that the financial requirements and treatment limitations on mental health or substance use disorder benefits they provide are no more restrictive than those on medical or surgical benefits.</p>	<p>Kaiser Permanente Insurance Company (KPIC) offers the Dual Choice Plan in Georgia. This plan is composed of an In-Network PPO plan and Out-of-Network PPO plan. The Preferred Provider Organization (PPO) In-Network plan is comprised of Kaiser Providers and Contracted Providers and also offers the Private Health Care System (PHCS) network. The Out-of-Network PPO allows members to access any licensed health care provider in the United States. The type of plan or network that the member elects for their medical care has different member cost-share. Kaiser Permanente administers both PPO plans. “Our goal at Kaiser Permanente Insurance Company (KPIC) is to offer affordable care to all Members through the provider networks.”</p> <p><u>Reimbursement for In Network PHCS:</u> KPIC partners with Provider Network, MultiPlan/ Private Health Care System (PHCS) to apply the pricing to be used for the Provider Network Reimbursement for medical care services received by members accessing the KPIC PPO. KPIC ensures that the financial requirements and treatment limitations on mental health or substance use disorder benefits they provide are no more restrictive than those on medical or surgical benefits.</p>

Medical/Surgical

Treatment limitations may be quantitative treatment limitations (QTLs) which are numerical in nature (such as visit limits) or non-quantitative treatment limitations (NQTLs), which are non-numerical limits on the scope or duration of benefits for treatment. NQTLs are processes, strategies, standards, or other criteria that limit the scope or duration of benefits for services provided under the plan. Examples of NQTLs include, but are not limited to, medical management standards limiting benefits based on medical necessity, and network admission standards such as credentialing or reimbursement rates.

The law does not prohibit the use of NQTLs as long as they are not applied more stringently to MH/SUD benefits as compared to Medical/Surgical benefits. Disparate results do not necessarily indicate a violation of the MHPAEA, so long as comparable processes are followed. MultiPlan, on behalf of itself and its subsidiaries (collectively “MultiPlan”) is neither a health care provider nor an insurance company, and does not reimburse physicians, hospitals, or other healthcare providers for their services. MultiPlan does not pay claims, determine eligibility, or make benefit determinations; those responsibilities lie with KPIC.

The Federal regulations prohibiting the imposition of a discriminatory NQTL for MH/SUD services does not directly apply to MultiPlan. However, KPIC purchased access to MultiPlan’s Negotiation Services, as defined below, may require information from MultiPlan to assist with their compliance of these federal requirements. MultiPlan’s services include access to both MH/SUD and Medical/Surgical providers. This comparative analysis is specific to MultiPlan’s Negotiation Services, including an analysis of MultiPlan’s Financial Negotiation Services and Clinical Negotiation Services.

Please note that although the regulation refers to the parity of “reimbursement,” this document will discuss the parity of the amount negotiated with providers, as described below, since MultiPlan does not “reimburse” providers. MultiPlan has adopted the six-step analysis outlined by the Kennedy Forum for conducting a comparative analysis.

MultiPlan offers two types of negotiation services which may be accessed jointly or individually by KPIC: (i) Financial Negotiation Services, and (ii) Clinical Negotiation Services (collectively “Negotiation Services”). A more detailed description of each service is provided below. Negotiation Services offered to KPIC were identified as NQTLs requiring a comparative analysis to ensure that the processes are applied no more stringently to MH/SUD providers than Medical/Surgical providers.

MultiPlan utilizes a standard set of criteria for Financial Negotiation Services and Clinical Negotiation Services as part of

Mental Health/Substance Use Disorder

Treatment limitations may be quantitative treatment limitations (QTLs) which are numerical in nature (such as visit limits) or non-quantitative treatment limitations (NQTLs), which are non-numerical limits on the scope or duration of benefits for treatment. NQTLs are processes, strategies, standards, or other criteria that limit the scope or duration of benefits for services provided under the plan. Examples of NQTLs include, but are not limited to, medical management standards limiting benefits based on medical necessity, and network admission standards such as credentialing or reimbursement rates.

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MultiPlan utilizes a standard set of criteria for Financial Negotiation Services and Clinical Negotiation Services as part of

Medical/Surgical

the Negotiation Services and does not differentiate in the application of those criteria based on whether the provider is a MH/SUD provider or a Medical/Surgical provider. Negotiations Services with MH/SUD providers are managed in the same fashion, using the same contract documents, rate methodologies, and processes as all other providers.

As supported by this comparative analysis, MultiPlan does not establish NQTLs on, or implied through, relationships with providers, as written and/or in operation, that are applied more stringently to MH/SUD services than those applicable to Medical/Surgical services. MultiPlan's policies, processes, and operational implementation of such processes are not designed to restrict access to, or discriminate against, specific provider types or services, including but not limited to, MH/SUD providers. All policies and processes are implemented to apply equally regardless of provider type.

FINANCIAL NEGOTIATION SERVICES

MultiPlan's Financial Negotiation Services provides KPIC with access to negotiated reductions on claims for health care services rendered to KPIC members by out-of-network health care providers ("Financial Negotiation Services"). A provider may be considered "out-of-network" if the provider has not contractually agreed to participate in a MultiPlan network and/or a KPIC network. Financial Negotiation Services by MultiPlan may be initiated before or after the services are rendered, but typically occur prior to payment for such health care services. As part of Financial Negotiation Services, MultiPlan utilizes prevailing market reimbursement amounts to negotiate reductions with out-of-network providers, and in exchange, the out-of-network providers agree not to balance bill KPIC members for the difference between the agreed upon negotiated reduction and the provider's billed charges.

Financial Negotiation Services apply to both MH/SUD and Medical/Surgical providers. MultiPlan Financial Negotiation Services with out-of-network health care providers are based on comprehensive financial benchmarks, including publicly-available claim pricing data, MultiPlan's provider network performance with like claims, and MultiPlan's proprietary commercial benchmarks which are based on the amounts generally accepted by providers as payment in full ("MultiPlan's Proprietary Valuation Tool").

NEGOTIATION SERVICES

Similar to MultiPlan's Financial Negotiation Services:

- take place after services have been rendered but prior to payment to providers for the services
- result in written agreements with providers where each agreement specifies reimbursement for an individual claim

Mental Health/Substance Use Disorder

the Negotiation Services and does not differentiate in the application of those criteria based on whether the provider is a MH/SUD provider or a Medical/Surgical provider. Negotiations Services with MH/SUD providers are managed in the same fashion, using the same contract documents, rate methodologies, and processes as all other providers.

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NEGOTIATION SERVICES

Similar to MultiPlan's Financial Negotiation Services:

- take place after services have been rendered but prior to payment to providers for the services
- result in written agreements with providers where each agreement specifies reimbursement for an individual claim

Medical/Surgical

- consider prevailing market reimbursement amounts when negotiating with providers
- include language in the agreements to help protect the KPIC's members from balance billing
- follow the same processes to seek agreement with MH/SUD providers and Medical/Surgical providers.

Negotiation Services differ from Financial Negotiation Services in that Negotiations involve an enhanced discussion between MultiPlan and the provider regarding potential billing waste, abuse or errors identified on the individual claims. Negotiations attempt to correct for potential billing waste, abuse or errors, negotiations are pursued with providers that have a MultiPlan network contract (where the contract allows) as well as out-of-network providers.

MultiPlan identifies billing issues on claims using a proprietary claims analytic system that evaluates the claims against industry-standard medical coding rules and clinical guidelines. The system then scores the claims to determine which claims should be resolved through Financial Negotiations versus Clinical Negotiations. The scoring process takes into account charges associated with the billing issues, confidence in the accuracy of the issues on the specific claim, and historical experience with the providers. A portion of the claims selected for Negotiations may be reviewed by certified medical coders, nurses and/or physicians to further evaluate the applicability of the system-identified issues. After analysis and expert evaluation of the claims, Negotiations are completed by negotiators who are specially trained in billing waste, abuse, and errors.

Reimbursement for In Network PHCS Contracted Providers for POS:

KPIC partners with Provider Network, MultiPlan/ Private Health Care System (PHCS) to apply the pricing to be used for the Provider Network Reimbursement for medical care services received by members that are accessing the KPIC POS. KPIC ensures that the financial requirements and treatment limitations on mental health or substance use disorder benefits they provide are no more restrictive than those on medical or surgical benefits.

Treatment limitations may be quantitative treatment limitations (QTLs) which are numerical in nature (such as visit limits) or non-quantitative treatment limitations (NQTLs), which are non-numerical limits on the scope or duration of benefits for treatment. NQTLs are processes, strategies, standards, or other criteria that limit the scope or duration of benefits for services provided under the plan. Examples of NQTLs include, but are not limited to, medical management standards limiting benefits based on medical necessity, and network admission standards such as credentialing or reimbursement rates.

Mental Health/Substance Use Disorder

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Treatment limitations may be quantitative treatment limitations (QTLs) which are numerical in nature (such as visit limits) or non-quantitative treatment limitations (NQTLs), which are non-numerical limits on the scope or duration of benefits for treatment. NQTLs are processes, strategies, standards, or other criteria that limit the scope or duration of benefits for services provided under the plan. Examples of NQTLs include, but are not limited to, medical management standards limiting benefits based on medical necessity, and network admission standards such as credentialing or reimbursement rates.

Medical/Surgical

Disparate results do not necessarily indicate a violation of the MHPAEA, so long as comparable processes are followed. MultiPlan, on behalf of itself and its subsidiaries (collectively “MultiPlan”) is neither a health care provider nor an insurance company, and does not reimburse physicians, hospitals, or other healthcare providers for their services. MultiPlan does not pay claims, determine eligibility, or make benefit determinations; those responsibilities KPIC.

The Federal regulations prohibiting the imposition of a discriminatory NQTL for MH/SUD services does not directly apply to MultiPlan. However, KPIC purchased access to MultiPlan’s Negotiation Services, as defined below, may require information from MultiPlan to assist with their compliance of these federal requirements. MultiPlan’s services include access to both MH/SUD and Medical/Surgical providers. This comparative analysis is specific to MultiPlan’s Negotiation Services, including an analysis of MultiPlan’s Financial Negotiation Services and Clinical Negotiation Services.

Please note that although the regulation refers to the parity of “reimbursement,” this document will discuss the parity of the amount negotiated with providers, as described below, since MultiPlan does not “reimburse” providers. MultiPlan has adopted the six-step analysis outlined by the Kennedy Forum for conducting a comparative analysis.

MultiPlan offers two types of negotiation services which may be accessed jointly or individually by KPIC: (i) Financial Negotiation Services, and (ii) Clinical Negotiation Services (collectively “Negotiation Services”). A more detailed description of each service is provided below. Negotiation Services offered to KPIC were identified as NQTLs requiring a comparative analysis to ensure that the processes are applied no more stringently to MH/SUD providers than Medical/Surgical providers.

MultiPlan utilizes a standard set of criteria for Financial Negotiation Services and Clinical Negotiation Services as part of the Negotiation Services and does not differentiate in the application of those criteria based on whether the provider is a MH/SUD provider or a Medical/Surgical provider. Negotiations Services with MH/SUD providers are managed in the same fashion, using the same contract documents, rate methodologies, and processes as all other providers.

As supported by this comparative analysis, MultiPlan does not establish NQTLs on, or implied through, relationships with providers, as written and/or in operation, that are applied more stringently to MH/SUD services than those applicable to Medical/Surgical services. MultiPlan’s policies, processes, and operational implementation of such processes are not designed to restrict access to, or discriminate against, specific provider

Mental Health/Substance Use Disorder

Disparate results do not necessarily indicate a violation of the MHPAEA, so long as comparable processes are followed. MultiPlan, on behalf of itself and its subsidiaries (collectively “MultiPlan”) is neither a health care provider nor an insurance company, and does not reimburse physicians, hospitals, or other healthcare providers for their services. MultiPlan does not pay claims, determine eligibility, or make benefit determinations; those responsibilities KPIC.

The Federal regulations prohibiting the imposition of a discriminatory NQTL for MH/SUD services does not directly apply to MultiPlan. However, KPIC purchased access to MultiPlan’s Negotiation Services, as defined below, may require information from MultiPlan to assist with their compliance of these federal requirements. MultiPlan’s services include access to both MH/SUD and Medical/Surgical providers. This comparative analysis is specific to MultiPlan’s Negotiation Services, including an analysis of MultiPlan’s Financial Negotiation Services and Clinical Negotiation Services.

Please note that although the regulation refers to the parity of “reimbursement,” this document will discuss the parity of the amount negotiated with providers, as described below, since MultiPlan does not “reimburse” providers. MultiPlan has adopted the six-step analysis outlined by the Kennedy Forum for conducting a comparative analysis.

MultiPlan offers two types of negotiation services which may be accessed jointly or individually by KPIC: (i) Financial Negotiation Services, and (ii) Clinical Negotiation Services (collectively “Negotiation Services”). A more detailed description of each service is provided below. Negotiation Services offered to KPIC were identified as NQTLs requiring a comparative analysis to ensure that the processes are applied no more stringently to MH/SUD providers than Medical/Surgical providers.

MultiPlan utilizes a standard set of criteria for Financial Negotiation Services and Clinical Negotiation Services as part of the Negotiation Services and does not differentiate in the application of those criteria based on whether the provider is a MH/SUD provider or a Medical/Surgical provider. Negotiations Services with MH/SUD providers are managed in the same fashion, using the same contract documents, rate methodologies, and processes as all other providers.

As supported by this comparative analysis, MultiPlan does not establish NQTLs on, or implied through, relationships with providers, as written and/or in operation, that are applied more stringently to MH/SUD services than those applicable to Medical/Surgical services. MultiPlan’s policies, processes, and operational implementation of such processes are not designed to restrict access to, or discriminate against, specific provider

Medical/Surgical

types or services, including but not limited to, MH/SUD providers. All policies and processes are implemented to apply equally regardless of provider type.

FINANCIAL NEGOTIATION SERVICES

MultiPlan's Financial Negotiation Services provides KPIC with access to negotiated reductions on claims for health care services rendered to KPIC members by out-of-network health care providers ("Financial Negotiation Services"). A provider may be considered "out-of-network" if the provider has not contractually agreed to participate in a MultiPlan network and/or a KPIC network. Financial Negotiation Services by MultiPlan may be initiated before or after the services are rendered, but typically occur prior to payment for such health care services. As part of Financial Negotiation Services, MultiPlan utilizes prevailing market reimbursement amounts to negotiate reductions with out-of-network providers, and in exchange, the out-of-network providers agree not to balance bill KPIC members for the difference between the agreed upon negotiated reduction and the provider's billed charges.

Financial Negotiation Services apply to both MH/SUD and Medical/Surgical providers. MultiPlan Financial Negotiation Services with out-of-network health care providers are based on comprehensive financial benchmarks, including publicly-available claim pricing data, MultiPlan's provider network performance with like claims, and MultiPlan's proprietary commercial benchmarks which are based on the amounts generally accepted by providers as payment in full ("MultiPlan's Proprietary Valuation Tool").

NEGOTIATION SERVICES

Similar to MultiPlan's Financial Negotiation Services:

- take place after services have been rendered but prior to payment to providers for the services
- result in written agreements with providers where each agreement specifies reimbursement for an individual claim
- consider prevailing market reimbursement amounts when negotiating with providers
- include language in the agreements to help protect the KPIC's members from balance billing
- follow the same processes to seek agreement with MH/SUD providers and Medical/Surgical providers.

Negotiation Services differ from Financial Negotiation Services in that Negotiations involve an enhanced discussion between MultiPlan and the provider regarding potential billing waste, abuse or errors identified on the individual claims. Negotiations attempt to correct for potential billing waste, abuse or errors, negotiations are pursued with providers that have a MultiPlan

Mental Health/Substance Use Disorder

types or services, including but not limited to, MH/SUD providers. All policies and processes are implemented to apply equally regardless of provider type.

FINANCIAL NEGOTIATION SERVICES

MultiPlan's Financial Negotiation Services provides KPIC with access to negotiated reductions on claims for health care services rendered to KPIC members by out-of-network health care providers ("Financial Negotiation Services"). A provider may be considered "out-of-network" if the provider has not contractually agreed to participate in a MultiPlan network and/or a KPIC network. Financial Negotiation Services by MultiPlan may be initiated before or after the services are rendered, but typically occur prior to payment for such health care services. As part of Financial Negotiation Services, MultiPlan utilizes prevailing market reimbursement amounts to negotiate reductions with out-of-network providers, and in exchange, the out-of-network providers agree not to balance bill KPIC members for the difference between the agreed upon negotiated reduction and the provider's billed charges.

Financial Negotiation Services apply to both MH/SUD and Medical/Surgical providers. MultiPlan Financial Negotiation Services with out-of-network health care providers are based on comprehensive financial benchmarks, including publicly-available claim pricing data, MultiPlan's provider network performance with like claims, and MultiPlan's proprietary commercial benchmarks which are based on the amounts generally accepted by providers as payment in full ("MultiPlan's Proprietary Valuation Tool").

NEGOTIATION SERVICES

Similar to MultiPlan's Financial Negotiation Services:

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- consider prevailing market reimbursement amounts when negotiating with providers
- include language in the agreements to help protect the KPIC's members from balance billing
- follow the same processes to seek agreement with MH/SUD providers and Medical/Surgical providers.

Negotiation Services differ from Financial Negotiation Services in that Negotiations involve an enhanced discussion between MultiPlan and the provider regarding potential billing waste, abuse or errors identified on the individual claims. Negotiations attempt to correct for potential billing waste, abuse or errors, negotiations are pursued with providers that have a MultiPlan

Medical/Surgical	Mental Health/Substance Use Disorder
<p>network contract (where the contract allows) as well as out-of-network providers.</p> <p>MultiPlan identifies billing issues on claims using a proprietary claims analytic system that evaluates the claims against industry-standard medical coding rules and clinical guidelines. The system then scores the claims to determine which claims should be resolved through Financial Negotiations versus Clinical Negotiations. The scoring process takes into account charges associated with the billing issues, confidence in the accuracy of the issues on the specific claim, and historical experience with the providers. A portion of the claims selected for Negotiations may be reviewed by certified medical coders, nurses and/or physicians to further evaluate the applicability of the system-identified issues. After analysis and expert evaluation of the claims, Negotiations are completed by negotiators who are specially trained in billing waste, abuse, and errors.</p>	<p>network contract (where the contract allows) as well as out-of-network providers.</p> <p>MultiPlan identifies billing issues on claims using a proprietary claims analytic system that evaluates the claims against industry-standard medical coding rules and clinical guidelines. The system then scores the claims to determine which claims should be resolved through Financial Negotiations versus Clinical Negotiations. The scoring process takes into account charges associated with the billing issues, confidence in the accuracy of the issues on the specific claim, and historical experience with the providers. A portion of the claims selected for Negotiations may be reviewed by certified medical coders, nurses and/or physicians to further evaluate the applicability of the system-identified issues. After analysis and expert evaluation of the claims, Negotiations are completed by negotiators who are specially trained in billing waste, abuse, and errors.</p>

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
<p>FACTORS USED IN NEGOTIATION SERVICES:</p> <p>Financial Negotiation Services and Clinical Negotiation Services have been established by MultiPlan to ensure that: (i) KPIC and their members have access to the greatest possible discount for health care services rendered to members which is based on prevailing market reimbursement data, while also offering members protection against balance billing for the difference between the agreed upon negotiated reduction and the provider's billed charges; (ii) MultiPlan applies consistent negotiation processes and standards throughout the organization when negotiating with MH/SUD and Medical/Surgical provider types for reductions on out of network health care services; and (iii) the negotiated discounts offered to, and agreed upon by, out of network providers are offered, processed, and managed in the same manner for MH/SUD providers as for all other provider types.</p> <p>"FINANCIAL NEGOTIATION SERVICES FACTORS" CONSIDERED FOR OUT-OF-NETWORK CLAIMS</p> <p>As introduced above, the primary goal of Financial Negotiation Services is to provide the greatest possible savings to KPIC members, which is agreed upon by the out-of-network provider, using a number of informational statistics and criteria as a baseline for negotiations ("Financial Negotiation Services</p>	<p>FACTORS USED IN NEGOTIATION SERVICES:</p> <p>Financial Negotiation Services and Clinical Negotiation Services have been established by MultiPlan to ensure that: (i) KPIC and their members have access to the greatest possible discount for health care services rendered to members which is based on prevailing market reimbursement data, while also offering members protection against balance billing for the difference between the agreed upon negotiated reduction and the provider's billed charges; (ii) MultiPlan applies consistent negotiation processes and standards throughout the organization when negotiating with MH/SUD and Medical/Surgical provider types for reductions on out of network health care services; and (iii) the negotiated discounts offered to, and agreed upon by, out of network providers are offered, processed, and managed in the same manner for MH/SUD providers as for all other provider types.</p> <p>"FINANCIAL NEGOTIATION SERVICES FACTORS" CONSIDERED FOR OUT-OF-NETWORK CLAIMS</p> <p>As introduced above, the primary goal of Financial Negotiation Services is to provide the greatest possible savings to KPIC members, which is agreed upon by the out-of-network provider, using a number of informational statistics and criteria as a baseline for negotiations ("Financial Negotiation Services</p>

Medical/Surgical

Factors”). The grid below identifies the Financial Negotiation Services Factors used when negotiating a discount for health care services with an out-of-network provider on behalf of KPIC who purchased access to Financial Negotiation Services.

Financial Negotiation may vary depending on whether the negotiation is for a single case (i.e., single patient for specific date of service) or whether the provider agreed to a more global approach to a negotiated discount. The same process is used to negotiate with both MH/SUD and Medical/Surgical providers, even though outcomes may differ.

Factor	Description	Outpatient (Physician) Services	Outpatient (Facility) Services	Inpatient Services	Emergency Services
Allowed Amount	KPIC may identify an Allowed Amount which Negotiation Services must negotiate below in order for KPIC to elect to access the negotiated discount. The negotiated amount may differ from claim to claim, but the process produces the same target discount amount in the same market, and KPIC determines if they will access the negotiated amount, based on their Allowed Amount determination.	✓	✓	✓	✓
Medicare Reimbursement Benchmark	The negotiation system captures Medicare rates for billed services which are used as a reference point for negotiations to compare billed charges to Medicare reimbursement. This information may be used in discussion or as a basis to generate an offer to a provider.	✓	✓	✓	✓
MultiPlan's Proprietary Valuation Tool	The negotiation system captures the value established by MultiPlan's Proprietary Valuation Tool which is used as a reference point for negotiations with a provider.	✓	✓	✓	✓
Negotiation Agreement	An agreement with a provider for an agreed upon rate for a claim. Financial Negotiation agreements may be for (i) a single case agreement; (ii) all claims submitted for KPIC and all patients; or (iii) all claims associated with a specific KPIC patient.	✓	✓	✓	✓

CLINICAL NEGOTIATION SERVICES FACTORS” CONSIDERED

Clinical Negotiation Services start with an automated computer analysis of claims used to identify potential billing waste, abuse, or errors. The analysis relies upon industry-standard medical coding rules and clinical guidelines that are publicly available and sponsored by well-recognized entities such as Medicare and the American Medical Association. Sources for Reimbursement Methodologies include:

- CMS Physician pricing guidelines
- CMS HCPCS pricing guidelines
- CMS DRG classification

When applicable, the analysis may also incorporate billing rules and guidelines utilized by KPIC. Common issues identified during the automated analysis include:

- billing a procedure that is inconsistent with the place of service (e.g., billing for a hospital emergency room visit in a doctor's office)
- billing both a component procedure and a more comprehensive procedure that includes the component

Mental Health/Substance Use Disorder

Factors”). The grid below identifies the Financial Negotiation Services Factors used when negotiating a discount for health care services with an out-of-network provider on behalf of KPIC who purchased access to Financial Negotiation Services.

Financial Negotiation may vary depending on whether the negotiation is for a single case (i.e., single patient for specific date of service) or whether the provider agreed to a more global approach to a negotiated discount. The same process is used to negotiate with both MH/SUD and Medical/Surgical providers, even though outcomes may differ.

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Allowed Amount	KPIC may identify an Allowed Amount which Negotiation Services must negotiate below in order for KPIC to elect to access the negotiated discount. The negotiated amount may differ from claim to claim, but the process produces the same target discount amount in the same market, and KPIC determines if they will access the negotiated amount, based on their Allowed Amount determination.	✓	✓	✓	✓
Medicare Reimbursement Benchmark	The negotiation system captures Medicare rates for billed services which are used as a reference point for negotiations to compare billed charges to Medicare reimbursement. This information may be used in discussion or as a basis to generate an offer to a provider.	✓	✓	✓	✓
MultiPlan's Proprietary Valuation Tool	The negotiation system captures the value established by MultiPlan's Proprietary Valuation Tool which is used as a reference point for negotiations with a provider.	✓	✓	✓	✓
Negotiation Agreement	An agreement with a provider for an agreed upon rate for a claim. Financial Negotiation agreements may be for (i) a single case agreement; (ii) all claims submitted for KPIC and all patients; or (iii) all claims associated with a specific KPIC patient.	✓	✓	✓	✓

CLINICAL NEGOTIATION SERVICES FACTORS” CONSIDERED

Clinical Negotiation Services start with an automated computer analysis of claims used to identify potential billing waste, abuse, or errors. The analysis relies upon industry-standard medical coding rules and clinical guidelines that are publicly available and sponsored by well-recognized entities such as Medicare and the American Medical Association. Sources for Reimbursement Methodologies include:

- CMS Physician pricing guidelines
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When applicable, the analysis may also incorporate billing rules and guidelines utilized by KPIC. Common issues identified during the automated analysis include:

- billing a procedure that is inconsistent with the place of service (e.g., billing for a hospital emergency room visit in a doctor's office)
- billing both a component procedure and a more comprehensive procedure that includes the component

Medical/Surgical

(e.g., billing an EKG and a cardiac stress test that includes an EKG)

- billing an incorrect number of services (e.g., can only bill one service per day when the service is defined as a per diem service)
- billing for incompatible procedures (repair an organ and remove an organ)

Note that MultiPlan does not create its own billing rules and guidelines. Instead, MultiPlan identifies billing waste, abuse, and errors based on the rules and guidelines published by reputable health care entities. MultiPlan also does not authorize services, deny services, perform utilization review, or determine the necessity of services. MultiPlan's claims analysis focuses on the correctness of the procedure, diagnosis, and other codes reported on claims.

The grid below identifies the Clinical Negotiation Services Factors used by MultiPlan when reviewing and negotiating MultiPlan network claims and out-of-network claims with providers on behalf of KPIC.

Factor	Description	Outpatient (Professional) Services	Outpatient (Facility) Services	Inpatient Services	Emergency Services
Billing waste, abuse, and errors analysis	Automated computerized analysis of claims data to identify potential billing situations that conflict with industry-standard coding rules and clinical guidelines. Expert review may occur on a portion of the claims to validate applicability of issues on the claims.	✓	✓	✓	✓
Allowed Amount	KPIC may identify an Allowed Amount which Negotiation Services must negotiate below in order for KPIC to elect to access the Negotiation Services agreement.	✓	✓	✓	✓
Medicare Reimbursement Benchmark	The negotiation system captures Medicare rates for billed services which are used as a reference point for negotiations to compare billed charges to Medicare reimbursement.	✓	✓	✓	✓
MultiPlan's Proprietary Valuation Tool	The negotiation system captures the value established by Multiplan's Proprietary Valuation Tool which is used as a reference point for negotiations with a provider.	✓	✓	✓	✓
Negotiation Agreement	An agreement with a provider for an agreed upon rate for a claim. KPIC Negotiation agreements are for a single case agreement only.	✓	✓	✓	✓

Mental Health/Substance Use Disorder

(e.g., billing an EKG and a cardiac stress test that includes an EKG)

- billing an incorrect number of services (e.g., can only bill one service per day when the service is defined as a per diem service)
- billing for incompatible procedures (repair an organ and remove an organ)

Note that MultiPlan does not create its own billing rules and guidelines. Instead, MultiPlan identifies billing waste, abuse, and errors based on the rules and guidelines published by reputable health care entities. MultiPlan also does not authorize services, deny services, perform utilization review, or determine the necessity of services. MultiPlan's claims analysis focuses on the correctness of the procedure, diagnosis, and other codes reported on claims.

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Factor	Description	Outpatient (Professional) Services	Outpatient (Facility) Services	Inpatient Services	Emergency Services
Billing waste, abuse, and errors analysis	Automated computerized analysis of claims data to identify potential billing situations that conflict with industry-standard coding rules and clinical guidelines. Expert review may occur on a portion of the claims to validate applicability of issues on the claims.	✓	✓	✓	✓
Allowed Amount	KPIC may identify an Allowed Amount which Negotiation Services must negotiate below in order for KPIC to elect to access the Negotiation Services agreement.	✓	✓	✓	✓
Medicare Reimbursement Benchmark	The negotiation system captures Medicare rates for billed services which are used as a reference point for negotiations to compare billed charges to Medicare reimbursement.	✓	✓	✓	✓
MultiPlan's Proprietary Valuation Tool	The negotiation system captures the value established by Multiplan's Proprietary Valuation Tool which is used as a reference point for negotiations with a provider.	✓	✓	✓	✓
Negotiation Agreement	An agreement with a provider for an agreed upon rate for a claim. KPIC Negotiation agreements are for a single case agreement only.	✓	✓	✓	✓

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical

MultiPlan's established proprietary processes and policies, industry-standard analytics, and guidelines, as well as certain state and federal requirements, are used to formulate the criteria that establish the Negotiation Services Factors. These evidentiary standards support MultiPlan's determinations of what constitutes an effective Negotiation Services program.

EVIDENTIARY STANDARDS FOR EACH FACTOR CONSIDERED WHEN ESTABLISHING FINANCIAL NEGOTIATION SERVICES FACTORS

The evidentiary standards for the Financial Negotiation Services Factors used in developing the processes for the review and negotiation of out-of-network MH/SUD and Medical/Surgical claims submitted to MultiPlan by Clients are detailed below:

Factor	Evidentiary Standard	MH Providers	SUD Providers	Medical Surgical Providers
Allowed Amount	1. KPIC's vendor (First Health) -Defined (Usual and Customary amount may vary depending on source used by Client). MultiPlan does not establish	✓	✓	✓
Medicare Reimbursement Benchmark	1. Reimbursement methods and rates published by CMS 2. Publicly available fee schedules published by CMS	✓	✓	✓
MultiPlan's Proprietary Valuation Tool	1. Relative Value Units (RVU) 2. Geographic Practice Cost Indices (GPCI) 3. Publicly Available Data Sets	✓	✓	✓
Negotiation Agreement	1. The creation, negotiation criteria, processing and application of the Financial Negotiation agreements are standardized to ensure a consistent process.	✓	✓	✓

EVIDENTIARY STANDARDS FOR EACH FACTOR CONSIDERED WHEN ESTABLISHING CLINICAL NEGOTIATION SERVICES FACTORS

The evidentiary standards for the Clinical Negotiation Services Factors used in developing the processes for the review and negotiation of MultiPlan network and out-of-network Medical/Surgical and MH/SUD claims submitted to MultiPlan by Clients are detailed below:

Mental Health/Substance Use Disorder

MultiPlan's established proprietary processes and policies, industry-standard analytics, and guidelines, as well as certain state and federal requirements, are used to formulate the criteria that establish the Negotiation Services Factors. These evidentiary standards support MultiPlan's determinations of what constitutes an effective Negotiation Services program.

EVIDENTIARY STANDARDS FOR EACH FACTOR CONSIDERED WHEN ESTABLISHING FINANCIAL NEGOTIATION SERVICES FACTORS

The evidentiary standards for the Financial Negotiation Services Factors used in developing the processes for the review and negotiation of out-of-network MH/SUD and Medical/Surgical claims submitted to MultiPlan by Clients are detailed below:

Factor	Evidentiary Standard	MH Providers	SUD Providers	Medical Surgical Providers
Allowed Amount	1. KPIC's vendor (First Health) -Defined (Usual and Customary amount may vary depending on source used by Client). MultiPlan does not establish	✓	✓	✓
Medicare Reimbursement Benchmark	1. Reimbursement methods and rates published by CMS 2. Publicly available fee schedules published by CMS	✓	✓	✓
MultiPlan's Proprietary Valuation Tool	1. Relative Value Units (RVU) 2. Geographic Practice Cost Indices (GPCI) 3. Publicly Available Data Sets	✓	✓	✓
Negotiation Agreement	1. The creation, negotiation criteria, processing and application of the Financial Negotiation agreements are standardized to ensure a consistent process.	✓	✓	✓

EVIDENTIARY STANDARDS FOR EACH FACTOR CONSIDERED WHEN ESTABLISHING CLINICAL NEGOTIATION SERVICES FACTORS

The evidentiary standards for the Clinical Negotiation Services Factors used in developing the processes for the review and negotiation of MultiPlan network and out-of-network Medical/Surgical and MH/SUD claims submitted to MultiPlan by Clients are detailed below:

Medical/Surgical

Mental Health/Substance Use Disorder

Factor	Evidentiary Standard	MH Providers	SUD Providers	Medical Surgical Providers
Billing waste, abuse, and errors analysis	<ol style="list-style-type: none"> 1. CPT coding guidelines published by the American Medical Association 2. National Correct Coding Initiative (NCCI) publicly available data files and manuals 3. Outpatient Code Editor (OCE) publicly available data files and manuals for outpatient facility services 4. Resource-Based Relative Value Scale (RBRVS) publicly available data files and manuals for professional reimbursement 5. HCPCS coding guidelines published by the American Hospital Association 6. Health care billing instructions published by the National Uniform Billing Committee for facility billing 7. Standards and guidelines published by coding organizations (e.g. AAPC, American Health Information Management Association (AHIMA)) 8. Standards and guidelines published by Professional Medical Associations (e.g., American Society of Anesthesiologists) 9. State regulations related to state-specific workers' compensation programs 10. KPIC's policies regarding reimbursement guidelines (applies only to specific KPIC claims) 11. Provider-Specific – When industry standards are not met, indicates if the provider is a statistical outlier for frequency of billing inaccuracy 	✓	✓	✓
Allowed Amount	<ol style="list-style-type: none"> 1. KPIC's vendor (Fair Health) Defined (Usual and Customary amount may vary depending on source used by Client). MultiPlan does not have establish this target value. 	✓	✓	✓
Medicare Benchmark	<ol style="list-style-type: none"> 1. Reimbursement methods and rates published by CMS 2. Publicly available fee schedules published by CMS 	✓	✓	✓
MultiPlan's Proprietary Valuation Tool	<ol style="list-style-type: none"> 1. Relative Value Units (RVU) 2. Geographic Practice Cost Indices (GPCI) 3. Publicly Available Data Sets 	✓	✓	✓
Negotiation Agreement	<ol style="list-style-type: none"> 1. The creation, negotiation criteria, processing, and application of the Clinical Negotiation agreements are standardized to ensure a consistent process. 	✓	✓	✓

Factor	Evidentiary Standard	MH Providers	SUD Providers	Medical Surgical Providers
Billing waste, abuse, and errors analysis	<ol style="list-style-type: none"> 1. CPT coding guidelines published by the American Medical Association 2. National Correct Coding Initiative (NCCI) publicly available data files and manuals 3. Outpatient Code Editor (OCE) publicly available data files and manuals for outpatient facility services 4. Resource-Based Relative Value Scale (RBRVS) publicly available data files and manuals for professional reimbursement 5. HCPCS coding guidelines published by the American Hospital Association 6. Health care billing instructions published by the National Uniform Billing Committee for facility billing 7. Standards and guidelines published by coding organizations (e.g. AAPC, American Health Information Management Association (AHIMA)) 8. Standards and guidelines published by Professional Medical Associations (e.g., American Society of Anesthesiologists) 9. State regulations related to state-specific workers' compensation programs 10. KPIC's policies regarding reimbursement guidelines (applies only to specific KPIC claims) 11. Provider-Specific – When industry standards are not met, indicates if the provider is a statistical outlier for frequency of billing inaccuracy 	✓	✓	✓
Allowed Amount	<ol style="list-style-type: none"> 1. KPIC's vendor (Fair Health) Defined (Usual and Customary amount may vary depending on source used by Client). MultiPlan does not have establish this target value. 	✓	✓	✓
Medicare Benchmark	<ol style="list-style-type: none"> 1. Reimbursement methods and rates published by CMS 2. Publicly available fee schedules published by CMS 	✓	✓	✓
MultiPlan's Proprietary Valuation Tool	<ol style="list-style-type: none"> 1. Relative Value Units (RVU) 2. Geographic Practice Cost Indices (GPCI) 3. Publicly Available Data Sets 	✓	✓	✓
Negotiation Agreement	<ol style="list-style-type: none"> 1. The creation, negotiation criteria, processing, and application of the Clinical Negotiation agreements are standardized to ensure a consistent process. 	✓	✓	✓

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical

Mental Health/Substance Use Disorder

WRITTEN POLICY AND PROCESS COMPARATIVE ANALYSIS:

This section includes the comparative analysis of MultiPlan's Negotiation Services processes to ensure that MultiPlan processes are applied no more stringently to MH/SUD providers than they would be to Medical/Surgical service providers. A summary of processes as outlined in MultiPlan proprietary policies and procedures is included.

DESCRIPTION OF THE NEGOTIATION SERVICES NQTL PROCESSES

KPIC will determine what types of claims should be considered (i.e., practitioner and/or facility), and may also establish a minimum claim threshold amount before a claim will be eligible for Negotiation Services (e.g., review claims over \$1,000.00 only). Once claim eligibility is established per the KPIC's criteria, MultiPlan will verify the provider's information to confirm whether the MH/SUD or Medical/Surgical provider has made a request not to be contacted or has a history of unsuccessful

WRITTEN POLICY AND PROCESS COMPARATIVE ANALYSIS:

This section includes the comparative analysis of MultiPlan's Negotiation Services processes to ensure that MultiPlan processes are applied no more stringently to MH/SUD providers than they would be to Medical/Surgical service providers. A summary of processes as outlined in MultiPlan proprietary policies and procedures is included.

DESCRIPTION OF THE NEGOTIATION SERVICES NQTL PROCESSES

KPIC will determine what types of claims should be considered (i.e., practitioner and/or facility), and may also establish a minimum claim threshold amount before a claim will be eligible for Negotiation Services (e.g., review claims over \$1,000.00 only). Once claim eligibility is established per the KPIC's criteria, MultiPlan will verify the provider's information to confirm whether the MH/SUD or Medical/Surgical provider has made a request not to be contacted or has a history of unsuccessful

Medical/Surgical

negotiations, in which case the claim will be returned to KPIC without MultiPlan attempting to conduct a Financial Negotiation. For those claims deemed eligible for Financial Negotiation Services, MultiPlan will contact the provider to attempt to negotiate.

A similar claim eligibility process is followed for KPIC Clinical Negotiation Services as it relates to claim thresholds only, but eligibility is not limited based on KPIC defined claim type (i.e., practitioner or facility). However, using the Waste and Abuse Review Factors described in the table above, the claim may also be reviewed to determine whether industry standard billing and coding practices were followed. If there is evidence of waste/abuse, then the claim becomes a Clinical Negotiation Services claim and Clinical negotiations are attempted. All providers for Clinical Negotiation Services are contacted due to the identified irregularities in the claim. KPIC purchased access to both Financial Negotiation Services and Clinical Negotiation Services, unsuccessful Clinical Negotiations may be forwarded to Financial Negotiations Services if the provider has an existing Financial Negotiation Agreement.

Once MultiPlan contacts the provider to attempt a financial or clinical negotiation, the negotiation generally ends in the three possible outcomes: (1) signed agreement with a negotiated amount; (2) no agreement is reached by time frame allowed by KPIC to obtain an agreement; or (3) no agreement is reached because the provider has not agreed to terms consistent with negotiation criteria established by KPIC. The same process is used to negotiate with both MH/SUD and Medical/Surgical providers, even though outcomes may differ. MultiPlan does not apply processes more stringently to MH/SUD providers that it does for Medical/Surgical providers.

NEGOTIATION SERVICES NQTL POLICY AUDIT RESULTS

The Negotiation Services policies and procedures are applied consistently for all claims and all provider types, which includes both MH/SUD and Medical/Surgical providers. Specific exceptions may be applied for a particular provider type (professional or facility); however, those exceptions are applied consistently for the applicable provider type (e.g., modifiers such as multiple procedures, bi-lateral, assistant surgeon, co-surgeon, and anesthesia that are applicable to professional providers but are not applicable to facility providers).

The previous subsections include a general overview of the content of the policies reviewed to ensure consistent application to all providers, MH/SUD or Medical/Surgical, equally. Therefore, the chart below includes an analysis of the content to support the findings of an internal review of MultiPlan's written policies.

Mental Health/Substance Use Disorder

negotiations, in which case the claim will be returned to KPIC without MultiPlan attempting to conduct a Financial Negotiation. For those claims deemed eligible for Financial Negotiation Services, MultiPlan will contact the provider to attempt to negotiate.

A similar claim eligibility process is followed for KPIC Clinical Negotiation Services as it relates to claim thresholds only, but eligibility is not limited based on KPIC defined claim type (i.e., practitioner or facility). However, using the Waste and Abuse Review Factors described in the table above, the claim may also be reviewed to determine whether industry standard billing and coding practices were followed. If there is evidence of waste/abuse, then the claim becomes a Clinical Negotiation Services claim and Clinical negotiations are attempted. All providers for Clinical Negotiation Services are contacted due to the identified irregularities in the claim. KPIC purchased access to both Financial Negotiation Services and Clinical Negotiation Services, unsuccessful Clinical Negotiations may be forwarded to Financial Negotiations Services if the provider has an existing Financial Negotiation Agreement.

Once MultiPlan contacts the provider to attempt a financial or clinical negotiation, the negotiation generally ends in the three possible outcomes: (1) signed agreement with a negotiated amount; (2) no agreement is reached by time frame allowed by KPIC to obtain an agreement; or (3) no agreement is reached because the provider has not agreed to terms consistent with negotiation criteria established by KPIC. The same process is used to negotiate with both MH/SUD and Medical/Surgical providers, even though outcomes may differ. MultiPlan does not apply processes more stringently to MH/SUD providers that it does for Medical/Surgical providers.

NEGOTIATION SERVICES NQTL POLICY AUDIT RESULTS

The Negotiation Services policies and procedures are applied consistently for all claims and all provider types, which includes both MH/SUD and Medical/Surgical providers. Specific exceptions may be applied for a particular provider type (professional or facility); however, those exceptions are applied consistently for the applicable provider type (e.g., modifiers such as multiple procedures, bi-lateral, assistant surgeon, co-surgeon, and anesthesia that are applicable to professional providers but are not applicable to facility providers).

The previous subsections include a general overview of the content of the policies reviewed to ensure consistent application to all providers, MH/SUD or Medical/Surgical, equally. Therefore, the chart below includes an analysis of the content to support the findings of an internal review of MultiPlan's written policies.

Medical/Surgical

Mental Health/Substance Use Disorder

POLICY	POLICY CONTENTS	APPLICABILITY		
		MH/SUD	SUD	MEDICAL/ SURGICAL
		PROVIDERS	PROVIDERS	PROVIDERS
Negotiation Services Agreements Policy	1. Written agreement between MultiPlan and out-of-network providers for a predetermined discount amount. 2. Ambulatory Surgical Centers are eligible for a single case agreement but not for a global negotiated agreement.	V	V	V
Assistant Surgeon and Co-Surgeon Claims Policy	1. Reduction in negotiated amount based on industry standard practices for Assistant Surgeons and Co-Surgeons.	N/A	N/A	V
Unsuccessful Negotiation History Provider Policy	1. A provider with a history of unsuccessful negotiations may prefer not be contacted to negotiate a reduction in billed charges.	V	V	V
Patient Benefits Policy	1. During negotiations, if a provider requests a copy of the patient's benefit plan, MultiPlan may request such information from KPIC or refer the provider to the insurer for benefit information. KPIC is responsible for benefit requirements, benefit determinations, and payment for healthcare services.	V	V	V
Stop Negotiation Policies	1. Negotiations for claims submitted with eligible charges that exceed KPIC's Allowed Amount or payor liability, as determined by benefit plan design, may be discontinued. MultiPlan does not determine the Allowed Amount or make benefit determinations. The same Allowed Amount for KPIC is used for both MH/SUD claims and Medical/Surgical claims.	V	V	V
Claim Negotiation Timelines Policy	1. Time frame established for contacting a provider after receipt of claim. 2. Automated reminders are sent on the specific dates following the initial contact. 3. Negotiations must close by KPIC's claim due date identified on each claim, unless an extension is granted by the KPIC due to potential for high likelihood of a successful negotiation identified by MultiPlan.	V	V	V
Multiple Bilateral Surgery Claims Guide Policy	1. Claims with surgical modifiers 50 and 51 require industry-standard reductions for procedures performed at the same time that share resources or are on identical opposing structures.	N/A	N/A	V
Anesthesia Claims Policy	1. Claims with modifiers QK, QX, or QY require minimum reductions for anesthesiology services provided that (a) more than 1 anesthesia procedure is performed, (b) they are performed by a CRNA, or (c) they are directed by an anesthesiologist to a CRNA.	N/A	N/A	V

POLICY	POLICY CONTENTS	APPLICABILITY		
		MH/SUD	SUD	MEDICAL/ SURGICAL
		PROVIDERS	PROVIDERS	PROVIDERS
Negotiation Services Agreements Policy	1. Written agreement between MultiPlan and out-of-network providers for a predetermined discount amount. 2. Ambulatory Surgical Centers are eligible for a single case agreement but not for a global negotiated agreement.	V	V	V
Assistant Surgeon and Co-Surgeon Claims Policy	1. Reduction in negotiated amount based on industry standard practices for Assistant Surgeons and Co-Surgeons.	N/A	N/A	V
Unsuccessful Negotiation History Provider Policy	1. A provider with a history of unsuccessful negotiations may prefer not be contacted to negotiate a reduction in billed charges.	V	V	V
Patient Benefits Policy	1. During negotiations, if a provider requests a copy of the patient's benefit plan, MultiPlan may request such information from KPIC or refer the provider to the insurer for benefit information. KPIC is responsible for benefit requirements, benefit determinations, and payment for healthcare services.	V	V	V
Stop Negotiation Policies	1. Negotiations for claims submitted with eligible charges that exceed KPIC's Allowed Amount or payor liability, as determined by benefit plan design, may be discontinued. MultiPlan does not determine the Allowed Amount or make benefit determinations. The same Allowed Amount for KPIC is used for both MH/SUD claims and Medical/Surgical claims.	V	V	V
Claim Negotiation Timelines Policy	1. Time frame established for contacting a provider after receipt of claim. 2. Automated reminders are sent on the specific dates following the initial contact. 3. Negotiations must close by KPIC's claim due date identified on each claim, unless an extension is granted by the KPIC due to potential for high likelihood of a successful negotiation identified by MultiPlan.	V	V	V
Multiple Bilateral Surgery Claims Guide Policy	1. Claims with surgical modifiers 50 and 51 require industry-standard reductions for procedures performed at the same time that share resources or are on identical opposing structures.	N/A	N/A	V
Anesthesia Claims Policy	1. Claims with modifiers QK, QX, or QY require minimum reductions for anesthesiology services provided that (a) more than 1 anesthesia procedure is performed, (b) they are performed by a CRNA, or (c) they are directed by an anesthesiologist to a CRNA.	N/A	N/A	V

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical

Mental Health/Substance Use Disorder

OPERATIONAL IMPLEMENTATION OF PROCESSES AND STRATEGIES COMPARATIVE ANALYSIS:

The grid below shows the percentage of claims that resulted in invalid, successful, and unsuccessful negotiations. These categories are defined as follows:

1. Invalid – A negotiation attempt could not be made due to claim-specific circumstances, including but not limited to the following: provider received reimbursement prior to negotiation attempt; KPIC already initiated direct negotiation with the provider; or the Allowed Amount was too low to attempt negotiation. Specific to mental health claims, for example, it is common that out-of-network mental health claims are paid to the provider by the member at the time the service is provided (i.e., up front) eliminating the opportunity for negotiation.

OPERATIONAL IMPLEMENTATION OF PROCESSES AND STRATEGIES COMPARATIVE ANALYSIS:

The grid below shows the percentage of claims that resulted in invalid, successful, and unsuccessful negotiations. These categories are defined as follows:

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Medical/Surgical

2. Successful – A successful negotiation is reached via an agreement with the provider.
3. Unsuccessful – Negotiation attempt was unsuccessful with provider.

For Financial Negotiations Services, 33.5% of MH/SUD claims and 52.37% of Medical/Surgical claims were determined to be invalid. These percentages are comparable given that MH/SUD claims were lower in volume. MultiPlan does not have responsibility for claims that are not submitted for negotiation. A higher percentage of claims were successfully negotiated for MH/SUD claims (34.72%) as compared to Medical/Surgical claims (26.25%); however, the Medical/Surgical claims were significantly higher volume. Financial Negotiation Services received approximately 99 times more Medical/Surgical claims than MH/SUD in 2022. The percentage of successfully negotiated claims volume is within an acceptable standard deviation of 10%.

For Clinical Negotiations Services, 24.25% of MH/SUD claims and 33.45% of Medical/Surgical claims were determined to be invalid. These percentages are comparable with a standard deviation of less than 1%. Medical/Surgical claims are successfully negotiated at a rate of 33.26%, which is higher than the percentage of the successfully negotiated MH/SUD claims at 24.25%. This variance of 9.51% is likely due to the lower volume of MH/SUD claims selected for Clinical Negotiation Services for the reasons noted earlier (higher volume of MH/SUD claims that are paid up front and are never routed to MultiPlan for negotiation attempts). Claims with unsuccessful clinical negotiations are returned to KPIC for repricing (or another MultiPlan product offering if purchased by KPIC), and therefore, MultiPlan Negotiation Services policies no longer apply. A slightly higher percentage of unsuccessful clinical negotiations does not imply a disparity in application of Multiplan's Clinical Negotiation Services processes.

MH/SUD providers are treated equally and do not have different criteria or processes.

State specific detail can be found on Appendix A, attached hereto.

Mental Health/Substance Use Disorder

2. Successful – A successful negotiation is reached via an agreement with the provider.
3. Unsuccessful – Negotiation attempt was unsuccessful with provider.

For Financial Negotiations Services, 33.5% of MH/SUD claims and 52.37% of Medical/Surgical claims were determined to be invalid. These percentages are comparable given that MH/SUD claims were lower in volume. MultiPlan does not have responsibility for claims that are not submitted for negotiation. A higher percentage of claims were successfully negotiated for MH/SUD claims (34.72%) as compared to Medical/Surgical claims (26.25%); however, the Medical/Surgical claims were significantly higher volume. Financial Negotiation Services received approximately 99 times more Medical/Surgical claims than MH/SUD in 2022. The percentage of successfully negotiated claims volume is within an acceptable standard deviation of 10%.

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MH/SUD providers are treated equally and do not have different criteria or processes.

State specific detail can be found on Appendix A, attached hereto.

Medical/Surgical

Mental Health/Substance Use Disorder

NEGOTIATION TYPE	CATEGORY	OUTCOME REASON	CLAIMS	% CLAIMS
FINANCIAL	MH/SUD	Invalid	614,214	33.55%
		Successful	635,648	33.26%
		Unsuccessful	580,910	31.73%
	MH/SUD Total		1,830,772	1.16% of Total
	MEDICAL/ SURGICAL	Invalid	81,735,997	52.37%
		Successful	40,967,900	26.25%
		Unsuccessful	33,367,30	21.38%
MEDICAL/ SURGICAL Total		156,071,213	98.84% of Total	
CLINICAL	MH/SUD	Invalid	2,621	24.52%
		Successful	2,539	23.75%
		Unsuccessful	5,529	51.73%
	MH/SUD Total		10,689	0.54% of Total
	MEDICAL/ SURGICAL	Invalid	656,520	33.45%
		Successful	652,850	33.26%
		Unsuccessful	653,562	33.30%
MEDICAL/ SURGICAL Total		1,962,932	99.46% of Total	
Grand Total		159,875,606	100.00%	

NEGOTIATION TYPE	CATEGORY	OUTCOME REASON	CLAIMS	% CLAIMS
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	MEDICAL/ SURGICAL	Invalid	81,735,997	52.37%
		Successful	40,967,900	26.25%
		Unsuccessful	33,367,30	21.38%
MEDICAL/ SURGICAL Total		156,071,213	98.84% of Total	
CLINICAL	MH/SUD	Invalid	2,621	24.52%
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	MH/SUD Total		10,689	0.54% of Total
	MEDICAL/ SURGICAL	Invalid	656,520	33.45%
		Successful	652,850	33.26%
		Unsuccessful	653,562	33.30%
MEDICAL/ SURGICAL Total		1,962,932	99.46% of Total	
Grand Total		159,875,606	100.00%	

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

FINDINGS/COMPLIANCE DETERMINATION:

MultiPlan applies the criteria for Negotiation Services in the same manner to both MH/SUD and Medical/Surgical providers, and all aspects of the Negotiation Services process are subject to MultiPlan's policies and procedures. At no time have NQTLs been established or implied through MultiPlan's Financial Negotiation Services and Clinical Negotiation Services that are applied more stringently to MH/SUD providers than those applicable to Medical/Surgical providers.

The same set of policies and procedures are utilized for all providers, whether MH/SUD or Medical/Surgical, when initiating and providing Negotiation Services. The same staff members work with MH/SUD and Medical/Surgical providers when initiating a financial or clinical negotiation with a provider. No criteria are applied more stringently to MH/SUD than to Medical/Surgical providers.

MultiPlan Negotiation Services standards, as well as certain state and federally defined criteria, have been used to define the evidentiary standards used in this analysis. Review of the standards and reporting of the negotiation results from the last calendar year, as well as a comparison of historical negotiation practices provides evidentiary support that MultiPlan is not applying policies and procedures more stringently to MH/SUD than to Medical/Surgical providers.

In 2022, MH/SUD claims accounted for 1.16% of the Financial Negotiations Services and 0.54% of the Clinical Negotiations Services for MultiPlan's total Negotiation Services claims. This low volume of MH/SUD claims compared to the Medical/Surgical claims received likely accounts for the slight deviation in the number of successful negotiations as it relates to MH/SUD claims. Due to the low volume of claims submitted for MH/SUD claims, and the results being within an acceptable standard deviation, MultiPlan concludes that Negotiation Services processes for both Financial Negotiation Services and Clinical Negotiation Services, as applied in writing and operation, are not applied more stringently to MH/SUD claims than that of Medical/Surgical Claims even with slightly disparate results.

Benefit Classification 4: Outpatient – Out-of-Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
<p>PPO</p> <ul style="list-style-type: none"> Outpatient Services <ul style="list-style-type: none"> Primary Care visits Specialty Care visits Allergy Testing (performed in Office Setting or Outpatient Hospital Setting) Allergy Serum Laboratory Services Radiology Services other than High Tech Radiology Services <ul style="list-style-type: none"> High Tech Radiology Services (including CT, PET, MRI, Myelogram and Nuclear Medicine scans) Chemotherapy, Radiation and Infusion Therapy Chiropractic Care (spinal manipulation only) <ul style="list-style-type: none"> Outpatient Surgery (includes Facility and Professional Charges) Hospital Outpatient (includes Facility and Professional Charges) Ambulance Services <ul style="list-style-type: none"> Ambulance (per trip) Non-Emergency Ambulance (per trip) AUTISM SPECTRUM DISORDER SERVICES <ul style="list-style-type: none"> CLINICAL TRIALS (M/S) Dialysis DURABLE MEDICAL EQUIPMENT (DME) <ul style="list-style-type: none"> Durable Medical Equipment (DME) Ultraviolet Light Therapy System (Light box) for Psoriasis and Atopic Dermatitis HEARING SERVICES <ul style="list-style-type: none"> Hearing exams and tests Pediatric Hearing Aid(s) and services for children through age 18: HOME HEALTH CARE Hospice Infertility Services Preventive Visits and Services <ul style="list-style-type: none"> Primary Care visits Specialty Care visits Well-child care visits (up to age 5) Well Child Exams (age 6 through 21) Screening Health Promotion 	<p>PPO</p> <ul style="list-style-type: none"> Outpatient Services <ul style="list-style-type: none"> Integrated Behavioral Health Consultation Telemedicine and Telehealth Visits <ul style="list-style-type: none"> Primary Care visits Specialty Care visits AUTISM SPECTRUM DISORDER SERVICES <ul style="list-style-type: none"> Applied Behavior Analysis Program (Limited to Children through age 20) Speech Therapy (Limited to Children through age 20) Physical and Occupational Therapy (Limited to Children through age 20): CLINICAL TRIALS (MH/SUD) MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES <ul style="list-style-type: none"> Outpatient Individual visits Group visits Medication visit Partial Hospitalization Intensive Outpatient Therapy Programs Neurophysiological and psychological testing Electroconvulsive treatment

Medical/Surgical

Mental Health/Substance Use Disorder

- Disease Prevention
- Routine Adult Physical Exams
- Preventive Care DME
- Blood Pressure Monitors for Hypertension
- Preventive Care Labs and Screening
- Prostate specific antigen (PSA) test
- Tobacco Cessation Drugs for Pregnant Women
- Iron Deficiency Anemia Screening for Pregnant Woman
- PROSTHETIC DEVICES AND ORTHOTICS
 - Prosthetic Devices (External) and Orthotics (P&O)
 - Internally Implanted Prosthetics
- REHABILITATION SERVICES AND HABILITATIVE SERVICES
 - Speech Therapy
 - Physical and Occupational Therapy
- Rehabilitative Services
 - Speech Therapy
 - Physical and Occupational Therapy
 - Pulmonary Therapy
 - Cardiac Rehabilitation
 - Cognitive Therapy for Traumatic Brain Injury
 - Multi-disciplinary Rehabilitation
 - Urgent Care

POS

- Outpatient Services
 - Primary Care visits
 - Specialty Care visits
 - Laboratory Services
 - X-Ray and other routine radiology Services
 - High Tech Radiology Services (including CT, PET, MRI, Myelogram and Nuclear Medicine scans)
 - Physician/Professional charges
 - Allergy treatment serum
 - Allergy injections visits
- Preventive Visits and Services
 - Well-child care visits (up to age 6)
 - Annual Physical exams for children age 6 and above and adults
 - Annual well-woman exams
 - Preventive care screening services and procedures (including pap smears, mammograms and prostate specific antigen (PSA) tests)
- Maternity Care
 - Routine prenatal visits and delivery (obstetrician, nurse midwife, OB nurse practitioner) and first postpartum visit

POS

- AUTISM SPECTRUM DISORDER SERVICES
 - Applied Behavior Analysis
 - Physical therapy visits
 - Occupational therapy visits
 - Speech therapy visits
- MENTAL HEALTH SERVICES
 - Outpatient individual therapy
 - Outpatient group therapy
 - Outpatient Mental Health visits for the purpose of monitoring drug therapy
 - Partial Hospital Services
- Outpatient Chemical Dependency Treatment
 - Outpatient individual therapy (performed in a physician's office)
 - Outpatient individual therapy (performed in an outpatient facility/hospital)
 - Outpatient group therapy

Medical/Surgical

Mental Health/Substance Use Disorder

- All other visits during pregnancy, (including genetics counselors and perinatologists)
- Physician/Professional charges
- OUTPATIENT SERVICES
 - Laboratory Services (When performed in an outpatient facility setting)
 - X-ray and other routine radiology Services (When performed in an outpatient facility setting)
 - High tech radiology Services (including CT, PET, MRI, myelograms, and nuclear medicine scans)
 - Outpatient surgery (including professional charges)
 - Outpatient facility/hospital charges (including professional charges)
 - Chemotherapy and other visits to infusion centers
 - Radiation therapy
- Rehabilitative Services: Physical, Occupational, Speech Therapy, Multidisciplinary Rehabilitation Care, and Cardiac Rehabilitation
 - Physical therapy visits
 - Occupational therapy visits
 - Speech therapy visits
 - Multidisciplinary Rehabilitation
 - Cardiac Rehabilitation
- Dialysis
- Ambulance Services
- After hours urgent care Services
- Home Health Care
 - Covered Services
- Hospice Care
 - Benefits for hospice care instead of traditional Services
- Durable Medical Equipment (DME)
 - Covered equipment or devices
- Pediatric Hearing Aids for Children to age 19
 - A hearing aid for each ear once every 48 months including fittings and follow-up care up to \$3,000 per aid per ear. One Medically Necessary replacement aid per ear every 48 months up to \$3,000 per aid per ear.
- PROSTHETIC AND ORTHOTICS
 - Covered devices
- Infertility Services
 - Diagnosis Services
 - Treatment Services (including related imaging, lab tests, procedures and professional Services)
- In Vitro Fertilization Services

Medical/Surgical	Mental Health/Substance Use Disorder
<ul style="list-style-type: none"> ○ \$25,000 Lifetime Maximum combined with Infertility Treatment combined across all provider levels ● Chiropractic Services <ul style="list-style-type: none"> ○ Chiropractic Services ○ Acupuncture Services ● Adult Hearing Aids – age 19 and Older <ul style="list-style-type: none"> ○ A hearing aid for each ear once every 24 months Limited to one aid per ear every 24 months 	

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>PPO Out of Network Reimbursement:</u></p> <p>Usual, Customary, and Reasonable (UCR) refers to a methodology used by a health plan to determine the reasonable value of services to compensate a provider where there is no agreement as to price between the plan and the provider. UCR reimbursement methodology is used for Out of Network professional and/or ancillary services, this reimbursement is commonly used for the out-of-network PPO. For facilities, if the service is Institutional and HB 888 and HR 133 do not apply, Institutional services are reimbursed at 100% of billed charges minus the member cost share.</p> <p>Kaiser Permanente Insurance Companies’ (KPIC) use of UCR is relatively limited given that KPIC plans in Georgia (GA) use the Private Healthcare System (PHCS) provider network contract for access of medical care for professional and ancillary services such as physicians, laboratory, radiology, etc.</p> <p>In addition, with limited exceptions discussed below, the Federal No Surprises Act now requires that many payors adjudicate emergency and “surprise” claims based on the “Qualifying Payment Amount (QPA),” which generally represents the payor’s median contract rate for the service in the relevant geography. In some jurisdictions, this has further limited the potential need for plans to employ a UCR method to adjudicate emergency and “surprise” claims. In other jurisdictions, existing state law requires payment of emergency and “surprise” claims based on specific methodologies, such as HB 888 in Georgia. A number of these state methodologies will continue to apply following enactment of the No Surprises Act.</p>	<p><u>PPO Out of Network Reimbursement:</u></p> <p>Usual, Customary, and Reasonable (UCR) refers to a methodology used by a health plan to determine the reasonable value of services to compensate a provider where there is no agreement as to price between the plan and the provider. UCR reimbursement methodology is used for Out of Network professional and/or ancillary services, this reimbursement is commonly used for the out-of-network PPO. For facilities, if the service is Institutional and HB 888 and HR 133 do not apply, Institutional services are reimbursed at 100% of billed charges minus the member cost share.</p> <p>Kaiser Permanente Insurance Companies’ (KPIC) use of UCR is relatively limited given that KPIC plans in Georgia (GA) use the Private Healthcare System (PHCS) provider network contract for access of medical care for professional and ancillary services such as physicians, laboratory, radiology, etc.</p> <p>In addition, with limited exceptions discussed below, the Federal No Surprises Act now requires that many payors adjudicate emergency and “surprise” claims based on the “Qualifying Payment Amount (QPA),” which generally represents the payor’s median contract rate for the service in the relevant geography. In some jurisdictions, this has further limited the potential need for plans to employ a UCR method to adjudicate emergency and “surprise” claims. In other jurisdictions, existing state law requires payment of emergency and “surprise” claims based on specific methodologies, such as HB 888 in Georgia. A number of these state methodologies will continue to apply following enactment of the No Surprises Act.</p>

Medical/Surgical

We note that a UCR method is only applied where there is no agreement as to pricing, and when no other law or regulation requires payment in a particular manner such as HB 888 in Georgia or Federal mandate HR 133 for Inpatient Professional claims only. In many circumstances, KPIC has mechanisms in place to arrive at an agreement as to price. In general, KPIC employs a payment “hierarchy” that first pays under a direct contract or a PHCS contract if one is in place. If there is no contract, KPIC may then send the claim for fee negotiation and potential execution of a letter of agreement or may utilize a partner rental network to price the claim.

What are the required qualifications/training for persons who create and implement the UCR process?

KPIC’s UCR methodology was created and is maintained by Fair Health and Multiplan.

Mental Health/Substance Use Disorder

We note that a UCR method is only applied where there is no agreement as to pricing, and when no other law or regulation requires payment in a particular manner such as HB 888 in Georgia or Federal mandate HR 133 for Inpatient Professional claims only. In many circumstances, KPIC has mechanisms in place to arrive at an agreement as to price. In general, KPIC employs a payment “hierarchy” that first pays under a direct contract or a PHCS contract if one is in place. If there is no contract, KPIC may then send the claim for fee negotiation and potential execution of a letter of agreement or may utilize a partner rental network to price the claim.

What are the required qualifications/training for persons who create and implement the UCR process?

KPIC’s UCR methodology was created and is maintained by Fair Health and Multiplan.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical

(a) The Usual, Customary and Reasonable Charge (UCR):

(i) the charge generally made by a Physician or other supplier of services, medicines, or supplies; or

(ii) the general level of charge made by Physicians or other suppliers within an area in which the charge is incurred for a Covered Service comparable in severity and nature to the Injury of Sickness being treated. The general level of charges is determined in accordance with schedules on file with the authorized Claims Administrator. For charges not listed in the schedules. If the Maximum Allowable Charge is the UCR, the Covered Person will be responsible for payment to a Non-Participating Provider of any amount in excess of the UCR when the UCR is less than the actual billed charges.

Only Non-PAR professional services are priced with UCR. Factors include:

- 1) Source UCR benchmark vendor (FairHealth/Multiplan)
- 2) Vendor methodology in compiling the data
- 3) KPIC selection of UCR percentile
- 4) KPIC application of UCR standard

Sources:

- 1) KPIC's own internal procedure document, "KPIC Pricing Hierarchy".

Mental Health/Substance Use Disorder

(a) The Usual, Customary and Reasonable Charge (UCR):

(i) the charge generally made by a Physician or other supplier of services, medicines, or supplies; or

(ii) the general level of charge made by Physicians or other suppliers within an area in which the charge is incurred for a Covered Service comparable in severity and nature to the Injury of Sickness being treated. The general level of charges is determined in accordance with schedules on file with the authorized Claims Administrator. For charges not listed in the schedules. If the Maximum Allowable Charge is the UCR, the Covered Person will be responsible for payment to a Non-Participating Provider of any amount in excess of the UCR when the UCR is less than the actual billed charges.

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Sources:

- 1) KPIC's own internal procedure document, "KPIC Pricing Hierarchy".

Medical/Surgical	Mental Health/Substance Use Disorder
<p>2) Correspondence between Fair Health and KPIC, quotation from Fair Health: "Fair Health does not prescribe, recommend or suggest any particular value or standard, nor determine applicability of UCR. FAIR Health's benchmarks are created by CPT, HCPC and ICD-10 procedure and revenue codes. To create benchmark values, FAIR Health applies the same methodology, geographical standards, and procedures to MH/SUD codes that we do to any other codes, including medical and surgical codes".</p> <p>In fact, in many cases, the same code is used for a service, whether it is associated with a Med/Surg or MH/SUD diagnosis, in which case we will provide one set of benchmark values for that code. In the relatively rare cases where a service code is specific to MH/SUD, the methodologies used are the same and are applied no more stringently than for Med/Surg codes."</p>	<p>2) Correspondence between Fair Health and KPIC, quotation from Fair Health: "Fair Health does not prescribe, recommend or suggest any particular value or standard, nor determine applicability of UCR. FAIR Health's benchmarks are created by CPT, HCPC and ICD-10 procedure and revenue codes. To create benchmark values, FAIR Health applies the same methodology, geographical standards, and procedures to MH/SUD codes that we do to any other codes, including medical and surgical codes".</p> <p>In fact, in many cases, the same code is used for a service, whether it is associated with a Med/Surg or MH/SUD diagnosis, in which case we will provide one set of benchmark values for that code. In the relatively rare cases where a service code is specific to MH/SUD, the methodologies used are the same and are applied no more stringently than for Med/Surg codes."</p>

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
<p>The basis of the evidentiary standard are:</p> <p>1) Confirmation from Fair Health that all methodologies used in compiling benchmark data are equivalent between MH/SUD and Med/Surg.</p> <p>2) KPIC's documented procedure for determination of UCR; a single procedure exists for out-of-network payments that applies to both MH/SUD and Med/Surg with no distinction between the two. KPIC's selection of a benchmark vendor, selection of benchmark percentile, and methodology for applying the benchmark for UCR purposes are equivalent for professional and ancillary services are applied to MH/SUD and Med/Surg. Analysis indicates that there is no difference.</p>	<p>The basis of the evidentiary standard are:</p> <p>1) Confirmation from Fair Health that all methodologies used in compiling benchmark data are equivalent between MH/SUD and Med/Surg.</p> <p>2) KPIC's documented procedure for determination of UCR; a single procedure exists for out-of-network payments that applies to both MH/SUD and Med/Surg with no distinction between the two. KPIC's selection of a benchmark vendor, selection of benchmark percentile, and methodology for applying the benchmark for UCR purposes are equivalent for professional and ancillary services are applied to MH/SUD and Med/Surg. Analysis indicates that there is no difference.</p>

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
Analysis indicates that as described in writing by Fair Health, no distinction exists in the Fair Health methodology for compiling MH/SUD benchmark or Med/Surg benchmarks. In addition, analysis of KPIC's written documentation of the UCR practice of using Fair Health 80 th percentile for out of network providers that are rendering professional and/or ancillary services indicates that there is no distinction between MH/SUD and Med/Surg. All factors are one and the same for MH/SUD and Med/Surg. Analysis indicates that there is no difference.	Analysis indicates that as described in writing by Fair Health, no distinction exists in the Fair Health methodology for compiling MH/SUD benchmark or Med/Surg benchmarks. In addition, analysis of KPIC's written documentation of the UCR practice of using Fair Health 80 th percentile for out of network providers that are rendering professional and/or ancillary services indicates that there is no distinction between MH/SUD and Med/Surg. All factors are one and the same for MH/SUD and Med/Surg. Analysis indicates that there is no difference.

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
Analysis confirmed that in operational practice, the four factors for UCR (selection of a benchmark vendor, vendor methodology in compiling benchmarks, KPIC's selection of 80 th percentile, and KPIC's application of the benchmark) are applied uniformly between MH/SUD and Med/Surg. Analysis indicates that there is no difference.	Analysis confirmed that in operational practice, the four factors for UCR (selection of a benchmark vendor, vendor methodology in compiling benchmarks, KPIC's selection of 80 th percentile, and KPIC's application of the benchmark) are applied uniformly between MH/SUD and Med/Surg. Analysis indicates that there is no difference.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Because KPIC's UCR methodology for MH/SUD benefits and Med/Surg benefits rendered by professional and/or ancillary are one and the same (both set at the 80th percentile of billed charges for the service/geography in question, based on benchmarks from

Summary Conclusion

Fair Health), and because Fair Health applies the exact same methodology to MH/SUD and Med/Surg services when compiling its benchmarks, no additional analysis is needed to confirm compliance.

Benefit Classification 5: Emergency Services

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
<u>PPO</u> <ul style="list-style-type: none">EMERGENCY SERVICES<ul style="list-style-type: none">Emergency Room Visits (per visit) <u>POS</u> <ul style="list-style-type: none">EMERGENCY SERVICES<ul style="list-style-type: none">Emergency Room Visits (per visit)	<u>PPO</u> <ul style="list-style-type: none">EMERGENCY SERVICES<ul style="list-style-type: none">Emergency Room Visits (per visit) <u>POS</u> <ul style="list-style-type: none">EMERGENCY SERVICES<ul style="list-style-type: none">Emergency Room Visits (per visit)

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
<p>Our goal at KPIC is to provide integrated, high-quality, affordable care to all Dual Choice members that may access exclusive delivery of medical services from Kaiser Permanente Providers.</p> <p>To ensure timely, high-quality, and efficient care for our members, we also contract with select external Non-Kaiser Providers, ancillaries, and facilities. At a high level, Kaiser Providers and the Provider Contracting Department work together to build a robust network to meet the needs of the members. Our goal at Kaiser Permanente Health Plan of Georgia is to provide integrated, high-quality, affordable care to all members. KPIC has an exclusive relationship with The Southeast Permanente Medical Group (TSPMG).</p> <p>The Kaiser Permanente Contracting department uses contract boilerplates/templates with standard language and starts with a standard reimbursement exhibit that can be modified as necessary. The reimbursement terms are typically the Medicare rates, a percentage of the Medicare rates, can carve out specific services where the market standards are applied, or sometimes refers to a standard fee schedule (the Kaiser Permanente</p>	<p>Our goal at KPIC is to provide integrated, high-quality, affordable care to all Dual Choice members that may access exclusive delivery of medical services from Kaiser Permanente Providers.</p> <p>To ensure timely, high-quality, and efficient care for our members, we also contract with select external Non-Kaiser Providers, ancillaries, and facilities. At a high level, Kaiser Providers and the Provider Contracting Department work together to build a robust network to meet the needs of the members. Our goal at Kaiser Permanente Health Plan of Georgia is to provide integrated, high-quality, affordable care to all members. KPIC has an exclusive relationship with The Southeast Permanente Medical Group (TSPMG).</p> <p>The Kaiser Permanente Contracting department uses contract boilerplates/templates with standard language and starts with a standard reimbursement exhibit that can be modified as necessary. The reimbursement terms are typically the Medicare rates, a percentage of the Medicare rates, can carve out specific services where the market standards are applied, or sometimes refers to a standard fee schedule (the Kaiser Permanente</p>

Medical/Surgical

Market Fee Schedule (KPMFS) that is based on RBRVS. When applicable, financial analysis is done for contracts and amendments, with a priority for hospitals and facilities expected to have the largest impact. Reimbursement methodologies for inpatient services can include, diagnosis-related group payment where the facility is paid a set amount when caring for certain conditions; per diems where a set amount is paid for each day a member was at the facility; case rates where a set fee is agreed upon for certain services; performance programs where the facility is paid based on agreed upon criteria such as quality of care; or on a discount basis where an agreed upon percentage of the total bill is paid. The reimbursement for some inpatient services may include a combination of these reimbursement methods. Periodically, reimbursement is compared to Milliman Benchmarks to ensure fair compensation.

In Georgia there is an existing state law that requires payment of emergency and “surprise” claims based on specific methodologies, such as HB 888. A number of these state methodologies will continue to apply following enactment of the No Surprises Act.

In addition, if there is no emergency services rate under HB 888, HR 133 Federal No Surprises Act now requires payors to adjudicate emergency and “surprise” claims based on the “Qualifying Payment Amount (QPA),” which generally represents the payor’s median contract rate for the service in the relevant geography.

The application of Kaiser Provider rates, Contracted provider rate, HB 888 rates, or HR 133 rates are not more restrictive for Med/Surg in comparison to MH/SUD.

Mental Health/Substance Use Disorder

Market Fee Schedule (KPMFS) that is based on RBRVS. When applicable, financial analysis is done for contracts and amendments, with a priority for hospitals and facilities expected to have the largest impact. Reimbursement methodologies for inpatient services can include, diagnosis-related group payment where the facility is paid a set amount when caring for certain conditions; per diems where a set amount is paid for each day a member was at the facility; case rates where a set fee is agreed upon for certain services; performance programs where the facility is paid based on agreed upon criteria such as quality of care; or on a discount basis where an agreed upon percentage of the total bill is paid. The reimbursement for some inpatient services may include a combination of these reimbursement methods. Periodically, reimbursement is compared to Milliman Benchmarks to ensure fair compensation.

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The application of Kaiser Provider rates, Contracted provider rate, HB 888 rates, or HR 133 rates are not more restrictive for Med/Surg in comparison to MH/SUD.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical

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

- a) The credential/provider type of the practitioner(s), (MD, NP, PHD, Master’s Degree, etc.)
- b) Treatment protocols and type of service defined within each CPT code as found in the AMA official CPT codebook
- c) Inpatient professional reimbursement is RBRVS based; the providers are paid on a conversion factor, which is multiplied by

Mental Health/Substance Use Disorder

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- b) Treatment protocols and type of service defined within each CPT code as found in the AMA official CPT codebook
- c) Inpatient professional reimbursement is RBRVS based; the providers are paid on a conversion factor, which is multiplied by

Medical/Surgical

the RVUs in the RBRVS fee schedule. The commercial rates are paid at a premium over Medicare rates.

d) Inpatient facility reimbursement is based on MSDRGs or Per Diems. The commercial rates are paid at a premium over Medicare rates.

e) Provider's market position

f) Geographic area in which services are delivered

g) Market benchmarks such as

- What the market will allow based on specialty and access
- Existing contract rates
- CMS Medicare reimbursement rates
- Claims Data
- Milliman Benchmarks
- Palmetto GBA h) Supply and demand conditions such as
- The number of providers of a particular provider type that are in the geographic market

Volume of referrals the plan would intend to send to the provider and the capacity of the provider to accept referrals. Any other unique market conditions.

KPIC is required by law to cover emergency services regardless of the plan design. Outpatient Emergency services does not require authorization. Inpatient emergency admission requires authorization up to the member's stabilization.

- Market Price and other community sources
- What the market will allow based on specialty and access
- CMS reimbursement rates and methodologies
- Claims data
- Utilization projections
- Internal and external market analysis
- Palmetto GBA
- Milliman Benchmarks

Member Certificate of Insurance outlines Emergency services to be covered based on precertification requirements when applicable.

Mental Health/Substance Use Disorder

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- CMS reimbursement rates and methodologies
- Claims data
- Utilization projections
- Internal and external market analysis
- Palmetto GBA
- Milliman Benchmarks

Member Certificate of Insurance outlines Emergency services to be covered based on precertification requirements when applicable.

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

Please note, the term “evidentiary standards” is not limited to a means for defining “factors”. Evidentiary standards also include all evidence considered in designing and applying its NQTL protocols such as recognized medical literature,

professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional guild associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations.

Medical/Surgical	Mental Health/Substance Use Disorder
Each contract is negotiated on an individual basis, looking at the unique situation for each group.	Each contract is negotiated on an individual basis, looking at the unique situation for each group.
The following factors are used in determining the appropriate reimbursement rates for both M/S and MH/SUD providers.	The following factors are used in determining the appropriate reimbursement rates for both M/S and MH/SUD providers.
<ul style="list-style-type: none"> a) The credential/provider type of the practitioner(s), (MD, NP, PHD, Master's Degree, etc.) b) Treatment protocols and type of service defined within each CPT code as found in the AMA official CPT codebook c) Provider's market position d) Geographic area in which services are delivered e) Market benchmarks such as <ul style="list-style-type: none"> • What the market will allow based on specialty and access • 	<ul style="list-style-type: none"> a) The credential/provider type of the practitioner(s), (MD, NP, PHD, Master's Degree, etc.) b) Treatment protocols and type of service defined within each CPT code as found in the AMA official CPT codebook c) Provider's market position d) Geographic area in which services are delivered e) Market benchmarks such as <ul style="list-style-type: none"> • What the market will allow based on specialty and access
<ul style="list-style-type: none"> Existing contract rates • CMS Medicare reimbursement rates • Claims Data • Milliman Benchmarks • Palmetto GBA f) Supply and demand conditions such as <ul style="list-style-type: none"> • The number of providers of a particular provider type that are in the geographic market. • Volume of referrals the plan would intend to send to the provider and the capacity of the provider to accept referrals. • Any other unique market conditions. 	<ul style="list-style-type: none"> Existing contract rates • CMS Medicare reimbursement rates • Claims Data • Milliman Benchmarks • Palmetto GBA f) Supply and demand conditions such as <ul style="list-style-type: none"> • The number of providers of a particular provider type that are in the geographic market. • Volume of referrals the plan would intend to send to the provider and the capacity of the provider to accept referrals. • Any other unique market conditions.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
In Network Emergency Kaiser Provider and Direct Contracts: There are weekly meetings between Contracting and TSPMG to discuss any M/S and MH/SUD inpatient issues, as well as to discuss when more facilities are needed, and if any are available in the needed area. Discussions will also include decisions to deviate from our standard templates or boilerplates. Any deviations are addressed on a case-by-case basis including reasons for why a deviation may be necessary. Reimbursement is compared to the current RBRVS and is compared periodically	In Network Emergency Kaiser Provider and Direct Contracts: There are weekly meetings between Contracting and TSPMG to discuss any M/S and MH/SUD inpatient issues, as well as to discuss when more facilities are needed, and if any are available in the needed area. Discussions will also include decisions to deviate from our standard templates or boilerplates. Any deviations are addressed on a case-by-case basis including reasons for why a deviation may be necessary. Reimbursement is compared to the current RBRVS and is compared periodically

Medical/Surgical

to the Milliman Benchmarks Our KP Market Fee Schedule, which is the standard reimbursement for many of our contracted providers, undergoes the same process from year to year with the same percentage of Medicare, but can be modified as needed. If a provider has questions or complaints, further analysis is conducted and researched to see if the code is valued differently elsewhere and can be modified accordingly.

PHCS Emergency Network Providers:

There are no limitations for covered services from a reimbursement perspective for Med/Surg. Other than pre-certification requirements may apply. The reimbursement methodology is outlined below.

- Reimbursement to the majority of physicians according to a negotiated fee schedule, most commonly a percentage of Medicare. The fee schedule also typically includes a “lesser-of” to guard against overpayments and to ensure a discount on services for which there is not an established Medicare rate.
- In general, PHCS provider network does not negotiate automatic reimbursement increases with network providers. In addition, PHCS does not typically provide either limits or guarantees for future reimbursement increases upon renewal or renegotiation. In some situations, though, PHCS may tie increases to a percentage of the Consumer Price Index (CPI), typically with a ceiling or a flat percentage increase.
- PHCS' network negotiation process is consistent nationally, although rates and specific reimbursement methodologies may vary by geography. The process involves a series of discussions with the provider to determine rates, discuss policies and negotiate the legal terms of the agreement. Training and continuing education programs are provided to PHCS negotiators to enhance skills and create a consistent and respectful experience for providers across the country.
- PHCS uses a variety of reimbursement arrangements when contracting with ancillary providers. They include case rates, fee schedules and/or percentage of charge arrangements.
- PHCS network negotiation process is consistent nationally, although rates and specific reimbursement methodologies may vary by geography. The process involves a series of discussions with the provider to determine rates, discuss policies and negotiate the legal terms of the agreement. Training and continuing education programs are provided to PHCS negotiators to enhance skills and create a consistent and respectful experience for providers across the country.
- PHCS has a variety of financial arrangements with hospitals. Inpatient reimbursement structures may include a combination of per diems, case rates, percentage of charges or other payment methodologies for covered services. Fee structures for outpatient care include case rates, fee schedules and percentage of charge arrangements. PHCS standard hospital contracts provide for the lesser of the eligible billed charge or the contracted amount to be paid.

Mental Health/Substance Use Disorder

to the Milliman Benchmarks Our KP Market Fee Schedule, which is the standard reimbursement for many of our contracted providers, undergoes the same process from year to year with the same percentage of Medicare, but can be modified as needed. If a provider has questions or complaints, further analysis is conducted and researched to see if the code is valued differently elsewhere and can be modified accordingly.

PHCS Emergency Network Providers:

There are no limitations for covered services from a reimbursement perspective for Med/Surg. Other than pre-certification requirements may apply. The reimbursement methodology is outlined below.

- Reimbursement to the majority of physicians according to a negotiated fee schedule, most commonly a percentage of Medicare. The fee schedule also typically includes a “lesser-of” to guard against overpayments and to ensure a discount on services for which there is not an established Medicare rate.
- In general, PHCS provider network does not negotiate automatic reimbursement increases with network providers. In addition, PHCS does not typically provide either limits or guarantees for future reimbursement increases upon renewal or renegotiation. In some situations, though, PHCS may tie increases to a percentage of the Consumer Price Index (CPI), typically with a ceiling or a flat percentage increase.
- PHCS' network negotiation process is consistent nationally, although rates and specific reimbursement methodologies may vary by geography. The process involves a series of discussions with the provider to determine rates, discuss policies and negotiate the legal terms of the agreement. Training and continuing education programs are provided to PHCS negotiators to enhance skills and create a consistent and respectful experience for providers across the country.
- PHCS uses a variety of reimbursement arrangements when contracting with ancillary providers. They include case rates, fee schedules and/or percentage of charge arrangements.
- PHCS network negotiation process is consistent nationally, although rates and specific reimbursement methodologies may vary by geography. The process involves a series of discussions with the provider to determine rates, discuss policies and negotiate the legal terms of the agreement. Training and continuing education programs are provided to PHCS negotiators to enhance skills and create a consistent and respectful experience for providers across the country.
- PHCS has a variety of financial arrangements with hospitals. Inpatient reimbursement structures may include a combination of per diems, case rates, percentage of charges or other payment methodologies for covered services. Fee structures for outpatient care include case rates, fee schedules and percentage of charge arrangements. PHCS standard hospital contracts provide for the lesser of the eligible billed charge or the contracted amount to be paid.

Medical/Surgical	Mental Health/Substance Use Disorder
All factors are the same for medical/surgical and MH/SUD.	All factors are the same for medical/surgical and MH/SUD.
<u>Out of Emergency Network Providers:</u> UCR for Professional and/or Ancillary and Institutional Services are reimbursed at 100% of billed amount minus member cost-share.	<u>Out of Emergency Network Providers:</u> UCR for Professional and/or Ancillary and Institutional Services are reimbursed at 100% of billed amount minus member cost-share.

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
The PHCS team evaluates the reimbursement rate compared to current RBRVS and is compared to other healthcare industry reimbursement benchmarks which maybe standard to out of network providers regardless of specialty and provider reimbursement rates may be modified as needed to stay competitive with the healthcare market. This review is not more stringent for Med/Surg than MH/SUD.	The PHCS team evaluates the reimbursement rate compared to current RBRVS and is compared to other healthcare industry reimbursement benchmarks which maybe standard to out of network providers regardless of specialty and provider reimbursement rates may be modified as needed to stay competitive with the healthcare market. This review is not more stringent for Med/Surg than MH/SUD.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion
The contracting processes are the same for external providers and providers that are part of our partner networks, whether they are primary care, mental health, or a specialty. Reimbursement rates are based on the geographic, market, RBRVS, Milliman Benchmarks, etc. and they are not more stringent for either Med/Surg or MH/SUD.

Benefit Classification 6: Pharmacy Services

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>PPO</u></p> <ul style="list-style-type: none"> • PREVENTIVE VISITS AND SERVICES <ul style="list-style-type: none"> ○ Certain Prescribed and Over the Counter Drugs and Contraceptives • Outpatient Prescription Drug Benefit <ul style="list-style-type: none"> ○ Individual ○ Family ○ Tier 1 - Generic Preventive (per prescription) ○ Tier 2 - Generic Preferred (per prescription) ○ Tier 3- Brand Preferred Drugs (per prescription) ○ Tier 4 - Generic/Brand Non-Preferred Drugs (per prescription) ○ Tier 5 - Specialty Drugs (per prescription) ○ Oral Chemotherapy Drugs (per prescription) <p><u>POS</u></p> <ul style="list-style-type: none"> • Drugs and Supplies <ul style="list-style-type: none"> ○ Contraceptive drugs and intrauterine devices, oral transdermal and vaginal ring ○ Administered drugs for treatment of infertility • Outpatient Prescription Drugs <ul style="list-style-type: none"> ○ Preferred Generic Drugs ○ Brand Name Drugs ○ Non-Preferred Drugs ○ Drugs for the treatment of infertility ○ Drugs for treatment of sexual dysfunction disorders ○ Home Delivery Drugs - Covered under In-Network Providers only 	<p><u>PPO</u></p> <ul style="list-style-type: none"> • Outpatient Prescription Drug Benefit <ul style="list-style-type: none"> ○ Individual ○ Family ○ Tier 1 - Generic Preventive (per prescription) ○ Tier 2 - Generic Preferred (per prescription) ○ Tier 3- Brand Preferred Drugs (per prescription) ○ Tier 4 - Generic/Brand Non-Preferred Drugs (per prescription) ○ Tier 5 - Specialty Drugs (per prescription) <p><u>POS</u></p> <ul style="list-style-type: none"> • Outpatient Prescription Drugs <ul style="list-style-type: none"> ○ Preferred Generic Drugs ○ Brand Name Drugs ○ Non-Preferred Drugs ○ Drugs for the treatment of infertility ○ Drugs for treatment of sexual dysfunction disorders ○ Home Delivery Drugs - Covered under In-Network Providers only

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
For pharmacy, KPIC applies authorization, medical necessity, and step therapy for some drugs. The formulary is noted with these classifications for members to view in a publicly accessible site known as the “KPIC Microsite”. The authorization, medical necessity, and step therapy requirements are no more stringent for Med/Surg than MH/SUD.	For pharmacy, KPIC applies authorization, medical necessity, and step therapy for some drugs. The formulary is noted with these classifications for members to view in a publicly accessible site known as the “KPIC Microsite”. The authorization, medical necessity, and step therapy requirements are no more stringent for Med/Surg than MH/SUD.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a

definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
KPIC is using the factors and sources below for Pharmacy.	KPIC is using the factors and sources below for Pharmacy.
<ul style="list-style-type: none"> • Market price • Volume of service capacity • Geographic location • Multi-specialty co-location • Disability accommodations • Community reputation 	<ul style="list-style-type: none"> • Market price • Volume of service capacity • Geographic location • Multi-specialty co-location • Disability accommodations • Community reputation
Sources:	Sources:
<ul style="list-style-type: none"> • Internal claims analyses • Internal quality standard studies • Expert medical review 	<ul style="list-style-type: none"> • Internal claims analyses • Internal quality standard studies • Expert medical review

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- KPIC does not distinguish benefits for Med/Surg and MH/SUD. KPIC benefits for Med/Surg are comparable and applied no more stringently.	N/A- KPIC does not distinguish benefits for Med/Surg and MH/SUD. KPIC benefits for Med/Surg are comparable and applied no more stringently.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical

Mental Health/Substance Use Disorder

N/A- KPIC does not deviate from standards or treatments.

N/A- KPIC does not deviate from standards or treatments.

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical

Mental Health/Substance Use Disorder

Benefits and exclusions are noted and addressed in the Certificate of Insurance (COI) provided to the member and included in submission of Regulatory filings. Clinical reviews and consultation processes are in place with licensed clinical pharmacist that determine the need for authorization, medical necessity, and step therapy for some drugs. The formulary is noted with these classifications for member to view in a publicly accessible site known as the “KPIC Microsite”.

Benefits and exclusions are noted and addressed in the Certificate of Insurance (COI) provided to the member and included in submission of Regulatory filings. Clinical reviews and consultation processes are in place with licensed clinical pharmacist that determine the need for authorization, medical necessity, and step therapy for some drugs. The formulary is noted with these classifications for member to view in a publicly accessible site known as the “KPIC Microsite”.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

KPIC benefits for MH/SUD are comparable to Med/Surg and applied no more stringently than the processes, strategies, evidentiary standards, and factors noted in the COI and formulary provided and accessible to all members for the awareness of their benefits.

Kaiser Permanente Insurance Company (KPIC) Georgia

Non-Quantitative Treatment Limits (NQTL)



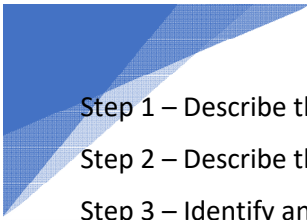
NQTL: Prior Authorization (PPO/POS)

Last Reviewed: December 20, 2023



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Benefits		Classifications					
Is NQTL applied to Medical/Surgical benefits?	Is NQTL applied to Mental Health/Substance Use Disorder benefits?	Is NQTL applied to In Network Inpatient classification?	Is NQTL applied to Out of Network Inpatient classification?	Is NQTL applied to In Network Outpatient classification?	Is NQTL applied to Out of Network Outpatient classification?	Is NQTL applied to Emergency classification?	Is NQTL applied to Prescription classification?
Yes	Yes	Yes	Yes	Yes	Yes	No	Yes

Benefit Classification 1: Inpatient – In Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage POS:</u> N/A	<u>Permanente Advantage POS:</u> N/A
<u>Permanente Advantage PPO:</u> <ul style="list-style-type: none"> Inpatient Medical / Surgical Hospital Care Inpatient Medically Necessary Bariatric Surgery (Morbid Obesity Services) Inpatient Infertility Services Inpatient Rehabilitation and Habilitation Services Skilled Nursing Facility Inpatient Transplant Services 	<u>Permanente Advantage PPO:</u> <ul style="list-style-type: none"> Inpatient Behavioral Health (BH)/Mental Health (MH) Hospital Care Inpatient Substance Use Disorder (SUD) Services

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage PPO</u> <u>Medical Review Program</u> means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person’s health care needs; and (3) manages Your plan of care. Precertification/Precertified means the required assessment of the necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review Program. If the Medical Review Program determines that the	<u>Permanente Advantage PPO</u> <u>Medical Review Program</u> means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person’s health care needs; and (3) manages Your plan of care. Precertification/Precertified means the required assessment of the necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review Program. If the Medical Review Program determines that the

Medical/Surgical

care is not Medically Necessary, Precertification will be denied. The Medical Review Program may be contacted twenty-four (24) hours per day, seven days per week. Precertification must be obtained for all Hospital stays and certain other services and procedures. Request for Precertification must be made by the Covered Person, the Covered Person's attending Physician, or the Covered Person's authorized representative prior to the commencement of any service or treatment. If Your services are provided by a Kaiser Permanente Provider, the Kaiser Permanente Provider will arrange for any necessary Precertification on Your behalf. If Precertification is required, it must be obtained to avoid a reduction in benefits. It is important to work with your provider to be certain services are Precertified when required or you will pay for the cost of the service.

Pregnancy Precertification:

When a Covered Person is admitted to a Hospital for the delivery of a child, the Covered Person is entitled to stay in the hospital without any Precertification for a minimum of:

1. Forty-eight (48) hours for a normal vaginal delivery; and
2. Ninety-six (96) hours for a Cesarean section delivery.

A stay longer than the above may be allowed provided the attending provider obtain authorization for an extended confinement through KPIC's Medical Review Program. In no case will KPIC require that a provider reduce the mother's or child's Hospital Confinement below the allowable minimums cited above. Treatment for Complications of Pregnancy is subject to the same Pre-certification requirements as any other Sickness.

Precertification Procedures

The Covered Person or his or her attending Physician must notify the Medical Review Program as follows:

1. Planned Hospital Confinement - as soon as reasonably possible after the Covered Person learns of a Hospital Confinement, but at least three days prior to admission for such Hospital Confinement.
2. Extension of a Hospital Confinement - as soon as reasonably possible prior to extending the number of days of Hospital Confinement beyond the number of days originally Precertified or within 48 hours following a vaginal delivery or 96 hours following a cesarean section, or as soon as reasonably possible, for Hospital Confinement in connection with childbirth expected to extend beyond the 48 or 96-hour period.
3. Other treatments or procedures requiring Precertification – As soon as reasonably possible after the Covered Person learns of the need for any other treatment or service requiring Precertification but at least three days prior to performance of any other treatment or service requiring Precertification.

A Covered Person must provide all necessary information to the Medical Review Program in order for it to make its determination. This means the Covered Person may be required to:

Mental Health/Substance Use Disorder

care is not Medically Necessary, Precertification will be denied. The Medical Review Program may be contacted twenty-four (24) hours per day, seven days per week. Precertification must be obtained for all Hospital stays and certain other services and procedures. Request for Precertification must be made by the Covered Person, the Covered Person's attending Physician, or the Covered Person's authorized representative prior to the commencement of any service or treatment. If Your services are provided by a Kaiser Permanente Provider, the Kaiser Permanente Provider will arrange for any necessary Precertification on Your behalf. If Precertification is required, it must be obtained to avoid a reduction in benefits. It is important to work with your provider to be certain services are Precertified when required or you will pay for the cost of the service.

Precertification Procedures

The Covered Person or his or her attending Physician must notify the Medical Review Program as follows:

1. Planned Hospital Confinement - as soon as reasonably possible after the Covered Person learns of a Hospital Confinement, but at least three days prior to admission for such Hospital Confinement.
2. Extension of a Hospital Confinement - as soon as reasonably possible prior to extending the number of days of Hospital Confinement beyond the number of days originally Precertified.
3. Other treatments or procedures requiring Precertification - As soon as reasonably possible after the Covered Person learns of the need for any other treatment or service requiring Precertification but at least three days prior to performance of any other treatment or service requiring Precertification.

A Covered Person must provide all necessary information to the Medical Review Program in order for it to make its determination. This means the Covered Person may be required to:

1. Obtain a second opinion from a Physician selected from a panel of three or more Physicians designated by the Medical Review Program. If the Covered Person is required to obtain a second medical opinion, it will be provided at no charge to the Covered Person;
2. Participate in the Medical Review Program's case management, Hospital discharge planning and long term case management programs; and/or
3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the requested treatment or service. If the Covered Person or the Covered Person's provider does not provide the necessary information or will not release necessary information, Precertification will be denied.

Of note if an inpatient stay is authorized all services, items pertaining to the inpatient stay are authorized ie. Medications.

Medical/Surgical

1. Obtain a second opinion from a Physician selected from a panel of three or more Physicians designated by the Medical Review Program. If the Covered Person is required to obtain a second medical opinion, it will be provided at no charge to the Covered Person;
2. Participate in the Medical Review Program's case management, Hospital discharge planning and long term case management programs; and/or
3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the requested treatment or service. If the Covered Person or the Covered Person's provider does not provide the necessary information or will not release necessary information, Precertification will be denied.

Of note if an inpatient stay is authorized all services, items pertaining to the inpatient stay are authorized ie. Medications.

Permanente Advantage utilizes the same prior authorization procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Prior authorization requests are reviewed and processed within the regulatory turnaround times.

Qualifications/Training:

Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing prior authorization requests are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

Mental Health/Substance Use Disorder

Permanente Advantage utilizes the same prior authorization procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Prior authorization requests are reviewed and processed within the regulatory turnaround times.

Qualifications/Training:

Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing prior authorization requests are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
Factors	
<u>Permanente Advantage PPO</u> High variability in cost of care Variation in length of stay Variability and/or lack of adherence to criteria Clinical effectiveness of the treatment or service Appropriate level of care Severity or chronicity of medical surgical conditions Consistency in prior authorization within market	<u>Permanente Advantage PPO</u> High variability in cost of care Variation in length of stay Variability and/or lack of adherence to criteria Clinical effectiveness of the treatment or service Appropriate level of care Severity or chronicity of MH/SUD conditions Consistency in prior authorization within market
Sources	
<u>Permanente Advantage PPO</u> Utilization data Internal quality audits National Accreditation standards Electronic medical record Internal and external market comparative Certification of Insurance	<u>Permanente Advantage PPO</u> Utilization data Internal quality audits National Accreditation standards Electronic medical record Internal and external market comparative Certification of Insurance

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage PPO</u> The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as Milliman Care Guidelines (MCG™) are utilized for M/S services. This standard applies to the following factors: 1. Variation in length of stay: a. MCG guideline goal length of stay is condition or diagnosis-specific length of stay, assuming optimal	<u>Permanente Advantage PPO</u> The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as American Society of Addiction Medicine (ASAM) criteria/guidelines are utilized for SUD services, Milliman Care Guidelines (MCG™) are utilized for MH services and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental

Medical/Surgical

Mental Health/Substance Use Disorder

recovery and decision making. MCG statistical benchmarks and data apply data science to clinical improvement efforts. They are available for utilization and management in inpatient, post-acute, and ambulatory settings of care.

2. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity:
 - a. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards.
3. Effectiveness of the treatment or service:
 - a. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes.
4. Severity or chronicity of the M/S conditions:
 - a. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.
5. Appropriate level of care:
 - a. MCG care guidelines offer evidence-based criteria, goals, and optimal care pathways to move the patient through the continuum of care. Clinical indications for admission or procedure, continued stay, extended stay, goal length of stay, readmission risk, and discharge planning. Transitions of care guidelines address transitions between care settings.
6. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, effectiveness of the treatment or service, severity or chronicity of the M/S conditions, and the appropriate level of care.
7. Claim cost if the utilization of services or treatment is in-network utilizing direct contracts (per diem), rental network and/or letter of agreements (% of billed charges); out-of-network (100%) billed charges for facilities. This standard applies to the following factors: High variability of cost of care per episode.

Health (MH) transgender and gender diverse (TGD) people. This standard applies to the following factors:

1. Variation in length of stay:
 - a. ASAM criteria concepts has moved from a fixed length of service to a variable length of service. The length of stay must be individualized, based on severity of illness and level of functioning, as well as response to treatment, progress, and outcomes.
 - b. MCG guideline goal length of stay is condition or diagnosis-specific length of stay, assuming optimal recovery and decision making. MCG statistical benchmarks and data apply data science to clinical improvement efforts. They are available for utilization and management in inpatient, post-acute, and ambulatory settings of care.
2. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity:
 - a. ASAM criteria developed to replace the 40-50 criteria sets of criteria used, proactively offer clinically sound alternatives to proprietary and variable criteria used by payers who funded or managed care. Coalition of National Clinical Criteria continues to work towards a national set of criteria (ASAM) accepted by providers, payers, managed care, and policy makers to reduce variability and/or adherence to standards of care.
 - b. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards.
 - c. WPATH standards of care are international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health, including gender dysphoria.
3. Effectiveness of the treatment or service:
 - a. ASAM criteria encourages moving from seeing diagnosis as sufficient justification for treatment, vs a treatment that is holistic and address multiple needs. Treatment tailored to needs of individual, guided by individual treatment plan in consultation with patient contributes to a significantly to treatment outcomes.
 - b. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes.
 - c. WPATH clinical guidance for health professionals to assist TGD people, including gender dysphoria with safe and effective pathways to achieving lasting personal

Medical/Surgical

- a. Utilization Management (pre-certification / concurrent review) assists in managing costs, ensure medical necessity, and reducing unnecessary services. Our ability to encourage or channel patient's to in-network providers or obtain letter of agreement for out-of-network providers (continuity of care, network inadequacy, transition of care) reduces variability in cost of care and reduces cost share of Covered Persons and reduces the cost of care. Improving quality of care by using evidence-based criteria reduces variability or reduction of cost of care.

Mental Health/Substance Use Disorder

- comfort with their gendered selves, with the aim of optimizing their overall health, psychological well-being, and self-fulfillment.
4. Severity or chronicity of the MH/BH/SUD conditions:
 - a. ASAM addresses co-occurring and complexity capability, recognizing that co-occurring mental health is an expectation, not an exception. This has been incorporated into the ASAM patient placement criteria utilized. Matrix is available for matching severity and level of function with type and intensity of service.
 - b. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.
 - c. WPATH standards of care incorporate the evaluation of coexisting mental health concerns as one of the steps in the assessment and referral process: assess, diagnose, and discuss treatment options for coexisting mental health concerns.
5. Appropriate level of care:
 - a. ASAM describes treatment as a continuum of care marked by 4 broad levels of care and an early intervention level. Diagnostic admission criteria for levels of care ensures appropriate level of care at admission. Levels of care 0.5 (early intervention) through 4 (medically managed intensive inpatient services). Movement through any level of service(s) the patient's progress in all six dimensions is assessed at regular intervals.
 - b. MCG care guidelines offer evidence-based criteria, goals, and optimal care pathways to move the patient through the continuum of care. Clinical indications for admission or procedure, continued stay, extended stay, goal length of stay, readmission risk, and discharge planning. Transitions of care guidelines address transitions between care settings. MCG behavioral health level of care comparison charts address 5 levels of care; inpatient, residential, partial hospital, intensive outpatient, and outpatient care.
6. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, effectiveness of the treatment or service, severity or chronicity of the MH/SUD conditions, and the appropriate level of care.
7. Claim cost if the utilization of services or treatment is in-network utilizing direct contracts (per diem), rental network

Medical/Surgical

Mental Health/Substance Use Disorder

and/or letter of agreements (% of billed charges); out-of-network (100%) billed charges for facilities. This standard applies to the following factors: High variability of cost of care per episode.

- Utilization Management (pre-certification/concurrent review) assists in managing costs, ensure medical necessity, and reducing unnecessary services. Our ability to encourage or channel patient's to in-network providers or obtain letter of agreement for out-of-network providers (continuity of care, network inadequacy, transition of care) reduces variability in cost of care and reduces cost share of Covered Persons and reduces the cost of care. Improving quality of care by using evidence-based criteria reduces variability or reduction of cost of care.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO

- Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of Pre-certification indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, providing comparable pre-certification lists.
- Market analysis of comparable Plans identified 100% of plans require Prior-Authorization review for all Inpatient services for MH/SUD and M/S, excluding services covered under the Newborns' and Mothers' Health Protection Act of 1996, which is consistent with the KPIC plans.
- Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.
- Internal audit for comparability and stringency of written policies and procedures for medical necessity review

Permanente Advantage PPO

- Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of Pre-certification indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, providing comparable pre-certification lists. (COI Per Plan)
- Market analysis of comparable Plans identified 100% of plans require Prior-Authorization review for all Inpatient services for MH/SUD and M/S, which is consistent with the KPIC plans.
- Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.
- Internal audit for comparability and stringency of written policies and procedures for medical necessity review

Medical/Surgical

(Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #2, #4

Mental Health/Substance Use Disorder

(Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #2, #4

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO

1. Permanente Advantage utilizes the same prior authorization procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how the member can file for an appeal. Prior authorization requests are reviewed and processed within the regulatory turnaround times.
2. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.
3. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.
4. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6
5. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and

Permanente Advantage PPO

1. Permanente Advantage utilizes the same prior authorization procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how the member can file for an appeal. Prior authorization requests are reviewed and processed within the regulatory turnaround times.
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3. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.
4. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6
5. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and

Medical/Surgical

Mental Health/Substance Use Disorder

Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.

6. Analysis of utilization data identified (47) pre-certification cases for In Network Inpatient for M/S services, which (43) were approved and (4) denied.

Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.

6. Analysis of utilization data identified (17) pre-certification cases for In Network Inpatient for MH/SUD services, which (12) were approved and (5) denied.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Permanente Advantage PPO

Permanente Advantage's market analysis for the KPIC Plans confirmed all comparable plans require pre-certification for all In Network Inpatient services for MH/SUD and M/S. No Pre-Certification of emergency services is required, coverage of ER services is under the HMO tier. Alignment of prior authorization and criteria with KFHP provides consistency, whether Point-of-Service (POS) members are utilizing inpatient services under the Kaiser Permanente HMO Tier benefit level or KPIC PPO Tier benefit level. KPIC plans utilize a rental network to provide contracted providers and facilities. Covered persons have a choice to utilize contracted (in-network) or non-contracted (out-of-network) providers and facilities. Pre-certification of services allows for Permanente Advantage to channel Covered Persons to a contracted provider, if agreeable, thus reducing their cost share and overall cost of care for non-emergent services. Also, Pre-certification of services allows us to determine network inadequacy and to secure a single case agreement for services to be paid in-network, resulting in reduced cost share to member and reduce the cost of care for non-emergent services. In comparing the utilization data, there is less volume for In Network Inpatient MH/SUD cases with few denials in each category, which we deem comparable. The URAC audit of Permanente Advantage's Utilization Management (UM) policies, procedures, and clinical chart review of denial and appeal charts, concluded Permanente Advantage met the URAC accreditation standards and were consistent and comparable as written and in operation for MH/SUD and M/S. Internal audits and inter-rater reliability confirmed the competency of selection and utilization of the Medical Necessity criteria for all services requiring pre-certification, as written and in operation, the caveat being that ASAM criteria is utilized for SUD, MCG is utilized for MH and M/S and WPATH is used for MH TGD people. Permanente Advantage concludes that as written and in operation, the UM policies, process, factors, and evidentiary standards used to develop and apply Pre-Certification NQTL for MH/SUD In Network Inpatient services is comparable and no more stringent than M/S for the KPIC Plans, and therefore are compliant with the final regulation of the Mental Health Parity and Addiction Equity Act.

Benefit Classification 2: Inpatient – Out-of-Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage POS:

- Inpatient Medical / Surgical Hospital Care
- Skilled Nursing Facility

Permanente Advantage PPO:

Permanente Advantage POS:

- Inpatient Behavioral Health (BH)/Mental Health (MH) Hospital Care
- Inpatient Substance Use Disorder (SUD) Services

Medical/Surgical

- Inpatient Medical / Surgical Hospital Care
- Inpatient Medically Necessary Bariatric Surgery (Morbid Obesity Services)
- Inpatient Infertility Services
- Inpatient Rehabilitation and Habilitation Services
- Skilled Nursing Facility
- Inpatient Transplant Services

Mental Health/Substance Use Disorder

Permanente Advantage PPO:

- Inpatient Behavioral Health (BH)/Mental Health (MH) Hospital Care
- Inpatient Substance Use Disorder (SUD) Services

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO & POS

Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person’s health care needs; and (3) manages Your plan of care.

Precertification/Precertified means the required assessment of the necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review Program. If the Medical Review Program determines that the care is not Medically Necessary, Precertification will be denied. The Medical Review Program may be contacted twenty-four (24) hours per day, seven days per week. Precertification must be obtained for all Hospital stays and certain other services and procedures. Request for Precertification must be made by the Covered Person, the Covered Person’s attending Physician, or the Covered Person’s authorized representative prior to the commencement of any service or treatment. If Your services are provided by a Kaiser Permanente Provider, the Kaiser Permanente Provider will arrange for any necessary Precertification on Your behalf. If Precertification is required, it must be obtained to avoid a reduction in benefits. It is important to work with your provider to be certain services are Precertified when required or you will pay for the cost of the service.

Pregnancy Precertification:

When a Covered Person is admitted to a Hospital for the delivery of a child, the Covered Person is entitled to stay in the hospital without any Precertification for a minimum of:

1. Forty-eight (48) hours for a normal vaginal delivery; and
2. Ninety-six (96) hours for a Cesarean section delivery.

A stay longer than the above may be allowed provided the attending provider obtain authorization for an extended

Permanente Advantage PPO & POS

Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person’s health care needs; and (3) manages Your plan of care.

Precertification/Precertified means the required assessment of the necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review Program. If the Medical Review Program determines that the care is not Medically Necessary, Precertification will be denied. The Medical Review Program may be contacted twenty-four (24) hours per day, seven days per week. Precertification must be obtained for all Hospital stays and certain other services and procedures. Request for Precertification must be made by the Covered Person, the Covered Person’s attending Physician, or the Covered Person’s authorized representative prior to the commencement of any service or treatment. If Your services are provided by a Kaiser Permanente Provider, the Kaiser Permanente Provider will arrange for any necessary Precertification on Your behalf. If Precertification is required, it must be obtained to avoid a reduction in benefits. It is important to work with your provider to be certain services are Precertified when required or you will pay for the cost of the service.

Precertification Procedures

The Covered Person or his or her attending Physician must notify the Medical Review Program as follows:

1. Planned Hospital Confinement - as soon as reasonably possible after the Covered Person learns of a Hospital Confinement, but at least three days prior to admission for such Hospital Confinement.

Medical/Surgical

confinement through KPIC's Medical Review Program. In no case will KPIC require that a provider reduce the mother's or child's Hospital Confinement below the allowable minimums cited above. Treatment for Complications of Pregnancy is subject to the same Pre-certification requirements as any other Sickness.

Precertification Procedures

The Covered Person or his or her attending Physician must notify the Medical Review Program as follows:

1. Planned Hospital Confinement - as soon as reasonably possible after the Covered Person learns of a Hospital Confinement, but at least three days prior to admission for such Hospital Confinement.
2. Extension of a Hospital Confinement - as soon as reasonably possible prior to extending the number of days of Hospital Confinement beyond the number of days originally Precertified or within 48 hours following a vaginal delivery or 96 hours following a cesarean section, or as soon as reasonably possible, for Hospital Confinement in connection with childbirth expected to extend beyond the 48 or 96-hour period.
3. Other treatments or procedures requiring Precertification - As soon as reasonably possible after the Covered Person learns of the need for any other treatment or service requiring Precertification but at least three days prior to performance of any other treatment or service requiring Precertification. A Covered Person must provide all necessary information to the Medical Review Program in order for it to make its determination. This means the Covered Person may be required to:
 1. Obtain a second opinion from a Physician selected from a panel of three or more Physicians designated by the Medical Review Program. If the Covered Person is required to obtain a second medical opinion, it will be provided at no charge to the Covered Person;
 2. Participate in the Medical Review Program's case management, Hospital discharge planning and long term case management programs; and/or
 3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the requested treatment or service. If the Covered Person or the Covered Person's provider does not provide the necessary information or will not release necessary information, Precertification will be denied.

Of note if an inpatient stay is authorized all services, items pertaining to the inpatient stay are authorized ie. Medications.

Permanente Advantage utilizes the same prior authorization procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For

Mental Health/Substance Use Disorder

2. Extension of a Hospital Confinement - as soon as reasonably possible prior to extending the number of days of Hospital Confinement beyond the number of days originally Precertified.
3. Other treatments or procedures requiring Precertification - As soon as reasonably possible after the Covered Person learns of the need for any other treatment or service requiring Precertification but at least three days prior to performance of any other treatment or service requiring Precertification. A Covered Person must provide all necessary information to the Medical Review Program in order for it to make its determination. This means the Covered Person may be required to:

1. Obtain a second opinion from a Physician selected from a panel of three or more Physicians designated by the Medical Review Program. If the Covered Person is required to obtain a second medical opinion, it will be provided at no charge to the Covered Person;
2. Participate in the Medical Review Program's case management, Hospital discharge planning and long term case management programs; and/or
3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the requested treatment or service. If the Covered Person or the Covered Person's provider does not provide the necessary information or will not release necessary information, Precertification will be denied.

Of note if an inpatient stay is authorized all services, items pertaining to the inpatient stay are authorized ie. Medications.

Permanente Advantage utilizes the same prior authorization procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Prior authorization requests are reviewed and processed within the regulatory turnaround times.

Qualifications/Training:

Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing prior authorization requests are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. The licensed physician is ultimately responsible for issuing denials using their

Medical/Surgical	Mental Health/Substance Use Disorder
denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Prior authorization requests are reviewed and processed within the regulatory turnaround times.	clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.
<u>Qualifications/Training:</u> Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing prior authorization requests are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.	

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
Factors	
<u>Permanente Advantage PPO & POS</u> High variability in cost of care Variation in length of stay Variability and/or lack of adherence to criteria Clinical effectiveness of the treatment or service Appropriate level of care Severity or chronicity of medical surgical conditions Consistency in prior authorization within market	<u>Permanente Advantage PPO & POS</u> High variability in cost of care Variation in length of stay Variability and/or lack of adherence to criteria Clinical effectiveness of the treatment or service Appropriate level of care Severity or chronicity of MH/SUD conditions Consistency in prior authorization within market
Sources	
<u>Permanente Advantage PPO & POS</u> Utilization data Internal quality audits National Accreditation standards Electronic medical record Internal and external market comparative Certification of Insurance	<u>Permanente Advantage PPO & POS</u> Utilization data Internal quality audits National Accreditation standards Electronic medical record Internal and external market comparative Certification of Insurance

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are

comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage PPO & POS</u></p> <p>The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as Milliman Care Guidelines (MCG™) are utilized for M/S services. This standard applies to the following factors:</p> <ol style="list-style-type: none"> Variation in length of stay: <ol style="list-style-type: none"> MCG guideline goal length of stay is condition or diagnosis-specific length of stay, assuming optimal recovery and decision making. MCG statistical benchmarks and data apply data science to clinical improvement efforts. They are available for utilization and management in inpatient, post-acute, and ambulatory settings of care. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity: <ol style="list-style-type: none"> MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards. Effectiveness of the treatment or service: <ol style="list-style-type: none"> MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes. Severity or chronicity of the M/S conditions: <ol style="list-style-type: none"> MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the 	<p><u>Permanente Advantage PPO & POS</u></p> <p>The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as American Society of Addiction Medicine (ASAM) criteria/guidelines are utilized for SUD services, Milliman Care Guidelines (MCG™) for are utilized MH services and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. This standard applies to the following factors:</p> <ol style="list-style-type: none"> Variation in length of stay: <ol style="list-style-type: none"> ASAM criteria concepts has moved from a fixed length of service to a variable length of service. The length of stay must be individualized, based on severity of illness and level of functioning, as well as response to treatment, progress, and outcomes. MCG guideline goal length of stay is condition or diagnosis-specific length of stay, assuming optimal recovery and decision making. MCG statistical benchmarks and data apply data science to clinical improvement efforts. They are available for utilization and management in inpatient, post-acute, and ambulatory settings of care. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity: <ol style="list-style-type: none"> ASAM criteria developed to replace the 40-50 criteria sets of criteria used, proactively offer clinically sound alternatives to proprietary and variable criteria used by payers who funded or managed care. Coalition of National Clinical Criteria continues to work towards a national set of criteria (ASAM) accepted by providers, payers, managed care, and policy makers to reduce variability and/or adherence to standards of care. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care

Medical/Surgical

Mental Health/Substance Use Disorder

recovery of patients with multiple active conditions.

5. Appropriate level of care:
 - a. MCG care guidelines offer evidence-based criteria, goals, and optimal care pathways to move the patient through the continuum of care. Clinical indications for admission or procedure, continued stay, extended stay, goal length of stay, readmission risk, and discharge planning. Transitions of care guidelines address transitions between care settings.
6. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, effectiveness of the treatment or service, severity or chronicity of the M/S conditions, and the appropriate level of care.
7. Claim cost if the utilization of services or treatment is in-network utilizing direct contracts (per diem), rental network and/or letter of agreements (% of billed charges); out-of-network (100%) billed charges for facilities. This standard applies to the following factors: High variability of cost of care per episode.
 - a. Utilization Management (pre-certification / concurrent review) assists in managing costs, ensure medical necessity, and reducing unnecessary services. Our ability to encourage or channel patient's to in-network providers or obtain letter of agreement for out-of-network providers (continuity of care, network inadequacy, transition of care) reduces variability in cost of care and reduces cost share of Covered Persons and reduces the cost of care. Improving quality of care by using evidence-based criteria reduces variability or reduction of cost of care.

guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards.

- c. WPATH standards of care are international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health, including gender dysphoria.
3. Effectiveness of the treatment or service:
 - a. ASAM criteria encourages moving from seeing diagnosis as sufficient justification for treatment, vs a treatment that is holistic and address multiple needs. Treatment tailored to needs of individual, guided by individual treatment plan in consultation with patient contributes to a significantly to treatment outcomes.
 - b. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes.
 - c. WPATH clinical guidance for health professionals to assist TGD people, including gender dysphoria with safe and effective pathways to achieving lasting personal comfort with their gendered selves, with the aim of optimizing their overall health, psychological well-being, and self-fulfillment.
4. Severity or chronicity of the MH/BH/SUD conditions:
 - a. ASAM addresses co-occurring and complexity capability, recognizing that co-occurring mental health is an expectation, not an exception. This has been incorporated into the ASAM patient placement criteria utilized. Matrix is available for matching severity and level of function with type and intensity of service.
 - b. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.
 - c. WPATH standards of care incorporate the evaluation of coexisting mental health concerns as one of the steps in the assessment and referral process: assess, diagnose, and discuss treatment options for coexisting mental health concerns.
5. Appropriate level of care:
 - a. ASAM describes treatment as a continuum of care marked by 4 broad levels of serve and an early intervention level. Diagnostic admission criteria for levels of care ensures appropriate level of care at admission. Levels of care 0.5 (early intervention) through 4 (medically managed intensive inpatient services). Movement through any level of service(s)

the patient's progress in all six dimensions is assessed at regular intervals.

- b. MCG care guidelines offer evidence-based criteria, goals, and optimal care pathways to move the patient through the continuum of care. Clinical indications for admission or procedure, continued stay, extended stay, goal length of stay, readmission risk, and discharge planning. Transitions of care guidelines address transitions between care settings. MCG behavioral health level of care comparison charts address 5 levels of care; inpatient, residential, partial hospital, intensive outpatient, and outpatient care.
6. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, effectiveness of the treatment or service, severity or chronicity of the MH/SUD conditions, and the appropriate level of care.
7. Claim cost if the utilization of services or treatment is in-network utilizing direct contracts (per diem), rental network and/or letter of agreements (% of billed charges); out-of-network (100%) billed charges for facilities. This standard applies to the following factors: High variability of cost of care per episode.
 - a. Utilization Management (pre-certification/concurrent review) assists in managing costs, ensure medical necessity, and reducing unnecessary services. Our ability to encourage or channel patient's to in-network providers or obtain letter of agreement for out-of-network providers (continuity of care, network inadequacy, transition of care) reduces variability in cost of care and reduces cost share of Covered Persons and reduces the cost of care. Improving quality of care by using evidence-based criteria reduces variability or reduction of cost of care.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO & POS

1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of Pre-certification indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, providing comparable pre-certification lists.
2. Market analysis of comparable Plans identified 100% of plans require Prior-Authorization review for all Inpatient services for MH/SUD and M/S, excluding services covered under the Newborns' and Mothers' Health Protection Act of 1996, which is consistent with the KPIC plans. Alignment of prior authorization provides consistency whether Point-of-Service (POS) members are utilizing inpatient services under the Kaiser Permanente HMO Tier benefit level or KPIC Tier benefit level.
3. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.
4. Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #2, #4

Permanente Advantage PPO & POS

1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of Pre-certification indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, providing comparable pre-certification lists.
2. Market analysis of comparable Plans identified 100% of plans require Prior-Authorization review for all Inpatient services for MH/SUD and M/S, which is consistent with the KPIC plans. Alignment of prior authorization provides consistency whether Point-of-Service (POS) members are utilizing inpatient services under the Kaiser Permanente HMO Tier benefit level or KPIC Tier benefit level.
3. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.
4. Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #2, #4

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO & POS

1. Permanente Advantage utilizes the same prior authorization procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the

Permanente Advantage PPO & POS

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Medical/Surgical

Mental Health/Substance Use Disorder

member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how the member can file for an appeal. Prior authorization requests are reviewed and processed within the regulatory turnaround times.

2. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.
3. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.
4. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6
5. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.
6. Analysis of utilization data identified (3) pre-certification cases for Out of Network Inpatient for M/S services, wherein all were approved.

member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how the member can file for an appeal. Prior authorization requests are reviewed and processed within the regulatory turnaround times.

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3. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.
4. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6
5. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.
6. Analysis of utilization data identified (1) pre-certification case for Out of Network Inpatient for MH/SUD services, in which it was approved.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Permanente Advantage PPO & POS

Permanente Advantage's market analysis for the KPIC Plans confirmed all comparable plans require pre-certification for all Out of Network Inpatient services for MH/SUD and M/S. No Pre-Certification of emergency services is required, coverage of ER services is under the HMO tier. Alignment of prior authorization and criteria with KFHP provides consistency, whether Point-of-Service (POS) members are utilizing inpatient services under the Kaiser Permanente HMO Tier benefit level or KPIC PPO Tier benefit level. KPIC plans utilize a rental network to provide contracted providers and facilities. Covered persons have a choice to utilize contracted (in-network) or non-contracted (out-of-network) providers and facilities. Pre-certification of services allows for Permanente Advantage to channel Covered Persons to a contracted provider, if agreeable, thus reducing their cost share and overall cost of care for non-emergent services. Also, Pre-certification of services allows us to determine network inadequacy and to secure a single case agreement for services to be paid in-network, resulting in reduced cost share to member and reduce the cost of care for non-emergent services. In reviewing the utilization data, there was low utilization for Out of Network Inpatient services with a total of 4

Summary Conclusion

combined M/S and MH/SUD cases wherein all were approved, which we deem comparable. The URAC audit of Permanente Advantage's Utilization Management (UM) policies, procedures, and clinical chart review of denial and appeal charts, concluded Permanente Advantage met the URAC accreditation standards and were consistent and comparable as written and in operation for MH/SUD and M/S. Internal audits and inter-rater reliability confirmed the competency of selection and utilization of the Medical Necessity criteria for all services requiring pre-certification, as written and in operation, the caveat being that ASAM criteria is utilized for SUD, MCG is utilized for MH and M/S and WPATH is used for MH TGD people. Permanente Advantage concludes that as written and in operation, the UM policies, process, factors, and evidentiary standards used to develop and apply Pre-Certification NQTL for all MH/SUD Out of Network Inpatient services is comparable and no more stringent than M/S for the KPIC Plans, and therefore are compliant with the final regulation of the Mental Health Parity and Addiction Equity Act.

Benefit Classification 3: Outpatient – In Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage POS:</u> N/A</p> <p><u>Permanente Advantage PPO:</u></p> <ul style="list-style-type: none"> Genetic Laboratory Services High Tech Radiology Services (e.g., MRI's, CTs, PET, Myelogram and Nuclear Medicine scans) Chemotherapy, Radiation, and Infusion Therapy Outpatient Surgery (includes Facility and Professional Charges) Hospital Outpatient (includes Facility and Professional Charges) Medically Necessary Non-Emergency Ambulance Clinical Trials Medically Necessary Dental Services Medically Necessary Durable Medical Equipment (DME) Medically Necessary Pediatric Hearing Aid(s) and services for children through age 18 Home Health Care Hospice Care Outpatient Infertility Services Outpatient Bariatric Surgery (Morbid Obesity Services) Office / Outpatient Administered Drugs Supplies Supplements Prosthetic Devices (External) and Orthotics (P&O) Prosthetic (Internally Implanted) Reconstructive Surgery Rehabilitation Services and Habilitative Services <ul style="list-style-type: none"> Speech Therapy Physical and Occupational Therapy Pulmonary Therapy (in-home only) Cognitive Therapy for Traumatic Brain Injury 	<p><u>Permanente Advantage POS:</u> N/A</p> <p><u>Permanente Advantage PPO:</u></p> <ul style="list-style-type: none"> Autism Spectrum Disorder Services <ul style="list-style-type: none"> Applied Behavior Analysis Program (Limited to Children through age 20) Speech Therapy (Limited to Children through age 20) Physical and Occupational Therapy (Limited to Children through age 20): Clinical Trials

Medical/Surgical

Mental Health/Substance Use Disorder

- Multi-disciplinary Rehabilitation
- Outpatient Transplant Services

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO

Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person’s health care needs; and (3) manages Your plan of care. Precertification/Precertified means the required assessment of the necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review Program. If the Medical Review Program determines that the care is not Medically Necessary, Precertification will be denied. The Medical Review Program may be contacted twenty-four (24) hours per day, seven days per week. Precertification must be obtained for all Hospital stays and certain other services and procedures. Request for Precertification must be made by the Covered Person, the Covered Person’s attending Physician, or the Covered Person’s authorized representative prior to the commencement of any service or treatment. If Your services are provided by a Kaiser Permanente Provider, the Kaiser Permanente Provider will arrange for any necessary Precertification on Your behalf. If Precertification is required, it must be obtained to avoid a reduction in benefits. It is important to work with your provider to be certain services are Precertified when required or you will pay for the cost of the service.

Precertification Procedures

The Covered Person or his or her attending Physician must notify the Medical Review Program as follows: Other treatments or procedures requiring Precertification - As soon as reasonably possible after the Covered Person learns of the need for any other treatment or service requiring Precertification but at least three days prior to performance of any other treatment or service requiring Precertification.

A Covered Person must provide all necessary information to the Medical Review Program in order for it to make its determination. This means the Covered Person may be required to:

1. Obtain a second opinion from a Physician selected from a panel of three or more Physicians designated by the Medical

Permanente Advantage PPO

Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person’s health care needs; and (3) manages Your plan of care. Precertification/Precertified means the required assessment of the necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review Program. If the Medical Review Program determines that the care is not Medically Necessary, Precertification will be denied. The Medical Review Program may be contacted twenty-four (24) hours per day, seven days per week. Precertification must be obtained for all Hospital stays and certain other services and procedures. Request for Precertification must be made by the Covered Person, the Covered Person’s attending Physician, or the Covered Person’s authorized representative prior to the commencement of any service or treatment. If Your services are provided by a Kaiser Permanente Provider, the Kaiser Permanente Provider will arrange for any necessary Precertification on Your behalf. If Precertification is required, it must be obtained to avoid a reduction in benefits. It is important to work with your provider to be certain services are Precertified when required or you will pay for the cost of the service.

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A Covered Person must provide all necessary information to the Medical Review Program in order for it to make its determination. This means the Covered Person may be required to:

1. Obtain a second opinion from a Physician selected from a panel of three or more Physicians designated by the Medical

Medical/Surgical

Review Program. If the Covered Person is required to obtain a second medical opinion, it will be provided at no charge to the Covered Person;

2. Participate in the Medical Review Program's case management, Hospital discharge planning and long term case management programs; and/or

3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the requested treatment or service. If the Covered Person or the Covered Person's provider does not provide the necessary information or will not release necessary information, Precertification will be denied.

Permanente Advantage utilizes the same prior authorization procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Prior authorization requests are reviewed and processed within the regulatory turnaround times.

Qualifications/Training:

Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing prior authorization requests are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

Mental Health/Substance Use Disorder

Review Program. If the Covered Person is required to obtain a second medical opinion, it will be provided at no charge to the Covered Person;

2. Participate in the Medical Review Program's case management, Hospital discharge planning and long term case management programs; and/or

3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the requested treatment or service. If the Covered Person or the Covered Person's provider does not provide the necessary information or will not release necessary information, Precertification will be denied.

Of note outpatient physician administered drugs do not require precertification.

Permanente Advantage utilizes the same prior authorization procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Prior authorization requests are reviewed and processed within the regulatory turnaround times.

Qualifications/Training:

Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing prior authorization requests are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical

Mental Health/Substance Use Disorder

Factors

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage PPO</u> High variability in cost of care Variability and/or lack of adherence to criteria Clinical effectiveness of the treatment or service Severity or chronicity of medical surgical conditions Consistency in prior authorization within market	<u>Permanente Advantage PPO</u> High variability in cost of care Variability and/or lack of adherence to criteria Clinical effectiveness of the treatment or service Severity or chronicity of MH/SUD conditions Consistency in prior authorization within market
Sources	
<u>Permanente Advantage PPO</u> Utilization data Internal quality audits National Accreditation standards Electronic medical record Internal and external market comparative Certification of Insurance	<u>Permanente Advantage PPO</u> Utilization data Internal quality audits National Accreditation standards Electronic medical record Internal and external market comparative Certification of Insurance

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage PPO</u> The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as Milliman Care Guidelines (MCG™) are utilized for M/S services. This standard applies to the following factors: 1. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity: a. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of	<u>Permanente Advantage PPO</u> The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as American Society of Addiction Medicine (ASAM) criteria/guidelines are utilized for SUD services, Milliman Care Guidelines (MCG™) are utilized for MH services and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. This standard applies to the following factors:

Medical/Surgical

Mental Health/Substance Use Disorder

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| <p>evidence-based medicine, reducing variability and adherence in guidelines and standards.</p> <ol style="list-style-type: none"> 2. Effectiveness of the treatment or service: <ol style="list-style-type: none"> a. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes. 3. Severity or chronicity of the M/S conditions: <ol style="list-style-type: none"> a. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions. 4. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, effectiveness of the treatment or service, severity or and chronicity of the M/S conditions. 5. Claim cost if the utilization of services or treatment is in-network utilizing direct contracts (per diem), rental network and/or letter of agreements (% of billed charges); out-of-network (100%) billed charges for facilities. This standard applies to the following factors: High variability of cost of care per episode. <ol style="list-style-type: none"> a. Utilization Management (pre-certification / concurrent review) assists in managing costs, ensure medical necessity, and reducing unnecessary services. Our ability to encourage or channel patient's to in-network providers or obtain letter of agreement for out-of-network providers (continuity of care, network inadequacy, transition of care) reduces variability in cost of care and reduces cost share of Covered Persons and reduces the cost of care. Improving quality of care by using evidence-based criteria reduces variability or reduction of cost of care. | <ol style="list-style-type: none"> 1. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity: <ol style="list-style-type: none"> a. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards. 2. Effectiveness of the treatment or service: <ol style="list-style-type: none"> a. ASAM criteria encourages moving from seeing diagnosis as sufficient justification for treatment, vs a treatment that is holistic and address multiple needs. Treatment tailored to needs of individual, guided by individual treatment plan in consultation with patient contributes to a significantly to treatment outcomes. b. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes. c. WPATH clinical guidance for health professionals to assist TGD people, including gender dysphoria with safe and effective pathways to achieving lasting personal comfort with their gendered selves, with the aim of optimizing their overall health, psychological well-being, and self-fulfillment. 3. Severity or chronicity of the MH/BH/SUD conditions: <ol style="list-style-type: none"> a. ASAM addresses co-occurring and complexity capability, recognizing that co-occurring mental health is an expectation, not an exception. This has been incorporated into the ASAM patient placement criteria utilized. Matrix is available for matching severity and level of function with type and intensity of service. b. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions. c. WPATH standards of care support assess, diagnose, and discuss treatment options for coexisting mental health concerns. 4. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality |
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Medical/Surgical

Mental Health/Substance Use Disorder

- standards, effectiveness of the treatment or service, and severity or chronicity of the MH/SUD conditions.
5. Claim cost if the utilization of services or treatment is in-network utilizing direct contracts (per diem), rental network and/or letter of agreements (% of billed charges); out-of-network (100%) billed charges for facilities. This standard applies to the following factors: High variability of cost of care per episode.
 - a. Utilization Management (pre-certification/concurrent review) assists in managing costs, ensure medical necessity, and reducing unnecessary services. Our ability to encourage or channel patient's to in-network providers or obtain letter of agreement for out-of-network providers (continuity of care, network inadequacy, transition of care) reduces variability in cost of care and reduces cost share of Covered Persons and reduces the cost of care. Improving quality of care by using evidence-based criteria reduces variability or reduction of cost of care.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO

1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of Pre-certification indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, providing comparable pre-certification lists.
2. Market analysis of comparable Plans identified 100% of plans require Prior-Authorization review for selected M/S Outpatient services which is comparable with KPIC M/S Prior Authorizations. Additionally, comparable Plans identified 33% require Prior-Authorization review for Outpatient MH/SUD Intensive Outpatient Program (IOP) and 100% for Partial Hospitalization Programs (PHP) services, wherein KPIC plans do not require prior authorization review for IOP or PHP.
3. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on

Permanente Advantage PPO

1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of Pre-certification indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, providing comparable pre-certification lists.
2. Market analysis of comparable Plans identified 100% of plans require Prior-Authorization review for selected M/S Outpatient services which is comparable with KPIC M/S Prior Authorizations. Additionally, comparable Plans identified 33% require Prior-Authorization review for Outpatient MH/SUD Intensive Outpatient Program (IOP) and 100% for Partial Hospitalization Programs (PHP) services, wherein KPIC plans do not require prior authorization review for IOP or PHP.
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Medical/Surgical

07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.

4. Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #2, #4

Mental Health/Substance Use Disorder

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Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO

1. Permanente Advantage utilizes the same prior authorization procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how the member can file for an appeal. Prior authorization requests are reviewed and processed within the regulatory turnaround times.
2. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.
3. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.

Permanente Advantage PPO

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3. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.

Medical/Surgical	Mental Health/Substance Use Disorder
<p>4. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6</p> <p>5. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.</p> <p>6. Analysis of utilization data identified (1152) pre-certification cases for In Network Outpatient for M/S services, where (1038) were approved and (114) were denied.</p>	<p>4. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6</p> <p>5. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.</p> <p>6. Analysis of utilization data identified (35) pre-certification cases for In Network Outpatient for MH/SUD services, where (32) were approved and (3) were denied.</p>

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Permanente Advantage PPO

Permanente Advantage's market analysis for the KPIC Plans confirmed all comparable plans require pre-certification for selected In Network Outpatient M/S services, yet KPIC plans were less restrictive, not requiring pre-certification review of Outpatient MH/SUD: Partial Hospitalization or Intensive Outpatient Programs. No Pre-Certification of emergency services is required. KPIC plans utilize a rental network to provide contracted providers and facilities. Covered persons have a choice to utilize contracted (in-network) or non-contracted (out-of-network) providers and facilities. Pre-certification of services allows for Permanente Advantage to channel Covered Persons to a contracted provider, if agreeable, thus reducing their cost share and overall cost of care for non-emergent services. Also, Pre-certification of services allows us to determine network inadequacy and to secure a single case agreement for services to be paid in-network, resulting in reduced cost share to member and reduce the cost of care for non-emergent services. In comparing the utilization data, there is less volume for In Network Outpatient MH/SUD cases with only 3 denials for MH/SUD wherein the denial rate for MH/SUD is less than that of M/S, which we deem comparable. The URAC audit of Permanente Advantage's Utilization Management (UM) policies, procedures, and clinical chart review of denial and appeal charts concluded Permanente Advantage met the URAC accreditation standards and were consistent and comparable as written and in operation for MH/SUD and M/S. Internal audits and inter-rater reliability confirmed the competency of selection and utilization of the Medical Necessity criteria for all services requiring pre-certification, as written and in operation, the caveat being that ASAM criteria is utilized for SUD, MCG is utilized for MH and M/S and WPATH is used for MH TGD people. Permanente Advantage concludes that as written and in operation, the UM policies, process, factors, and evidentiary standards used to develop and apply Pre-Certification NQTL for all In Network MH/SUD Outpatient services is comparable and no more stringent than M/S for the KPIC Plans, and therefore are compliant with the final regulation of the Mental Health Parity and Addiction Equity Act.

Benefit Classification 4: Outpatient – Out-of-Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage POS:

- Genetic Laboratory Services
- High Tech Radiology Services (e.g., MRI's, CTs, PET, Myelogram and Nuclear Medicine scans)
- Chemotherapy, Radiation, and Infusion Therapy
- Outpatient Surgery (includes Facility and Professional Charges)
- Hospital Outpatient (includes Facility and Professional Charges)
- Clinical Trials
- Medically Necessary Durable Medical Equipment (DME)
- Medically Necessary Pediatric Hearing Aid(s) and services for children through age 18
- Home Health Care
- Hospice Care
- Office / Outpatient Administered Drugs Supplies Supplements
- Prosthetic Devices (External) and Orthotics (P&O)
- Prosthetic (Internally Implanted)
- Rehabilitation Services
 - Speech Therapy
 - Physical and Occupational Therapy

Permanente Advantage PPO:

- Genetic Laboratory Services
- High Tech Radiology Services (e.g., MRI's, CTs, PET, Myelogram and Nuclear Medicine scans):
- Chemotherapy, Radiation, and Infusion Therapy
- Outpatient Surgery (includes Facility and Professional Charges)
- Hospital Outpatient (includes Facility and Professional Charges)
- Medically Necessary Non-Emergency Ambulance
- Clinical Trials
- Medically Necessary Dental Services
- Medically Necessary Durable Medical Equipment (DME)
- Medically Necessary Pediatric Hearing Aid(s) and services for children through age 18
- Home Health Care
- Hospice Care
- Outpatient Infertility Services
- Outpatient Bariatric Surgery (Morbid Obesity Services)
- Office / Outpatient Administered Drugs Supplies Supplements
- Prosthetic Devices (External) and Orthotics (P&O)
- Prosthetic (Internally Implanted)
- Reconstructive Surgery
- Rehabilitation Services and Habilitative Services
 - Speech Therapy
 - Physical and Occupational Therapy

Permanente Advantage POS:

- Autism Spectrum Disorder Services
 - Applied Behavior Analysis Program (Limited to Children through age 20)
 - Speech Therapy (Limited to Children through age 20)
 - Physical and Occupational Therapy (Limited to Children through age 20)
- Clinical Trials

Permanente Advantage PPO:

- Autism Spectrum Disorder Services
 - Applied Behavior Analysis Program (Limited to Children through age 20)
 - Speech Therapy (Limited to Children through age 20)
 - Physical and Occupational Therapy (Limited to Children through age 20)
- Clinical Trials

Medical/Surgical

- Pulmonary Therapy (in-home only)
- Cognitive Therapy for Traumatic Brain Injury
- Multi-disciplinary Rehabilitation
- Outpatient Transplant Services

Mental Health/Substance Use Disorder

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO & POS

Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person’s health care needs; and (3) manages Your plan of care. Precertification/Precertified means the required assessment of the necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review Program. If the Medical Review Program determines that the care is not Medically Necessary, Precertification will be denied. The Medical Review Program may be contacted twenty-four (24) hours per day, seven days per week. Precertification must be obtained for all Hospital stays and certain other services and procedures. Request for Precertification must be made by the Covered Person, the Covered Person’s attending Physician, or the Covered Person’s authorized representative prior to the commencement of any service or treatment. If Your services are provided by a Kaiser Permanente Provider, the Kaiser Permanente Provider will arrange for any necessary Precertification on Your behalf. If Precertification is required, it must be obtained to avoid a reduction in benefits. It is important to work with your provider to be certain services are Precertified when required or you will pay for the cost of the service.

Precertification Procedures

The Covered Person or his or her attending Physician must notify the Medical Review Program as follows: Other treatments or procedures requiring Precertification - As soon as reasonably possible after the Covered Person learns of the need for any other treatment or service requiring Precertification but at least three days prior to performance of any other treatment or service requiring Precertification.

A Covered Person must provide all necessary information to the Medical Review Program in order for it to make its determination. This means the Covered Person may be required to:

Permanente Advantage PPO & POS

Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person’s health care needs; and (3) manages Your plan of care. Precertification/Precertified means the required assessment of the necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review Program. If the Medical Review Program determines that the care is not Medically Necessary, Precertification will be denied. The Medical Review Program may be contacted twenty-four (24) hours per day, seven days per week. Precertification must be obtained for all Hospital stays and certain other services and procedures. Request for Precertification must be made by the Covered Person, the Covered Person’s attending Physician, or the Covered Person’s authorized representative prior to the commencement of any service or treatment. If Your services are provided by a Kaiser Permanente Provider, the Kaiser Permanente Provider will arrange for any necessary Precertification on Your behalf. If Precertification is required, it must be obtained to avoid a reduction in benefits. It is important to work with your provider to be certain services are Precertified when required or you will pay for the cost of the service.

Precertification Procedures

The Covered Person or his or her attending Physician must notify the Medical Review Program as follows: Other treatments or procedures requiring Precertification - As soon as reasonably possible after the Covered Person learns of the need for any other treatment or service requiring Precertification but at least three days prior to performance of any other treatment or service requiring Precertification.

A Covered Person must provide all necessary information to the Medical Review Program in order for it to make its determination. This means the Covered Person may be required to:

Medical/Surgical

1. Obtain a second opinion from a Physician selected from a panel of three or more Physicians designated by the Medical Review Program. If the Covered Person is required to obtain a second medical opinion, it will be provided at no charge to the Covered Person;
2. Participate in the Medical Review Program's case management, Hospital discharge planning and long term case management programs; and/or
3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the requested treatment or service. If the Covered Person or the Covered Person's provider does not provide the necessary information or will not release necessary information, Precertification will be denied.

Permanente Advantage utilizes the same prior authorization procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Prior authorization requests are reviewed and processed within the regulatory turnaround times.

Qualifications/Training:

Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing prior authorization requests are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

Mental Health/Substance Use Disorder

1. Obtain a second opinion from a Physician selected from a panel of three or more Physicians designated by the Medical Review Program. If the Covered Person is required to obtain a second medical opinion, it will be provided at no charge to the Covered Person;
2. Participate in the Medical Review Program's case management, Hospital discharge planning and long term case management programs; and/or
3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the requested treatment or service. If the Covered Person or the Covered Person's provider does not provide the necessary information or will not release necessary information, Precertification will be denied.

Of note outpatient physician administered drugs do not require precertification.

Permanente Advantage utilizes the same prior authorization procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Prior authorization requests are reviewed and processed within the regulatory turnaround times.

Qualifications/Training:

Pertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing prior authorization requests are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical

Mental Health/Substance Use Disorder

Factors

Permanente Advantage PPO & POS

High variability in cost of care
 Variability and/or lack of adherence to criteria
 Clinical effectiveness of the treatment or service
 Severity or chronicity of medical surgical conditions
 Consistency in prior authorization within market

Permanente Advantage PPO & POS

High variability in cost of care
 Variability and/or lack of adherence to criteria
 Clinical effectiveness of the treatment or service
 Severity or chronicity of MH/SUD conditions
 Consistency in prior authorization within market

Sources

Permanente Advantage PPO & POS

Utilization data
 Internal quality audits
 National Accreditation standards
 Electronic medical record
 Internal and external market comparative
 Certification of Insurance

Permanente Advantage PPO & POS

Utilization data
 Internal quality audits
 National Accreditation standards
 Electronic medical record
 Internal and external market comparative
 Certification of Insurance

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO & POS

The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as Milliman Care Guidelines (MCG™) are utilized for M/S services. This standard applies to the following factors:

1. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity:
 - a. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of

Permanente Advantage PPO & POS

The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as American Society of Addiction Medicine (ASAM) criteria/guidelines are utilized for SUD services, Milliman Care Guidelines (MCG™) are utilized for MH services and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. This standard applies to the following factors:

Medical/Surgical

- evidence-based medicine, reducing variability and adherence in guidelines and standards.
- 2. Effectiveness of the treatment or service:
 - a. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes.
- 3. Severity or chronicity of the M/S conditions:
 - a. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.
- 4. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, effectiveness of the treatment or service, severity or and chronicity of the M/S conditions.
- 5. Claim cost if the utilization of services or treatment is in-network utilizing direct contracts (per diem), rental network and/or letter of agreements (% of billed charges); out-of-network (100%) billed charges for facilities. This standard applies to the following factors: High variability of cost of care per episode.
 - a. Utilization Management (pre-certification / concurrent review) assists in managing costs, ensure medical necessity, and reducing unnecessary services. Our ability to encourage or channel patient's to in-network providers or obtain letter of agreement for out-of-network providers (continuity of care, network inadequacy, transition of care) reduces variability in cost of care and reduces cost share of Covered Persons and reduces the cost of care. Improving quality of care by using evidence-based criteria reduces variability or reduction of cost of care.

Mental Health/Substance Use Disorder

- 1. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity:
 - a. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards.
- 2. Effectiveness of the treatment or service:
 - a. ASAM criteria encourages moving from seeing diagnosis as sufficient justification for treatment, vs a treatment that is holistic and address multiple needs. Treatment tailored to needs of individual, guided by individual treatment plan in consultation with patient contributes to a significantly to treatment outcomes.
 - b. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes.
 - c. WPATH clinical guidance for health professionals to assist TGD people, including gender dysphoria with safe and effective pathways to achieving lasting personal comfort with their gendered selves, with the aim of optimizing their overall health, psychological well-being, and self-fulfillment.
- 3. Severity or chronicity of the MH/BH/SUD conditions:
 - a. ASAM addresses co-occurring and complexity capability, recognizing that co-occurring mental health is an expectation, not an exception. This has been incorporated into the ASAM patient placement criteria utilized. Matrix is available for matching severity and level of function with type and intensity of service.
 - b. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.
 - c. WPATH standards of care support assess, diagnose, and discuss treatment options for coexisting mental health concerns.
- 4. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality

Medical/Surgical

Mental Health/Substance Use Disorder

- standards, effectiveness of the treatment or service, and severity or chronicity of the MH/SUD conditions.
5. Claim cost if the utilization of services or treatment is in-network utilizing direct contracts (per diem), rental network and/or letter of agreements (% of billed charges); out-of-network (100%) billed charges for facilities. This standard applies to the following factors: High variability of cost of care per episode.
 - a. Utilization Management (pre-certification/concurrent review) assists in managing costs, ensure medical necessity, and reducing unnecessary services. Our ability to encourage or channel patient's to in-network providers or obtain letter of agreement for out-of-network providers (continuity of care, network inadequacy, transition of care) reduces variability in cost of care and reduces cost share of Covered Persons and reduces the cost of care. Improving quality of care by using evidence-based criteria reduces variability or reduction of cost of care.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO & POS

1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of Pre-certification indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, providing comparable pre-certification lists.
2. Market analysis of comparable Plans identified 100% of plans require Prior-Authorization review for selected M/S Outpatient services which is comparable with KPIC M/S Prior Authorizations. Additionally, comparable Plans identified 33% require Prior-Authorization review for Outpatient MH/SUD Intensive Outpatient Program (IOP) and 100% for Partial Hospitalization Programs (PHP) services, wherein KPIC plans do not require prior authorization review for IOP or PHP.
3. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on

Permanente Advantage PPO & POS

1. Review of Kaiser Permanente Insurance Company Certificate of Insurance definition of Pre-certification indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, providing comparable pre-certification lists.
2. Market analysis of comparable Plans identified 100% of plans require Prior-Authorization review for selected M/S Outpatient services which is comparable with KPIC M/S Prior Authorizations. Additionally, comparable Plans identified 33% require Prior-Authorization review for Outpatient MH/SUD Intensive Outpatient Program (IOP) and 100% for Partial Hospitalization Programs (PHP) services, wherein KPIC plans do not require prior authorization review for IOP or PHP.
3. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on

Medical/Surgical

07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.

4. Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #2, #4

Mental Health/Substance Use Disorder

07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.

4. Internal audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #2, #4

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO & POS

1. Permanente Advantage utilizes the same prior authorization procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how the member can file for an appeal. Prior authorization requests are reviewed and processed within the regulatory turnaround times.
2. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.
3. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.

Permanente Advantage PPO & POS

1. Permanente Advantage utilizes the same prior authorization procedures and forms for MH/SUD and M/S. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how the member can file for an appeal. Prior authorization requests are reviewed and processed within the regulatory turnaround times.
2. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.
3. Internal audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.

Medical/Surgical

4. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6
5. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.
6. Analysis of utilization data identified (86) pre-certification cases for Out of Network Outpatient for M/S services, which (69) were approved and (17) were denied.

Mental Health/Substance Use Disorder

4. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6
5. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.
6. Analysis of utilization data identified (7) pre-certification cases for Out of Network Outpatient for MH/SUD services, which were all approved.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Permanente Advantage PPO & POS

Permanente Advantage's market analysis for the KPIC Plans confirmed all comparable plans require pre-certification for selected M/S Out of Network Outpatient services, yet KPIC plans were less restrictive, not requiring pre-certification review of Outpatient MH/SUD: Partial Hospitalization or Intensive Outpatient Programs. No Pre-Certification of emergency services is required. KPIC plans utilize a rental network to provide contracted providers and facilities. Covered persons have a choice to utilize contracted (in-network) or non-contracted (out-of-network) providers and facilities. Pre-certification of services allows for Permanente Advantage to channel Covered Persons to a contracted provider, if agreeable, thus reducing their cost share and overall cost of care for non-emergent services. Also, Pre-certification of services allows us to determine network inadequacy and to secure a single case agreement for services to be paid in-network, resulting in reduced cost share to member and reduce the cost of care for non-emergent services. In comparing the utilization data, there was a significantly lower volume for MH/SUD Out of Network Outpatient services, where all cases were approved, which shows MH/SUD is less stringent than M/S. The URAC audit of Permanente Advantage's Utilization Management (UM) policies, procedures, and clinical chart review of denial and appeal charts concluded Permanente Advantage met the URAC accreditation standards and were consistent and comparable as written and in operation for MH/SUD and M/S. Internal audits and inter-rater reliability confirmed the competency of selection and utilization of the Medical Necessity criteria for all services requiring pre-certification, as written and in operation, the caveat being that ASAM criteria is utilized for SUD, MCG is utilized for MH and M/S and WPATH is used for MH TGD people. Permanente Advantage concludes that as written and in operation, the UM policies, process, factors, and evidentiary standards used to develop and apply Pre-Certification NQTL for all Out of Network MH/SUD Outpatient services is comparable and no more stringent than M/S for the KPIC plans, and therefore are compliant with the final regulation of the Mental Health Parity and Addiction Equity Act.

Benefit Classification 5: Emergency Services

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical

Mental Health/Substance Use Disorder

N/A – Pre-certification is not required for Emergency Services

N/A – Pre-certification is not required for Emergency Services

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical

Mental Health/Substance Use Disorder

N/A – Pre-certification is not required for Emergency Services

N/A – Pre-certification is not required for Emergency Services

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical

Mental Health/Substance Use Disorder

N/A – Pre-certification is not required for Emergency Services

N/A – Pre-certification is not required for Emergency Services

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical

Mental Health/Substance Use Disorder

N/A – Pre-certification is not required for Emergency Services

N/A – Pre-certification is not required for Emergency Services

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – Pre-certification is not required for Emergency Services	N/A – Pre-certification is not required for Emergency Services

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – Pre-certification is not required for Emergency Services	N/A – Pre-certification is not required for Emergency Services

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion
N/A – Pre-certification is not required for Emergency Services

Benefit Classification 6: Pharmacy Services

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical

Mental Health/Substance Use Disorder

Pharmacy POS & PPO

Prescription drugs (self-administered)

Pharmacy POS & PPO

Prescription drugs (self-administered)

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical

Mental Health/Substance Use Disorder

POS Pharmacy:

For certain drugs, Kaiser Permanente requires review and authorization prior to dispensing. Your Provider must obtain this review and authorization. The list of prescriptions drugs requiring review and authorization is subject to periodic review and modification by our Pharmacy and Therapeutics Committee.

A Participating Provider may initiate prior authorization after he or she determines that the drug or supply is Medically Necessary. Prescribing Participating Providers must supply to Company the medical information necessary for Company to make the prior authorization determination. Coverage for a prescribed drug or supply that is approved for prior authorization begins on the date Company approves the request. A list of those drugs and supplies that require prior authorization is available online at kp.org or you may contact Member Services. We apply Prior Authorization prescribing criteria, developed by Kaiser Foundation Health Plan of Georgia, and endorsed by The Southeast Permanente Medical Group.

Medical necessity criteria is established by Kaiser or applied using industry standard criteria (such as MCG) have been analyzed for parity within the applicable utilization management NQTLs.

Prescription drugs are covered under the benefit plan and available for the member’s applicable cost share when prescribed for medically necessary covered medical conditions and the member meets any established coverage criteria.

Clinicians requesting a Prior Authorization drug will evaluate and document as required:

- Use of one or more alternatives, if alternatives exist.
- Contraindication, treatment failure, intolerance, or allergy to one or more alternatives, if applicable.
- Diagnosis of any approved indication.
- Specialist consultation or recommendation.

POS Pharmacy:

For certain drugs, Kaiser Permanente requires review and authorization prior to dispensing. Your Provider must obtain this review and authorization. The list of prescriptions drugs requiring review and authorization is subject to periodic review and modification by our Pharmacy and Therapeutics Committee.

A Participating Provider may initiate prior authorization after he or she determines that the drug or supply is Medically Necessary. Prescribing Participating Providers must supply to Company the medical information necessary for Company to make the prior authorization determination. Coverage for a prescribed drug or supply that is approved for prior authorization begins on the date Company approves the request. A list of those drugs and supplies that require prior authorization is available online at kp.org or you may contact Member Services. We apply Prior Authorization prescribing criteria, developed by Kaiser Foundation Health Plan of Georgia, and endorsed by The Southeast Permanente Medical Group.

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Prescription drugs are covered under the benefit plan and available for the member’s applicable cost share when prescribed for medically necessary covered medical conditions and the member meets any established coverage criteria.

Clinicians requesting a Prior Authorization drug will evaluate and document as required:

- Use of one or more alternatives, if alternatives exist.
- Contraindication, treatment failure, intolerance, or allergy to one or more alternatives, if applicable.

Medical/Surgical

- e. Laboratory monitoring.
- f. Age appropriateness.
- g. Lab values.
- h. Prescribing program enrollment for clinicians or members.
- i. Any other criteria required to support evidence-based use.

If a prior authorization medication is selected by the clinician, an order notification is transmitted electronically to and processed by Utilization Management (Quality Resource Management (QRM) or the Pharmacy Consult Service (PCS). A nurse, pharmacist or physician will review the patient's chart, to determine if criteria are met.

If criteria are not met, a note will be sent to the prescriber, and he or she is given the opportunity to update to a preferred alternative or provide additional clinical information. If within the timeline additional justification sufficient to satisfy criteria or a preferred alternative is not ordered, determination of approval or denial is rendered by the PCS pharmacist. Only UM physician (MD or DO) or pharmacist (Pharm D) will make a decision to deny a prescription based on medical necessity. The prescriber and member are informed of all approvals and denials. In the event of a denial, the member is informed of the right to appeal.

Qualifications/Training:

Licensed physicians and pharmacists oversee all utilization management decisions pertaining to behavioral medications and non-behavioral medication to ensure consistent medical necessity decision-making and to provide high-level involvement in complex cases. Staff members responsible for processing medication coverage requests are trained on the workflow and utilize their clinical education to complete a clinical case review and issue denials using their clinical knowledge, UM workflow and standardized criteria due the review process.

Timelines:

Kaiser reviews prior authorization requests and responds with a determination to the ordering clinician and the member in writing as soon as possible to accommodate the clinical urgency of the situation, not to exceed the turn-around time requirements established by state and federal regulators and accrediting agencies.

PPO Pharmacy:

Prior Authorization ("PA") is the process undertaken to make a benefit determination that is made prior to and concurrent with the intended delivery of the healthcare service, treatment, or supply under review.

Mental Health/Substance Use Disorder

- c. Diagnosis of any approved indication.
- d. Specialist consultation or recommendation.
- e. Laboratory monitoring.
- f. Age appropriateness.
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- h. Prescribing program enrollment for clinicians or members.
- i. Any other criteria required to support evidence-based use.

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PPO Pharmacy:

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

Medical/Surgical

PA requests are evaluated utilizing the recommended guidelines of the P&T Committee or the plan. If the request meets the approved guidelines, the request will be approved. If the request does not meet the approved guidelines, the request will not be approved, and alternative therapy may be recommended along with the proper course of alternative action.

This NQTL analysis sets forth the factors, sources, and evidentiary standards that the Pharmacy Benefit Manager (PBM), MedImpact, and KPIC use to determine which medications to subject to PA. The same authorization process, that is used for PA is also used for step therapy overrides, non-formulary medication requests, excluded medications, specialty overrides, and Copayment exceptions. Factors, sources, and evidentiary standards for formulary-related limits are set forth in the separate NQTL analyses for Formulary Design and Step Therapy.

All PA requests are processed following the same policies and procedures regardless of whether the request is for a M/S or MH/SUD drug.

The plan's PA process is monitored by CMS and NCQA and is conducted in accordance with all CMS and NCQA requirements. Internally, the PA process is monitored and supervised by the Pharmacist in Charge or Supervisor of PA/UM Programs, with oversight by the Manager and/or Director of PA/UM Programs. The following processes apply to PA reviews, including requests for formulary exceptions:

- PA requests are received via various modes including phone, fax, ePA. If received via fax, the MedImpact Medication Request Form is available online and may be used but is not required.
- All exception decisions based upon medical necessity are rendered by appropriate pharmacists and practitioners in a timely fashion and follow all state applicable timeframes.
- A PA Coordinator reviews the information provided to see whether it meets the approval criteria set forth in the guideline.
- Pharmacists review cases that cannot be approved by a PA Coordinator. A Clinical Pharmacist Reviewer having appropriate expertise reviews the case. Clinical Pharmacist Reviewers are licensed pharmacists in good standing in a state of the United States and receive orientation and training in the principles and standards of utilization management from the pharmacy benefit manager.
- The Clinical Pharmacist Reviewer may consult with the Prescribing Professional regarding the requested services when appropriate, or to request additional information, if necessary, to review the case.

Mental Health/Substance Use Disorder

Prior Authorization ("PA") is the process undertaken to make a benefit determination that is made prior to and concurrent with the intended delivery of the healthcare service, treatment, or supply under review.

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- The Clinical Pharmacist Reviewer may consult with the Prescribing Professional regarding the requested

Medical/Surgical

- In the event that MedImpact does not have all the necessary information needed to make an exception based on medical necessity, MedImpact shall make reasonable and diligent efforts to obtain all necessary information, including medical records and other pertinent documentation, from the patient's Prescribing Physician.
- The Clinical Pharmacist Reviewer consults the PA guideline to review the case. Where guidelines do not exist, the Clinical Pharmacist Reviewer utilizes the Labeled and Compendia Supported Indications Guideline. If the request meets guidelines, the request is approved. The duration of approval is specified in the PA guidelines. If the request does not meet the guidelines, the Pharmacist documents the clinical reasoning for the denial, and the PA Coordinator notifies the physician via fax, ePA and the patient via phone (if available) and mail.

Mental Health/Substance Use Disorder

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Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical

POS Pharmacy:

The Formulary process is intended to enhance the quality of patient care by ensuring that available drugs meet established quality standards and by limiting the availability of drugs that are unsafe, less effective, and ineffective or have high potential for toxicity or abuse.

PPO Pharmacy:

Medical/Surgical:

PA is applied when the new medication or medication class meets one or more of the following criteria:

- Relative therapeutic efficacy
- Drug safety and relative risks of drug versus alternatives
- Cost-effectiveness
- Risk for off-label or experimental use

Factors

Mental Health/Substance Use Disorder

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Factors

Medical/Surgical

Mental Health/Substance Use Disorder

POS Pharmacy:

In review of the application rationale for behavioral health and medical/ surgical drugs the use of prior authorization drugs requires the satisfaction of clinical criteria before benefit coverage may be extended. These criteria restrictions may include:

- a. Potential for significant safety concerns
- b. High potential for adverse effects
- c. High cost-to-benefit ratio in conjunction with other clinical
- d. High potential for abuse
- e. Use of one or more alternatives, if alternatives exist.
- f. Contraindication, treatment failure, intolerance, or allergy to one or more alternatives, if applicable.
- g. Diagnosis of any approved indication.
- h. Specialist consultation or recommendation

PPO Pharmacy:

The P&T Committee members evaluate the following factors based on the identified evidentiary standards and sources to arrive at a determination based on the totality of the evidence. All factors are assessed on a qualitative basis and are balanced according to the professional judgment of the member.

- Relative therapeutic efficacy
 - Definition: Efficacy is defined as the potential outcome of treatment under optimal circumstances. Relative therapeutic efficacy is defined as the efficacy of a drug compared to other medications that are determined to be therapeutically equivalent.
 - Evidentiary standard: The medication (or class) does not have significant therapeutic advantage over existing medication classes but a select population may require the new therapy be prescribed first line, as determined by the P&T Committee applying professional judgment to the sources cited below.
 - Sources: see below
- Drug safety and relative risks of drug versus alternatives
 - Definition: drug safety and relative risks are defined as the potential for patient harm or adverse outcomes.
 - Evidentiary standard: Careful patient selection is needed in order to achieve the best therapeutic outcome or because of medication safety implications, relative to alternatives within the same therapeutic class, as determined by the P&T Committee applying professional judgment to the sources cited below.
 - Sources: see below
- Cost-effectiveness
 - Definition: The medication is associated with a high net cost when compared to accepted alternative therapies that are effective, and safe, and associated with lower net cost in most patients

POS Pharmacy:

In review of the application rationale for behavioral health and medical/ surgical drugs the use of prior authorization drugs requires the satisfaction of clinical criteria before benefit coverage may be extended. These criteria restrictions may include:

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- c. High cost-to-benefit ratio in conjunction with other clinical
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- Relative therapeutic efficacy
 - Definition: Efficacy is defined as the potential outcome of treatment under optimal circumstances. Relative therapeutic efficacy is defined as the efficacy of a drug compared to other medications that are determined to be therapeutically equivalent.
 - Evidentiary standard: The medication (or class) does not have significant therapeutic advantage over existing medication classes but a select population may require the new therapy be prescribed first line, as determined by the P&T Committee applying professional judgment to the sources cited below.
 - Sources: see below
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 - Definition: drug safety and relative risks are defined as the potential for patient harm or adverse outcomes.
 - Evidentiary standard: Careful patient selection is needed in order to achieve the best therapeutic outcome or because of medication safety implications, relative to alternatives within the same therapeutic class, as determined by the P&T Committee applying professional judgment to the sources cited below.
 - Sources: see below

Medical/Surgical

- Evidentiary standard: Cost-effectiveness is evaluated through utilization of pharmacoeconomic principles and/or published pharmacoeconomic or outcomes research evaluations where available (such as reports by the U.S. Institute for Clinical and Economic Review or the International Society for Pharmacoeconomics and Outcomes Research), to determine whether the drug offers an acceptable cost-effectiveness ratio comparative to therapeutic alternatives, as determined by the P&T Committee applying professional judgment to the sources cited below.
- Sources: see below
- Risk for off-label or experimental use
 - Definition: Off-label Use means use of an FDA-approved medication that has been prescribed by a provider for treatment of a condition or disease other than for an indication specifically designated in the product's FDA-approved labeling. Experimental use is defined according to the factors set forth in the Experimental and Investigational NQTL analysis.
 - Evidentiary standard: risk is evaluated in the judgment the P&T Committee based on professional knowledge and experience. This factor is given extra weight for drugs with higher-than-average costs, but no quantitative threshold is applied for cost.
 - Sources: see below

Sources

POS Pharmacy:

All drugs or drug classes are reviewed using evidence-based criteria from credible sources including:

- Peer-reviewed medical literature
- Accepted national treatment guidelines
- Drug compendia in common use
- Other authoritative medical sources
- ICER analyses
- MediSpan data
- Expert opinion where necessary
- Prescribing guidelines

PPO Pharmacy:

Sources: All drugs or drug classes are reviewed using evidence-based criteria from credible sources including:

- Peer-reviewed medical literature
- Accepted national treatment guidelines

Mental Health/Substance Use Disorder

- Cost-effectiveness
 - Definition: The medication is associated with a high net cost when compared to accepted alternative therapies that are effective, and safe, and associated with lower net cost in most patients
 - Evidentiary standard: Cost-effectiveness is evaluated through utilization of pharmacoeconomic principles and/or published pharmacoeconomic or outcomes research evaluations where available (such as reports by the U.S. Institute for Clinical and Economic Review or the International Society for Pharmacoeconomics and Outcomes Research), to determine whether the drug offers an acceptable cost-effectiveness ratio comparative to therapeutic alternatives, as determined by the P&T Committee applying professional judgment to the sources cited below.
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 - Evidentiary standard: risk is evaluated in the judgment the P&T Committee based on professional knowledge and experience. This factor is given extra weight for drugs with higher-than-average costs, but no quantitative threshold is applied for cost.
 - Sources: see below

Sources

POS Pharmacy:

All drugs or drug classes are reviewed using evidence-based criteria from credible sources including:

- Peer-reviewed medical literature
- Accepted national treatment guidelines
- Drug compendia in common use
- Other authoritative medical sources
- ICER analyses
- MediSpan data
- Expert opinion where necessary
- Prescribing guidelines

PPO Pharmacy:

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

Medical/Surgical	Mental Health/Substance Use Disorder
<ul style="list-style-type: none"> -Drug compendia in common use -Other authoritative medical sources -ICER analyses - MediSpan data -Expert opinion where necessary -Prescribing guidelines 	<p>Sources: All drugs or drug classes are reviewed using evidence-based criteria from credible sources including:</p> <ul style="list-style-type: none"> -Peer-reviewed medical literature -Accepted national treatment guidelines -Drug compendia in common use -Other authoritative medical sources -ICER analyses -MediSpan data -Expert opinion where necessary -Prescribing guidelines

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>POS Pharmacy:</u> Upon review of the process of adding either behavioral health and medical/surgical drugs to the prior authorization list, both benefit classifications follow the same evidentiary standards in the development of the criteria. Prior Authorization criteria are developed in partnership by Kaiser Foundation Health Plan of Georgia pharmacists partnering with applicable physician Department Chiefs from The Southeast Permanente Medical Group, review available information, including the prescribing information, independent studies, practice recommendations, guidelines and other recognized authoritative compendia and creates criteria for review for endorsement by the Pharmacy and Therapeutics committee.</p> <p>Medical and behavioral health prior authorization drug selection decisions are made primarily based on safety and effectiveness. Safety and effectiveness are determined by a thorough review of pertinent medical evidence, incorporating expert opinion and relevant findings from appropriate external organizations (e.g., Centers for Disease Control, National Institutes of Health, American Academy of Pediatrics, etc.). After safety and effectiveness are investigated, cost is considered.</p>	<p><u>POS Pharmacy:</u> Upon review of the process of adding either behavioral health and medical/surgical drugs to the prior authorization list, both benefit classifications follow the same evidentiary standards in the development of the criteria. Prior Authorization criteria are developed in partnership by Kaiser Foundation Health Plan of Georgia pharmacists partnering with applicable physician Department Chiefs from The Southeast Permanente Medical Group, review available information, including the prescribing information, independent studies, practice recommendations, guidelines and other recognized authoritative compendia and creates criteria for review for endorsement by the Pharmacy and Therapeutics committee.</p> <p>Medical and behavioral health prior authorization drug selection decisions are made primarily based on safety and effectiveness. Safety and effectiveness are determined by a thorough review of pertinent medical evidence, incorporating expert opinion and relevant findings from appropriate external organizations (e.g., Centers for Disease Control, National Institutes of Health, American Academy of Pediatrics, etc.). After safety and effectiveness are investigated, cost is considered.</p>

Medical/Surgical

Mental Health/Substance Use Disorder

Medical evidence can include peer reviewed journal articles obtained through library searches and on-line search engines, as well as Kaiser Permanente Drug Information Services in other Kaiser Permanente regions. Medical evidence provides insight into the following:

- i. Documentation of effectiveness
- ii. Results and extent of clinical investigation
- iii. Severity and incidence of toxicity and side effects

Expert opinion is obtained from practitioners who serve as consultants. Consultants may be invited to a Pharmacy and Therapeutics Committee meeting to present their opinions, or they may present their opinions in writing or verbally communicate with a P and T committee member. Consultants are required to provide a Conflict-of-Interest disclosure before participation.

Relevant findings of appropriate external organizations are included in the monographs presented for consideration. Information is usually obtained via reliable sites on the internet or from peer reviewed journals.

Additional information considered in making decisions include:

- i. Availability of current formulary drugs to meet the therapeutic need.
- ii. Reliability and quality control of the drug manufacturer
- iii. Current utilization of the drug by practitioners within the program
- iv. Comparative cost of alternative equivalent therapy
- v. Other unique attributes which may warrant inclusion of the drug.

PPO Pharmacy:

Sources consulted by MedImpact for the development of each PA guideline include:

- FDA approval
- Peer-reviewed medical literature, where at least 2 peer-reviewed journal articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses for humans as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal. When evaluating this literature, reviewers will consider (among other things) the following:
 - (1) Whether the clinical characteristics of the beneficiary and the cancer are adequately represented in the published evidence.
 - (2) Whether the administered chemotherapy regimen is adequately represented in the published evidence.

Medical evidence can include peer reviewed journal articles obtained through library searches and on-line search engines, as well as Kaiser Permanente Drug Information Services in other Kaiser Permanente regions. Medical evidence provides insight into the following:

- i. Documentation of effectiveness
- ii. Results and extent of clinical investigation
- iii. Severity and incidence of toxicity and side effects

Expert opinion is obtained from practitioners who serve as consultants. Consultants may be invited to a Pharmacy and Therapeutics Committee meeting to present their opinions, or they may present their opinions in writing or verbally communicate with a P and T committee member. Consultants are required to provide a Conflict-of-Interest disclosure before participation.

Relevant findings of appropriate external organizations are included in the monographs presented for consideration. Information is usually obtained via reliable sites on the internet or from peer reviewed journals.

Additional information considered in making decisions include:

- i. Availability of current formulary drugs to meet the therapeutic need.
- ii. Reliability and quality control of the drug manufacturer
- iii. Current utilization of the drug by practitioners within the program
- iv. Comparative cost of alternative equivalent therapy
- v. Other unique attributes which may warrant inclusion of the drug.

PPO Pharmacy:

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

Sources consulted by MedImpact for the development of each PA guideline include:

- FDA approval
- Peer-reviewed medical literature, where at least 2 peer-reviewed journal articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses for humans as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal. When evaluating this literature, reviewers will consider (among other things) the following:

Medical/Surgical

- (3) Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients.
- (4) Whether the study is appropriate to address the clinical question. The contractor will consider:
 - (a) Whether the experimental design, in light of the drugs and conditions under investigation, is appropriate to address the investigative question. (For example, in some clinical studies, it may be unnecessary or not feasible to use randomization, double blind trials, placebos, or crossover.).
 - (b) That non-randomized clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs; and (c) That case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.
- Therapy recommendations listed in guidelines issued by leading nationally recognized associations and agencies, such as the CDC (Centers for Disease Control and Prevention), the AASLD (American Association for the Study of Liver Diseases) or IDSA guidelines (Infectious Diseases Society of America). The reviewer will be looking for recommended regimens based on the patient's diagnosis and clinical characteristics. In addition, the reviewer will consider the strength of the rating for the particular treatment, should that be available.
- Drug compendia in common use, including:
 - (1) American Hospital Formulary Service-Drug Information (AHFS-DI)
 - (2) Clinical Pharmacology
 - (3) National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
 - (4) Truven Health Analytics Micromedex DrugDex
 - (5) Wolters Kluwer Lexi-Drugs
- Other authoritative medical sources.
- Expert opinion where necessary

Mental Health/Substance Use Disorder

- (1) Whether the clinical characteristics of the beneficiary and the cancer are adequately represented in the published evidence.
- (2) Whether the administered chemotherapy regimen is adequately represented in the published evidence.
- (3) Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients.
- (4) Whether the study is appropriate to address the clinical question. The contractor will consider:
 - (a) Whether the experimental design, in light of the drugs and conditions under investigation, is appropriate to address the investigative question. (For example, in some clinical studies, it may be unnecessary or not feasible to use randomization, double blind trials, placebos, or crossover.).
 - (b) That non-randomized clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs; and (c) That case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.
- Therapy recommendations listed in guidelines issued by leading nationally recognized associations and agencies, such as the CDC (Centers for Disease Control and Prevention), the AASLD (American Association for the Study of Liver Diseases) or IDSA guidelines (Infectious Diseases Society of America). The reviewer will be looking for recommended regimens based on the patient's diagnosis and clinical characteristics. In addition, the reviewer will consider the strength of the rating for the particular treatment, should that be available.
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 - (2) Clinical Pharmacology
 - (3) National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
 - (4) Truven Health Analytics Micromedex DrugDex
 - (5) Wolters Kluwer Lexi-Drugs
- Other authoritative medical sources.
- Expert opinion where necessary

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>POS Pharmacy:</u> The ordering clinician will determine appropriate medical or psychiatric medication therapy based on current regional treatment guidelines, the member's known drug history, and documented diagnosis.</p> <p>If a prior authorization medication is selected, an order notification is transmitted electronically to and processed by the designated UM team (QRM or PCS).</p> <ol style="list-style-type: none">1. A nurse or pharmacist will review the patient's chart to determine if criteria are met. If criteria are met, an approval is rendered.2. If criteria are not met, a note will be sent to the prescriber, and he or she is given the opportunity to update to a preferred alternative. If within the timeline either additional justification satisfying criteria or a preferred alternative is not ordered, determination of denial is rendered by the UM team (QRM or PCS pharmacist)3. Member is notified of approval or denial in writing within regulatory guidelines and will issue a formal denial letter if medication is approved or denied.4. When all criteria are met, the drug will be covered at the member's pharmacy co-pay or coinsurance (after the deductible is met, if applicable). When criteria are not met, the drug will not be covered by the member's pharmacy benefit.5. UM (QRM or PCS) will generate a denial letter with appropriate appeal information.6. At any time, a member may choose to purchase a prescribed drug that has been deemed not medically necessary by paying full price for the drug.7. The member may also appeal the denial of the drug. <p>The Kaiser Permanente Georgia Pharmacy and Therapeutics Committee (PTC) has developed prescribing criteria to apply to selected medical and psychiatric medications. The Committee members include:</p> <ol style="list-style-type: none">A. The Physician Program Director of Pharmacy and Therapeutics/Medication Safety serves as Chairperson and serves unlimited terms as deemed appropriate by the Medical Director and President,	<p><u>POS Pharmacy:</u> The prior authorization process is the same regardless of the medication's treatment indication for both behavioral health and medical surgical benefit areas.</p> <p>The ordering clinician will determine appropriate medical or psychiatric medication therapy based on current regional treatment guidelines, the member's known drug history, and documented diagnosis.</p> <p>If a prior authorization medication is selected, an order notification is transmitted electronically to and processed by the designated UM team (QRM or PCS).</p> <ol style="list-style-type: none">1. A nurse or pharmacist will review the patient's chart to determine if criteria are met. If criteria are met, an approval is rendered.2. If criteria are not met, a note will be sent to the prescriber, and he or she is given the opportunity to update to a preferred alternative. If within the timeline either additional justification satisfying criteria or a preferred alternative is not ordered, determination of denial is rendered by the UM team (QRM or PCS pharmacist)3. Member is notified of approval or denial in writing within regulatory guidelines and will issue a formal denial letter if medication is approved or denied.4. When all criteria are met, the drug will be covered at the member's pharmacy co-pay or coinsurance (after the deductible is met, if applicable). When criteria are not met, the drug will not be covered by the member's pharmacy benefit.5. UM (QRM or PCS) will generate a denial letter with appropriate appeal information.6. At any time, a member may choose to purchase a prescribed drug that has been deemed not medically necessary by paying full price for the drug.7. The member may also appeal the denial of the drug. <p>The Kaiser Permanente Georgia Pharmacy and Therapeutics Committee (PTC) has developed prescribing criteria to apply to selected medical and psychiatric medications. The Committee members include:</p>

Medical/Surgical

- B. Two actively practicing physicians representing Adult Primary Care (Internal Medicine/Family Medicine), two actively practicing physicians representing Pediatrics, at least one actively practicing physician representing Obstetrics and Gynecology, Behavioral Health, Hospitalists, Hematology/Oncology, and Infectious Disease. Members from other disciplines may be added as determined appropriate by the Chairperson
- C. At least one actively practicing dispensing and clinical pharmacist selected by the Committee Chairperson and Executive Director of Pharmacy
- D. One pharmacist member and one physician member are expert in care of the elderly and disabled.
- E. The Executive Director of Pharmacy shall serve as secretary or shall appoint a suitable designee and serve unlimited terms as deemed appropriate by the Medical Director and President
- F. The Sr. Manager of Clinical Pharmacy Operations shall serve unlimited terms as deemed appropriate by the Medical Director and President
- G. A representative from the Department of Nursing, nominated by Nursing, the Chairperson, and the Executive Director of Pharmacy
- H. Ex-officio Members: Ex-officio members include: The Physician Lead, Pharmacy Initiatives; Manager, Clinical Pharmacy; and Manager, Drug Utilization.

Qualifications/Training:

Licensed pharmacists and physicians oversee delegated outpatient prescription coverage utilization management decisions pertaining to behavioral medications and non-behavioral medication to ensure consistent medical necessity decision-making and to provide high-level involvement in complex cases. Staff members responsible for processing fail-first medication requests are trained on the workflow and utilize their clinical education to complete a clinical case review and issuing denials using their clinical knowledge, UM workflow and standardized criteria due the review process. The UM team of physicians, licensed staff and unlicensed staff are trained and qualified to assess clinical information used to make UM decisions. Appropriately licensed health professionals supervise all review decisions. Only UM physician (MD or DO) or pharmacist (Pharm D) will make a decision to deny a prescription based on medical necessity.

The prior authorization process is the same regardless of the medication's treatment indication for both behavioral health and medical surgical benefit areas.

PPO Pharmacy:

The MedImpact PA guideline development process follows the following steps:

Mental Health/Substance Use Disorder

- A. The Physician Program Director of Pharmacy and Therapeutics/Medication Safety serves as Chairperson and serves unlimited terms as deemed appropriate by the Medical Director and President,
- B. Two actively practicing physicians representing Adult Primary Care (Internal Medicine/Family Medicine), two actively practicing physicians representing Pediatrics, at least one actively practicing physician representing Obstetrics and Gynecology, Behavioral Health, Hospitalists, Hematology/Oncology, and Infectious Disease. Members from other disciplines may be added as determined appropriate by the Chairperson
- C. At least one actively practicing dispensing and clinical pharmacist selected by the Committee Chairperson and Executive Director of Pharmacy
- D. One pharmacist member and one physician member are expert in care of the elderly and disabled.
- E. The Executive Director of Pharmacy shall serve as secretary or shall appoint a suitable designee and serve unlimited terms as deemed appropriate by the Medical Director and President
- F. The Sr. Manager of Clinical Pharmacy Operations shall serve unlimited terms as deemed appropriate by the Medical Director and President
- G. A representative from the Department of Nursing, nominated by Nursing, the Chairperson, and the Executive Director of Pharmacy
- H. Ex-officio Members: Ex-officio members include: The Physician Lead, Pharmacy Initiatives; Manager, Clinical Pharmacy; and Manager, Drug Utilization.

Qualifications/Training:

Licensed pharmacists and physicians oversee delegated outpatient prescription coverage utilization management decisions pertaining to behavioral medications and non-behavioral medication to ensure consistent medical necessity decision-making and to provide high-level involvement in complex cases. Staff members responsible for processing fail-first medication requests are trained on the workflow and utilize their clinical education to complete a clinical case review and issuing denials using their clinical knowledge, UM workflow and standardized criteria due the review process. The UM team of physicians, licensed staff and unlicensed staff are trained and qualified to assess clinical information used to make UM decisions. Appropriately licensed health professionals supervise all review decisions. Only UM physician (MD or DO) or pharmacist (Pharm D) will make a decision to deny a prescription based on medical necessity.

PPO Pharmacy:

Medical/Surgical

- (1) A PA guideline is developed whenever it is determined that a new drug or drug class is appropriate to subject to PA. The need for a proposed PA guideline is agreed upon by the Medical Director, the Director of Drug Information, and the Director of Formulary Administration and Strategy and is reflective of a comprehensive review of drug safety, cost, and disease management strategy.
- (2) Clinical criteria recommendations are developed by a designated Drug Information Pharmacist using an evidence-based process taking into consideration published peer reviewed medical literature and national treatment guidelines whenever available.
- (3) If a guideline appears to be controversial or is deemed to need specialized input, independent expert medical specialty reviewer input is routinely requested.
- (4) After internal and independent external (if necessary) review is complete, the guideline is presented to the MedImpact P&T Committee in conjunction with the presentation of the medication or medication class monograph for final approval.
- (5) PA Guidelines are developed by a designated Clinical PA Pharmacist according to clinical criteria approved at the quarterly P&T Committee meeting.
 - (a) An interim PA per label (e.g., FDA approved indication, dosing limits, etc.) may be applied and developed at drug launch prior to the P&T Committee meeting upon approval by the P&T chairman and co-chairperson or their designee.

The MedImpact P&T Committee is chaired by the VP/ Medical Director of MedImpact or, in cases of unavailability, a qualified physician committee member as his/her designee. The Director of Drug Information serves as Co-Chairperson of the Committee.

The duties of Co-Chair may be delegated to the Manager of Drug Information. The P&T Committee is comprised of at least ten, but not more than fifteen voting members, all of whom are healthcare professionals with unrestricted licenses to practice in their professions in a state or territory of the United States, and whose training and expertise materially contributes to the goals of the P&T Committee; all of whom are physicians or pharmacists, and a majority of whom are actively practicing in their professions. A maximum of two MedImpact employees may be voting members. The P&T Committee includes at least one actively practicing physician and at least one actively practicing pharmacist who are experts, defined as a person who has training and/or ongoing clinical practice experience, in the care of the elderly or disabled persons and who are not employees of MedImpact. The P&T Committee includes at least one: (a) licensed psychiatrist, or (b) licensed physician who is an expert, defined as a person who has training and/or ongoing clinical practice experience, in the treatment of substance abuse disorders.

Mental Health/Substance Use Disorder

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

The MedImpact PA guideline development process follows the following steps:

- (1) A PA guideline is developed whenever it is determined that a new drug or drug class is appropriate to subject to PA. The need for a proposed PA guideline is agreed upon by the Medical Director, the Director of Drug Information, and the Director of Formulary Administration and Strategy and is reflective of a comprehensive review of drug safety, cost, and disease management strategy.
- (2) Clinical criteria recommendations are developed by a designated Drug Information Pharmacist using an evidence-based process taking into consideration published peer reviewed medical literature and national treatment guidelines whenever available.
- (3) If a guideline appears to be controversial or is deemed to need specialized input, independent expert medical specialty reviewer input is routinely requested.
- (4) After internal and independent external (if necessary) review is complete, the guideline is presented to the MedImpact P&T Committee in conjunction with the presentation of the medication or medication class monograph for final approval.
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The duties of Co-Chair may be delegated to the Manager of Drug Information. The P&T Committee is comprised of at least ten, but not more than fifteen voting members, all of whom are healthcare professionals with unrestricted licenses to practice in their professions in a state or territory of the United States, and whose training and expertise materially contributes to the goals of the P&T Committee; all of whom are physicians or pharmacists, and a majority of whom are actively practicing in their professions. A maximum of two MedImpact employees may be voting members. The P&T Committee includes at least one actively practicing physician and at least one actively practicing pharmacist who are experts, defined as a person who has training and/or ongoing clinical practice experience, in the care of the elderly or disabled persons and who are not

Medical/Surgical

Mental Health/Substance Use Disorder

employees of MedImpact. The P&T Committee includes at least one: (a) licensed psychiatrist, or (b) licensed physician who is an expert, defined as a person who has training and/or ongoing clinical practice experience, in the treatment of substance abuse disorders.

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical

Mental Health/Substance Use Disorder

POS Pharmacy:

The prior authorization process for both medical/surgical and mental health/SUD medication follow the same regional treatment guidelines that are informed by published clinical evidence. To ensure criteria are used correctly and consistently prior authorization medication(s) are reviewed, as apart of UM Inter-Rater Reliability (IRR) annual process.

Reviews for medical necessity were conducted by applying established criteria to requests for services/items that require health plan prior authorization. Hypothetical cases specific to the clinical area being studied were developed and sent to the individual reviewers and maintained by QRM to confirm interrater reviewer reliability.

PPO Pharmacy:

The comparative analysis conducted included review of the prior authorization review process for medications included within the GA Dual Choice PPO formulary that contain a prior authorization parameter. MedImpact utilizes the same processes for application of PA criteria and other forms of Utilization Management (UM) for both MH/SUD and M/S prescription drug benefits. All processes rely on evidence-based clinical guidelines to determine whether the requested medication is medically necessary.

The same methodology is utilized to develop prior authorization criteria and utilization management parameters. Thus, the NQTLs that are in place with respect to prior authorization criteria for MH/SUD benefits are the same and applied no more stringently than those applied to M/S benefits.

POS Pharmacy:

The prior authorization process for both medical/surgical and mental health/SUD medication follow the same regional treatment guidelines that are informed by published clinical evidence. To ensure criteria are used correctly and consistently prior authorization medication(s) are reviewed, as apart of UM Inter-Rater Reliability (IRR) annual process.

Reviews for medical necessity were conducted by applying established criteria to requests for services/items that require health plan prior authorization. Hypothetical cases specific to the clinical area being studied were developed and sent to the individual reviewers and maintained by QRM to confirm interrater reviewer reliability.

PPO Pharmacy:

The comparative analysis conducted included review of the prior authorization review process for medications included within the GA Dual Choice PPO formulary that contain a prior authorization parameter. MedImpact utilizes the same processes for application of PA criteria and other forms of Utilization Management (UM) for both MH/SUD and M/S prescription drug benefits. All processes rely on evidence-based clinical guidelines to determine whether the requested medication is medically necessary.

The same methodology is utilized to develop prior authorization criteria and utilization management parameters. Thus, the NQTLs that are in place with respect to prior authorization criteria for MH/SUD benefits are the same and applied no more stringently than those applied to M/S benefits.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

POS Pharmacy:

The medical/surgical and mental health/substance use disorder outpatient drug benefits for the plan selected follow the same processes, from criteria development to the procedural application of the prior authorization process. The Pharmacy and Therapeutics Committee uses both internal and external resources when developing medication criteria for both medical and behavioral health drugs, including Specialty Department physician chief input, Food and Drug Administration recommendations, and clinical trials published in the medical literature to guide them in the creation of prescribing criteria. The application of these guidelines/criteria are audited regularly and accordance with our NCQA Accreditation for both benefits areas. Our NCQA Accreditation has provided a very clear and regimented process when designing/reviewing the plans use of prior authorization. The application of the prior authorization process is carried out in the same manner; from receipt of the request, application of the criteria, to rendering coverage decision. The two benefit areas; medical/surgical and mental health/substance uses disorder equally apply the prior authorization process, allowing for parity across both areas.

PPO Pharmacy:

- MedImpact utilizes the same processes, strategies, evidentiary standards, and other factors to apply PA to both MH/SUD and M/S drugs.
- The same process and staff are used to perform authorizations regardless of whether the requested drug is prescribed to treat a M/S or MH/SUD condition. The PA reviewers do not differentiate or apply any review factors differently based on the drug's primary indication or utilization. All drugs are reviewed and follow the same processes without regard to their primary indication.

Thus, MedImpact concludes that the processes, strategies, evidentiary standards, and other factors used to apply PA to MH/SUD drugs are comparable to and no more stringent than the processes, strategies, evidentiary standards, and other factors used to apply PA to M/S drugs, as written and in operation.

Kaiser Permanente Insurance Company

Non-Quantitative Treatment Limits (NQTL)



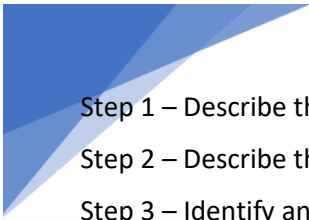
NQTL: GA Provider Credentialing

Last Reviewed: 12/14/23



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Benefits		Classifications					
Is NQTL applied to Medical/Surgical benefits?	Is NQTL applied to Mental Health/Substance Use Disorder benefits?	Is NQTL applied to In Network Inpatient classification?	Is NQTL applied to Out of Network Inpatient classification?	Is NQTL applied to In Network Outpatient classification?	Is NQTL applied to Out of Network Outpatient classification?	Is NQTL applied to Emergency classification?	Is NQTL applied to Prescription classification?
Yes	Yes	Yes	No	Yes	No	n/a	n/a

Benefit Classification 1: Inpatient – In Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. Do not state “Refer to Classification of Benefits”. Please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
Hospital (includes Facility and Professional Charges) Maternity Services (includes Facility and Professional Charges) Multi-disciplinary Rehabilitation in a Comprehensive Rehabilitation Facility Skilled Nursing Facility	Hospital (includes Facility and Professional Charges)

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
Kaiser Permanente Insurance Company’s (KPIC) Participating Provider network is an open network and consists of network providers contracted with MultiPlan, Inc. Network providers are health care providers contracted with MultiPlan for participation in MultiPlan networks which include, but are not limited to, the PHCS Network, and the MultiPlan Network. MultiPlan, Inc., develops and manages a primary network of health care providers and hospitals that includes access to both MH/SUD and Medical/Surgical providers. MultiPlan credentials providers applying to the MultiPlan Networks, and recredentials the same providers every thirty-six (36) months, unless otherwise required by law. MultiPlan has implemented a standard set of credentialing criteria for all	Kaiser Permanente Insurance Company’s (KPIC) Participating Provider network is an open network and consists of network providers contracted with MultiPlan, Inc. Network providers are health care providers contracted with MultiPlan for participation in MultiPlan networks which include, but are not limited to, the PHCS Network, and the MultiPlan Network. MultiPlan, Inc., develops and manages a primary network of health care providers and hospitals that includes access to both MH/SUD and Medical/Surgical providers. MultiPlan credentials providers applying to the MultiPlan Networks, and recredentials the same providers every thirty-six (36) months, unless otherwise required by law. MultiPlan has implemented a standard set of credentialing criteria for all

Medical/Surgical

MultiPlan Networks and does not differentiate in the application of that criteria based on whether the provider is a MH/SUD facility or a Medical/Surgical facility.

MultiPlan credentials and recredentials Network facilities, including at a minimum, acute care hospitals, home health agencies, skilled nursing facilities, free-standing ambulatory surgical centers, inpatient/acute physical rehabilitation facilities, inpatient MH/SUD facilities, residential MH/SUD facilities, and ambulatory MH/SUD facilities, and verifies the following every thirty-six (36) months:

1. Submission of complete Request For Information ("RFI") or application
2. Verification of licensure
3. Verification of Accreditation/CMS Certification⁶
4. Acceptable EPLS/SAM and OIG query with no exclusions
5. Acceptable liability insurance limits

MultiPlan does not establish NQTLs on, or implied through, relationships with providers that are applied more stringently to MH/SUD services than those applicable to Medical/Surgical services, whether in writing or in operation. MultiPlan's policies, processes, and operational implementation of such processes are not designed to restrict access to, or discriminate against, specific provider types or services, including but not limited to, MH/SUD providers. All policies and processes are implemented to apply equally regardless of provider type.

PROVIDER TYPES ANALYZED FOR PURPOSES OF THE CREDENTIALING/RECORDING NQTL

Provider Type	Description	Med/Surg
Hospital-Based Practitioners	Hospital-based practitioners solely practicing in a Network facility location are not subject to the credentialing/recording process	✓

Mental Health/Substance Use Disorder

MultiPlan Networks and does not differentiate in the application of that criteria based on whether the provider is a MH/SUD facility or a Medical/Surgical facility.

MultiPlan credentials and recredentials Network facilities, including at a minimum, acute care hospitals, home health agencies, skilled nursing facilities, free-standing ambulatory surgical centers, inpatient/acute physical rehabilitation facilities, inpatient MH/SUD facilities, residential MH/SUD facilities, and ambulatory MH/SUD facilities, and verifies the following every thirty-six (36) months:

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PROVIDER TYPES ANALYZED FOR PURPOSES OF THE CREDENTIALING/RECORDING NQTL

Provider Type	Description	MH/SUD
Hospital-Based Practitioners	Hospital-based practitioners solely practicing in a Network facility location are not subject to the credentialing/recording process	✓

Medical/Surgical			Mental Health/Substance Use Disorder		
Facilities	MultiPlan requires all acute care hospitals, home health agencies, skilled nursing facilities, free-standing ambulatory surgical centers, inpatient/acute physical rehabilitation facilities, inpatient behavioral health/mental health/substance use disorder facilities, residential behavioral health/mental health/substance use disorder facilities, and ambulatory behavioral health/mental	✓	Facilities	MultiPlan requires all acute care hospitals, home health agencies, skilled nursing facilities, free-standing ambulatory surgical centers, inpatient/acute physical rehabilitation facilities, inpatient behavioral health/mental health/substance use disorder facilities, residential behavioral health/mental health/substance use disorder facilities, and ambulatory behavioral health/mental	✓

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
<p>The Credentialing Factors identified in this section have been established by MultiPlan to ensure that members accessing MultiPlan Network Services have access to high quality Network Providers that meet minimum professional competency requirements, including but not limited to, hospitals, physicians, MH/SUD providers, and other providers. In addition, the Credentialing Factors enable MultiPlan to maintain NCQA Network Accreditation in Credentialing for MultiPlan's PHCS Network and comply with applicable federal and/or state laws.'</p> <p>The grid below shows the rationale for applying the credentialing/recredentialing NQTL that was used in developing the Credentialing Factors, as it relates to both Medical/Surgical services and MH/SUD services.</p>	<p>The Credentialing Factors identified in this section have been established by MultiPlan to ensure that members accessing MultiPlan Network Services have access to high quality Network Providers that meet minimum professional competency requirements, including but not limited to, hospitals, physicians, MH/SUD providers, and other providers. In addition, the Credentialing Factors enable MultiPlan to maintain NCQA Network Accreditation in Credentialing for MultiPlan's PHCS Network and comply with applicable federal and/or state laws.'</p> <p>The grid below shows the rationale for applying the credentialing/recredentialing NQTL that was used in developing the Credentialing Factors, as it relates to both Medical/Surgical services and MH/SUD services.</p>

Medical/Surgical

Mental Health/Substance Use Disorder

Rationale for Applying NQTL Factors	Med/Surg Providers
MultiPlan applies Credentialing Factors to ensure Network Providers meet minimum participation criteria including professional competency.	✓
MultiPlan applies Credentialing Factors to ensure members have access to high quality care and Network Providers that meet minimum professional competency requirements.	✓
MultiPlan applies Credentialing Factors to meet NCQA accreditation requirements.	✓
MultiPlan applies Credentialing Factors to meet state and/or federal requirements.	✓

“CREDENTIALING FACTORS” CONSIDERED WHEN ESTABLISHING SPECIFIC MED/Surg FACILITY CREDENTIALING CRITERIA

The grid below identifies the Credentialing Factors used in developing credentialing/ re-credentialing processes for all providers applying to or participating in the MultiPlan Network(s).

Factor	Description	MED/ SURG
Credentialing Application	Credentialing applications are required by the accreditation standards to collect information on a practitioner or facility to determine eligibility for participation in the Network and provide authorization for verification of application contents. All practitioners and specified facilities are required to complete a comprehensive application to verify the applicant is in full compliance with MultiPlan’s Network participation criteria.	✓

Rationale for Applying NQTL Factors	MH/SUD Providers
MultiPlan applies Credentialing Factors to ensure Network Providers meet minimum participation criteria including professional competency.	✓
MultiPlan applies Credentialing Factors to ensure members have access to high quality care and Network Providers that meet minimum professional competency requirements.	✓
MultiPlan applies Credentialing Factors to meet NCQA accreditation requirements.	✓
MultiPlan applies Credentialing Factors to meet state and/or federal requirements.	✓

“CREDENTIALING FACTORS” CONSIDERED WHEN ESTABLISHING SPECIFIC MH/ SUD FACILITY CREDENTIALING CRITERIA

The grid below identifies the Credentialing Factors used in developing credentialing/ re-credentialing processes for all providers applying to or participating in the MultiPlan Network(s).

Factor	Description	MH/ SUD
Credentialing Application	Credentialing applications are required by the accreditation standards to collect information on a practitioner or facility to determine eligibility for participation in the Network and provide authorization for verification of application contents. All practitioners and specified facilities are required to complete a comprehensive application to verify the applicant is in full compliance with MultiPlan’s Network participation criteria.	✓

Medical/Surgical

Credentials Verification	To ensure practitioners and facilities are qualified to provide services and quality care, verification of the application contents is required. Verification of the contents of the provider application is done directly through primary sources or secondary sources, as permitted by the National Accreditation Standards and state laws. Verifications are completed every 36 months or earlier as defined by state laws. Credentials Verifications include the MultiPlan Practitioner Credentialing Criteria and MultiPlan Facility Credentialing Criteria, as defined above in Section 1.	✓
Facility Type Assignment	Facility Type is verified to ensure Facilities meet Network participation criteria and are appropriately listed in provider directories. Facility Type is consistent with state licensing and/or accreditation/certification requirements.	✓
Credentialing Decisions	The Credentials Committee makes all credentialing determinations. It is a multidisciplinary committee with representation from different types of practitioners that participate in the Networks and is composed of the Medical Director and four Network Providers. All clinical aspects of the MultiPlan Credentialing Plan are the responsibility of the Medical Director as dictated by National Accreditation Standards.	✓
Credentialing Timeframes	Timely credentialing is required to ensure prompt Network participation and access to services in the Network. Credentialing Decisions are made within the timeframes specified by the National Accreditation Standards or as required by law.	✓
Monitoring Activities	Performance of monitoring activities is required to ensure that Network Providers continue to meet MultiPlan Practitioner Credentialing Criteria and MultiPlan Facility Credentialing Criteria and have not been the subject of licensing or board actions, as required by the National Accreditation Standards.	✓
Credentialing Oversight	Credentialing oversight is required to ensure that processes are consistent with National Accreditation Standards and Network Providers meet, and continue to meet, high quality standards to treat members.	✓

Mental Health/Substance Use Disorder

Credentials Verification	To ensure practitioners and facilities are qualified to provide services and quality care, verification of the application contents is required. Verification of the contents of the provider application is done directly through primary sources or secondary sources, as permitted by the National Accreditation Standards and state laws. Verifications are completed every 36 months or earlier as defined by state laws. Credentials Verifications include the MultiPlan Practitioner Credentialing Criteria and MultiPlan Facility Credentialing Criteria, as defined above in Section 1.	✓
Facility Type Assignment	Facility Type is verified to ensure Facilities meet Network participation criteria and are appropriately listed in provider directories. Facility Type is consistent with state licensing and/or accreditation/certification requirements.	✓
Credentialing Decisions	The Credentials Committee makes all credentialing determinations. It is a multidisciplinary committee with representation from different types of practitioners that participate in the Networks and is composed of the Medical Director and four Network Providers. All clinical aspects of the MultiPlan Credentialing Plan are the responsibility of the Medical Director as dictated by National Accreditation Standards.	✓
Credentialing Timeframes	Timely credentialing is required to ensure prompt Network participation and access to services in the Network. Credentialing Decisions are made within the timeframes specified by the National Accreditation Standards or as required by law.	✓
Monitoring Activities	Performance of monitoring activities is required to ensure that Network Providers continue to meet MultiPlan Practitioner Credentialing Criteria and MultiPlan Facility Credentialing Criteria and have not been the subject of licensing or board actions, as required by the National Accreditation Standards.	✓
Credentialing Oversight	Credentialing oversight is required to ensure that processes are consistent with National Accreditation Standards and Network Providers meet, and continue to meet, high quality standards to treat members.	✓

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical			Mental Health/Substance Use Disorder		
<p>MultiPlan Practitioner Credentialing Criteria, MultiPlan Facility Credentialing Criteria, National Accreditation Standards, and federal/state laws are used by MultiPlan to define the criteria that establish the Credentialing Factors. These evidentiary standards support MultiPlan’s determinations on what constitutes an effective credentialing program.</p> <p><i>EVIDENTIARY STANDARDS FOR EACH FACTOR CONSIDERED WHEN ESTABLISHING SPECIFIC PRACTITIONER AND FACILITY CREDENTIALING CRITERIA</i></p> <p>The grid below identifies the various evidentiary standards for the factors used in developing credentialing/recredentialing processes for all providers applying to, or participating in, the MultiPlan Network(s) as applied to Medical/Surgical providers or to MH/SUD providers.</p>			<p>MultiPlan Practitioner Credentialing Criteria, MultiPlan Facility Credentialing Criteria, National Accreditation Standards, and federal/state laws are used by MultiPlan to define the criteria that establish the Credentialing Factors. These evidentiary standards support MultiPlan’s determinations on what constitutes an effective credentialing program.</p> <p><i>EVIDENTIARY STANDARDS FOR EACH FACTOR CONSIDERED WHEN ESTABLISHING SPECIFIC PRACTITIONER AND FACILITY CREDENTIALING CRITERIA</i></p> <p>The grid below identifies the various evidentiary standards for the factors used in developing credentialing/recredentialing processes for all providers applying to, or participating in, the MultiPlan Network(s) as applied to Medical/Surgical providers or to MH/SUD providers.</p>		
Factor	Documentation	MED/ SURG Providers	Factor	Documentation	MH/SUD Providers
Credentialing Application	1. National Accreditation Standards 2. State Mandated Applications	✓	Credentialing Application	1. National Accreditation Standards 2. State Mandated Applications	✓

Medical/Surgical

Mental Health/Substance Use Disorder

Credentials Verification	<ol style="list-style-type: none"> 1. National Accreditation Standards 2. Medicare Managed Care Manual for Government Programs 3. State laws 4. Facility Accreditation/Certification Bodies 	✓	Credentials Verification	<ol style="list-style-type: none"> 1. National Accreditation Standards 2. Medicare Managed Care Manual for Government Programs 3. State laws 4. Facility Accreditation/Certification Bodies 	✓
Facility Type Assignment	<ol style="list-style-type: none"> 1. National Accreditation Standards 2. State Licensing Requirements 	✓	Facility Type Assignment	<ol style="list-style-type: none"> 1. National Accreditation Standards 2. State Licensing Requirements 	✓
Credentialing Decisions	<ol style="list-style-type: none"> 1. National Accreditation Standards 	✓	Credentialing Decisions	<ol style="list-style-type: none"> 1. National Accreditation Standards 	✓
Credentialing Timeframes	<ol style="list-style-type: none"> 1. National Accreditation Standards 2. State Laws 	✓	Credentialing Timeframes	<ol style="list-style-type: none"> 1. National Accreditation Standards 2. State Laws 	✓
Monitoring Activities	<ol style="list-style-type: none"> 1. National Accreditation Standards 	✓	Monitoring Activities	<ol style="list-style-type: none"> 1. National Accreditation Standards 	✓
Credentialing Oversight	<ol style="list-style-type: none"> 1. National Accreditation Standards 	✓	Credentialing Oversight	<ol style="list-style-type: none"> 1. National Accreditation Standards 	✓
Hospital-Based Providers	<ol style="list-style-type: none"> 1. National Accreditation Standards 	✓	Hospital-Based Providers	<ol style="list-style-type: none"> 1. National Accreditation Standards 	✓

Facility Credentialing Data					
State	Facility Type	Credentialed/ Processed	Accepted	Rejected	Percent Rejected
GA	Total Medical/Surgical	98	98	0	0.00%
	Total MH/SUD Providers	1	1	0	0.00%
	<i>Mental Health Only</i>	0	0	0	N/A
	<i>Substance Use Disorder Only</i>	1	1	0	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	0	0	0	N/A
	State Total	99	99	0	0.00%

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
<p>The Medical Director oversees and has overall responsibility for the clinical aspects of credentialing network providers and monitors the achievement of quality and outcome measures. The executive committee has delegated the operational responsibility for the credentialing program to the Credentials Committee (the “Committee”), a multidisciplinary committee with representation from different types of practitioners that participate in the networks. The Committee is composed of the Medical Director (non-voting), five network providers (voting), and at least one Credentialing Specialist (nonvoting operational staff member that supports the Committee for the credentialing and recredentialing programs). The Medical Director has the requisite training and qualifications for internal medicine. The five network providers have the requisite training for internal medicine, general surgery, hematology/oncology, psychiatry, and emergency medicine. In instances where matters arise that require subject matter expertise beyond those available from the members of the Committee, the Medical Director seeks consultation from participating network specialists in the same or similar specialty as the practitioner being discussed. The Committee makes decisions based on provider applicants meeting MultiPlan credentialing guidelines. MultiPlan’s credentialing guidelines are comprised of NCQA credentialing criteria and state/federal regulatory obligations. The Committee provides guidance on the overall direction of the credentialing program by overseeing all credentialing policies and procedures. A separate network provider that is, not on the Committee audits decisions quarterly to ensure credentialing decisions are not made in a discriminatory manner. The Committee applies the same criteria in</p>	<p>The Medical Director oversees and has overall responsibility for the clinical aspects of credentialing network providers, and monitors the achievement of quality and outcome measures. The executive committee has delegated the operational responsibility for the credentialing program to the Credentials Committee (the “Committee”), a multidisciplinary committee with representation from different types of practitioners that participate in the networks. The Committee is composed of the Medical Director (non-voting), five network providers (voting), and at least one Credentialing Specialist (nonvoting operational staff member that supports the Committee for the credentialing and recredentialing programs). The Medical Director has the requisite training and qualifications for internal medicine. The five network providers have the requisite training for internal medicine, general surgery, hematology/oncology, psychiatry and emergency medicine. In instances where matters arise that require subject matter expertise beyond those available from the members of the Committee, the Medical Director seeks consultation from participating network specialists in the same or similar specialty as the practitioner being discussed, including but not limited to MH/SUD practitioners. The Committee makes decisions based on provider applicants meeting MultiPlan credentialing guidelines. MultiPlan’s credentialing guidelines are comprised of NCQA credentialing criteria and state/federal regulatory obligations. The Committee provides guidance on the overall direction of the</p>

Medical/Surgical

its decision-making for MH/SUD practitioners as it does for medical/surgical practitioners.

All applications are reviewed for completeness in accordance with MultiPlan's Complete Applications policy. Practitioners are notified when relevant information is missing and/or if additional information is required to complete the credentialing process. In accordance with National Accreditation Standards and applicable state laws, portions of the application are verified with appropriate sources as specified in MultiPlan policies and procedures. All clean and complete applications that meet MultiPlan Practitioner Credentialing Criteria and/or MultiPlan Facility Credentialing Criteria are reviewed and approved by the Medical Director. All completed applications, including required attachments that do not meet MultiPlan Practitioner Credentialing Criteria and/or MultiPlan Facility Credentialing Criteria are presented to the Credentials Committee. Credentialing decisions are made within one hundred eighty ("180") days of the attestation date on the application. MultiPlan's turn-around times for processing credentialing applications are typically ninety ("90") to one hundred twenty ("120") days from receipt of a complete application. The Credentials Committee consists of MultiPlan clinical and administrative staff, and Network Providers in accordance with MultiPlan's Credentials Committee policy. The Credentials Committee makes Credentialing Decisions related to the acceptance, rejection, continued participation, and termination of practitioners (including Medical/Surgical practitioner specialties), acute care hospitals, home health agencies, skilled nursing facilities, free standing ambulatory surgical centers, inpatient acute physical rehabilitation facilities and behavioral health facilities (all MH/SUD facility types).

The Credentials Committee meets in person and/or telephonically on a weekly basis. It is a multidisciplinary committee with representation from different types of practitioners that participate in the MultiPlan Network(s). Specifically, the Credentials Committee is composed of the Medical Director and three Network practitioners. The Credentials Committee reviews and has final authority regarding Network participation for all Network practitioners and facilities. All applicants or Network practitioners under recredentialing review are presented to the committee for consideration and approval.

Providers that do not meet MultiPlan Practitioner Credentialing Criteria or MultiPlan Facility Credentialing Criteria for their discipline are discussed by the Credentials Committee to determine whether they are meeting reasonable standards of care. After review, the committee votes on all applicants and determines whether to accept or reject the applicants. Cases are presented by the Medical Director or Credentialing Specialist to the Credentials Committee. In instances where matters arise that require subject matter expertise beyond that available from the members of the committee, the Medical Director seeks consultation from participating MultiPlan Network(s) provider specialists in the same or similar specialty as the practitioner being discussed (including MH/SUD providers as needed). This information is made available to the other members of the committee prior to a deciding vote being taken.

Mental Health/Substance Use Disorder

credentialing program by overseeing all credentialing policies and procedures. A separate network provider that is, not on the Committee audits decisions quarterly to ensure credentialing decisions are not made in a discriminatory manner. The Committee applies the same criteria in its decision-making for MH/SUD practitioners as it does for medical/surgical practitioners.

All applications are reviewed for completeness in accordance with MultiPlan's Complete Applications policy. Practitioners are notified when relevant information is missing and/or if additional information is required to complete the credentialing process. In accordance with National Accreditation Standards and applicable state laws, portions of the application are verified with appropriate sources as specified in MultiPlan policies and procedures. All clean and complete applications that meet MultiPlan Practitioner Credentialing Criteria and/or MultiPlan Facility Credentialing Criteria are reviewed and approved by the Medical Director. All completed applications, including required attachments that do not meet MultiPlan Practitioner Credentialing Criteria and/or MultiPlan Facility Credentialing Criteria are presented to the Credentials Committee. Credentialing decisions are made within one hundred eighty ("180") days of the attestation date on the application. MultiPlan's turn-around times for processing credentialing applications are typically ninety ("90") to one hundred twenty ("120") days from receipt of a complete application. The Credentials Committee consists of MultiPlan clinical and administrative staff, and Network Providers in accordance with MultiPlan's Credentials Committee policy. The Credentials Committee makes Credentialing Decisions related to the acceptance, rejection, continued participation, and termination of practitioners (including MH/SUD practitioner specialties), acute care hospitals, home health agencies, skilled nursing facilities, free standing ambulatory surgical centers, inpatient acute physical rehabilitation facilities and behavioral health facilities (all MH/SUD facility types).

The Credentials Committee meets in person and/or telephonically on a weekly basis. It is a multidisciplinary committee with representation from different types of practitioners that participate in the MultiPlan Network(s). Specifically, the Credentials Committee is composed of the Medical Director and three Network practitioners. The Credentials Committee may invite an MH/SUD practitioner to participate on the committee, as needed, for review of MH/SUD provider applicants. The Credentials Committee reviews and has final authority regarding Network participation for all Network practitioners and facilities. All applicants or Network practitioners under recredentialing review are presented to the committee for consideration and approval.

Providers that do not meet MultiPlan Practitioner Credentialing Criteria or MultiPlan Facility Credentialing Criteria for their discipline are discussed by the Credentials Committee to determine whether they are meeting reasonable standards of care. After review, the committee votes on all applicants and determines whether to accept or reject the

Medical/Surgical

All Credentials Committee actions are documented. The committee maintains meeting minutes for each meeting. The Quality Management Committee receives a quarterly report of credentialing metrics, including but not limited to, the number of credentialed/recredentialed practitioners, delegation oversight results, and sanctions monitoring results. Information presented by the Manager of Credentialing Operations/PNQ in these quarterly reports is used to measure the overall effectiveness of the credentialing program.

All rejected and terminated practitioners (inclusive of MH/SUD providers) are informed of their right to a two level appeal process. This process is detailed within MultiPlan's Network Provider Appeal policy, and conforms to National Accreditation Standards, and applicable state and federal laws.

Formal recredentialing occurs on a thirty-six (36) month cycle and is conducted in accordance with MultiPlan's Credentialing policies. All policies are structured to be in full compliance with National Accreditation Standards and state and federal laws. In addition, MultiPlan will initiate off-cycle recredentialing of practitioners as a result of complaints and grievances received through Corporate Quality Management or as a result of information obtained from our ongoing monitoring process.

Mental Health/Substance Use Disorder

applicants. Cases are presented by the Medical Director or Credentialing Specialist to the Credentials Committee. In instances where matters arise that require subject matter expertise beyond that available from the members of the committee, the Medical Director seeks consultation from participating MultiPlan Network(s) provider specialists in the same or similar specialty as the practitioner being discussed (including MH/SUD providers as needed). This information is made available to the other members of the committee prior to a deciding vote being taken.

All Credentials Committee actions are documented. The committee maintains meeting minutes for each meeting. The Quality Management Committee receives a quarterly report of credentialing metrics, including but not limited to, the number of credentialed/recredentialed practitioners, delegation oversight results, and sanctions monitoring results. Information presented by the Manager of Credentialing Operations/PNQ in these quarterly reports is used to measure the overall effectiveness of the credentialing program.

All rejected and terminated practitioners (inclusive of MH/SUD providers) are informed of their right to a two level appeal process. This process is detailed within MultiPlan's Network Provider Appeal policy, and conforms to National Accreditation Standards, and applicable state and federal laws.

Formal recredentialing occurs on a thirty-six (36) month cycle and is conducted in accordance with MultiPlan's Credentialing policies. All policies are structured to be in full compliance with National Accreditation Standards and state and federal laws. In addition, MultiPlan will initiate off-cycle recredentialing of practitioners as a result of complaints and grievances received through Corporate Quality Management or as a result of information obtained from our ongoing monitoring process.

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical

MultiPlan's credentialing guidelines are comprised of NCQA credentialing criteria and state/federal regulatory obligations. The Committee provides guidance on the overall direction of the

Mental Health/Substance Use Disorder

MultiPlan's credentialing guidelines are comprised of NCQA credentialing criteria and state/federal regulatory obligations. The Committee provides guidance on the overall direction of the

Medical/Surgical

credentialing program by overseeing all credentialing policies and procedures. A separate network provider that is, not on the Committee audits decisions quarterly to ensure credentialing decisions are not made in a discriminatory manner. The Committee applies the same criteria in its decision-making for MH/SUD practitioners as it does for medical/surgical practitioners. MultiPlan's Credentialing Comparative Analysis shows how review of provider credentials for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing NQTL for medical surgical benefits. The rejection percentage is 0.19% for medical/surgical providers. Upon quarterly non-discrimination audits, zero instances of discrimination were found. Credentialing decisions for medical/surgical providers are made within an average of 18.04 business days.

Mental Health/Substance Use Disorder

credentialing program by overseeing all credentialing policies and procedures. A separate network provider that is, not on the Committee audits decisions quarterly to ensure credentialing decisions are not made in a discriminatory manner. The Committee applies the same criteria in its decision-making for MH/SUD practitioners as it does for medical/surgical practitioners. MultiPlan's Credentialing Comparative Analysis shows how review of provider credentials for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing NQTL for medical surgical benefits. The rejection percentage is 0.10% for MH/SUD providers. Upon quarterly non-discrimination audits, zero instances of discrimination were found. Credentialing decisions for MH/SUD providers are made within an average of 16.18 business days.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Multiplan applies Facility Credentialing Criteria to both Medical/Surgical and MH/SUD providers in the same manner, as written and in operation. The same set of policies and procedures are utilized to process and make Credentialing Decisions regarding Network participation for all provider applications, and the same staff members process MH/SUD provider files and Medical/Surgical provider files. As evidenced by the data and policy review depicted above, no criteria are applied more stringently to MH/SUD providers than Medical/Surgical providers.

MultiPlan also conducts discrimination audits on a quarterly basis. An impartial physician reviewer audits a sample of credentialing rejections/terminations for any evidence of potential discrimination, including any bias based on specialty or area of practice as well as any other form of discrimination. These findings, along with data on all credentialing outcomes, are reported to MultiPlan's Quality Management Committee where the information is reviewed to ensure quality and the equal application of policies and procedures.

The Credentialing Factors defined above are reflective of the credentialing process for all MultiPlan Network practitioners and facilities including both inpatient and outpatient services. All practitioners are credentialed to the same standard regardless of practice setting with the exception of Hospital Based Providers which are out of scope for credentialing in accordance with National Accreditation Standards. The MultiPlan Practitioner Credentialing Criteria and MultiPlan Facility Credentialing Criteria are not more stringently applied to any one provider population over another as evidenced by the credentialing outcome data, which shows no marked disparities between MH/SUD providers and Medical/Surgical providers. In fact, the data shows that, on average, the network rejects 0.21% of Medical/Surgical providers and only rejects 0.08% of MH/SUD providers. Although the volume of Medical/Surgical applicants is much larger than the MH/SUD providers, many more specialty categories fall into the Medical/Surgical category, which may explain the deviation.

Based on the above analysis, MultiPlan's processes, as applied in writing and operation, are comparable to and no more stringently applied to MH/SUD providers than to Medical/Surgical providers.

Benefit Classification 2: Inpatient – Out-of-Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – There is no credentialing of out of network providers	N/A – There is no credentialing of out of network providers

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – There is no credentialing of out of network providers	N/A – There is no credentialing of out of network providers

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – There is no credentialing of out of network providers	N/A – There is no credentialing of out of network providers

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical

Mental Health/Substance Use Disorder

N/A – There is no credentialing of out of network providers

N/A – There is no credentialing of out of network providers

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical

Mental Health/Substance Use Disorder

N/A – There is no credentialing of out of network providers

N/A – There is no credentialing of out of network providers

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical

Mental Health/Substance Use Disorder

N/A – There is no credentialing of out of network providers

N/A – There is no credentialing of out of network providers

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

N/A – There is no credentialing of out of network providers

N/A – There is no credentialing of out of network providers

Benefit Classification 3: Outpatient – In Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
Primary Care:	Integrated Behavioral Health Consultation
Specialty Care:	Applied Behavior Analysis Program (Limited to Children through age 20):
Telemedicine and Telehealth Visits:	Speech Therapy (Limited to Children through age 20):
Primary Care*:	Physical and Occupational Therapy (Limited to Children through age 20):
Specialty Care:	Individual visits:
Allergy Testing (performed in Office Setting or Outpatient Hospital Setting):	Group visits
Chiropractic Care (spinal manipulation only):	Medication visit:
Hearing exams and tests	
Primary Care Visit:	
Specialty Care Visit:	
Well Child Exams (through age 5)	
Well Child Exams (age 6 through 21)	
Routine Adult Physical Exams	
Primary Care Visit:	
Specialty Care Visit:	
Speech Therapy:	
Physical and Occupational Therapy:	
Speech Therapy:	
Physical and Occupational Therapy:	
Pulmonary Therapy:	
Cardiac Rehabilitation:	
Cognitive Therapy for Traumatic Brain Injury	
Multi-disciplinary Rehabilitation:	
Urgent Care:	
Adult Routine Eye Exam:	
Pediatric Routine Eye Exam (Children through age 18):	

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
Kaiser Permanente Insurance Company’s (KPIC) Participating Provider network is an open network and consists of network providers contracted with MultiPlan, Inc. Network providers	Kaiser Permanente Insurance Company’s (KPIC) Participating Provider network is an open network and consists of network providers contracted with MultiPlan, Inc. Network providers

Medical/Surgical

are health care providers contracted with MultiPlan for participation in MultiPlan networks which include, but are not limited to, the PHCS Network, and the MultiPlan Network. MultiPlan, Inc., develops and manages a primary network of health care providers and hospitals that includes access to both MH/SUD and Medical/Surgical providers.

MultiPlan credentials providers applying to the MultiPlan Networks, and recredentials the same providers every thirty-six (36) months, unless otherwise required by law. MultiPlan has implemented a standard set of credentialing criteria for all MultiPlan Networks and does not differentiate in the application of that criteria based on whether the provider is a MH/SUD provider or a Medical/Surgical provider. All non-hospital-based providers that are newly contracted with MultiPlan are subject to the credentialing process. Only MultiPlan's PHCS Network is NCQA Accredited in Credentialing, however, MultiPlan has adopted the NCQA standards ("National Accreditation Standards") as the basis for credentialing/recredentialing for all MultiPlan Networks. MH/SUD provider applications and related documentation are processed and maintained in accordance with NCQA standards, and the same NCQA standards for credentialing are followed for all other providers. MultiPlan credentials and recredentials Network practitioners according to National Accreditation Standards and takes the following steps every thirty-six (36) months, as applicable:

1. Collects of a complete application
2. Verifies of current licensure
3. Verifies of DEA certification
4. Verifies of education/training
5. Verifies of board certification, if applicable
6. Verifies of work history
7. Reviews professional liability claim history
8. Reviews board actions and Medicare sanctions

MultiPlan does not establish NQTLs on, or implied through, relationships with providers that are applied more stringently to MH/SUD services than those applicable to Medical/Surgical services, whether in writing or in operation. MultiPlan's policies, processes, and operational implementation of such processes are not designed to restrict access to, or discriminate against, specific provider types or services, including but not limited to, MH/SUD providers. All policies and processes are implemented to apply equally regardless of provider type.

PROVIDER TYPES ANALYZED FOR PURPOSES OF THE CREDENTIALING/RECREREDENTIALING NQTL

Mental Health/Substance Use Disorder

are health care providers contracted with MultiPlan for participation in MultiPlan networks which include, but are not limited to, the PHCS Network, and the MultiPlan Network. MultiPlan, Inc., develops and manages a primary network of health care providers and hospitals that includes access to both MH/SUD and Medical/Surgical providers.

MultiPlan credentials providers applying to the MultiPlan Networks, and recredentials the same providers every thirty-six (36) months, unless otherwise required by law. MultiPlan has implemented a standard set of credentialing criteria for all MultiPlan Networks and does not differentiate in the application of that criteria based on whether the provider is a MH/SUD provider or a Medical/Surgical provider. All non-hospital-based providers that are newly contracted with MultiPlan are subject to the credentialing process. Only MultiPlan's PHCS Network is NCQA Accredited in Credentialing, however, MultiPlan has adopted the NCQA standards ("National Accreditation Standards") as the basis for credentialing/recredentialing for all MultiPlan Networks. MH/SUD provider applications and related documentation are processed and maintained in accordance with NCQA standards, and the same NCQA standards for credentialing are followed for all other providers. MultiPlan credentials and recredentials Network practitioners according to National Accreditation Standards and takes the following steps every thirty-six (36) months, as applicable:

1. Collects of a complete application
2. Verifies of current licensure
3. Verifies of DEA certification
4. Verifies of education/training
5. Verifies of board certification, if applicable
6. Verifies of work history
7. Reviews professional liability claim history
8. Reviews board actions and Medicare sanctions

MultiPlan does not establish NQTLs on, or implied through, relationships with providers that are applied more stringently to MH/SUD services than those applicable to Medical/Surgical services, whether in writing or in operation. MultiPlan's policies, processes, and operational implementation of such processes are not designed to restrict access to, or discriminate against, specific provider types or services, including but not limited to, MH/SUD providers. All policies and processes are implemented to apply equally regardless of provider type.

PROVIDER TYPES ANALYZED FOR PURPOSES OF THE CREDENTIALING/RECREREDENTIALING NQTL

Medical/Surgical			Mental Health/Substance Use Disorder		
Provider Type	Description	Med/Surg	Provider Type	Description	MH/SUD
Non-Hospital Based Practitioners	MultiPlan requires all non-hospital-based practitioners applying to, and those participating in, the MultiPlan Networks to meet MultiPlan Practitioner Credentialing Criteria	✓	Non-Hospital Based Practitioners	MultiPlan requires all non-hospital-based practitioners applying to, and those participating in, the MultiPlan Networks to meet MultiPlan Practitioner Credentialing Criteria	✓
Hospital-Based Practitioners	Hospital-based practitioners solely practicing in a Network facility location are not subject to the credentialing/recredentialing process	✓	Hospital-Based Practitioners	Hospital-based practitioners solely practicing in a Network facility location are not subject to the credentialing/recredentialing process	✓

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
<p>The Credentialing Factors identified in this section have been established by MultiPlan to ensure that members accessing MultiPlan Network Services have access to high quality Network Providers that meet minimum professional competency requirements, including but not limited to, hospitals, physicians, MH/SUD providers, and other providers. In addition, the Credentialing Factors enable MultiPlan to maintain NCQA Network Accreditation in Credentialing for MultiPlan's PHCS Network and comply with applicable federal and/or state laws.'</p> <p>The grid below shows the rationale for applying the credentialing/recredentialing NQTL that was used in developing the Credentialing Factors, as it relates to both Medical/Surgical</p>	<p>The Credentialing Factors identified in this section have been established by MultiPlan to ensure that members accessing MultiPlan Network Services have access to high quality Network Providers that meet minimum professional competency requirements, including but not limited to, hospitals, physicians, MH/SUD providers, and other providers. In addition, the Credentialing Factors enable MultiPlan to maintain NCQA Network Accreditation in Credentialing for MultiPlan's PHCS Network and comply with applicable federal and/or state laws.'</p> <p>The grid below shows the rationale for applying the credentialing/recredentialing NQTL that was used in developing the Credentialing Factors, as it relates to both Medical/Surgical</p>

Medical/Surgical

services and MH/SUD services.

Rationale for Applying NQTL Factors	Med/Surg Providers
MultiPlan applies Credentialing Factors to ensure Network Providers meet minimum participation criteria including professional competency.	✓
MultiPlan applies Credentialing Factors to ensure members have access to high quality care and Network Providers that meet minimum professional competency requirements.	✓
MultiPlan applies Credentialing Factors to meet NCQA accreditation requirements.	✓
MultiPlan applies Credentialing Factors to meet state and/or federal requirements.	✓

"CREDENTIALING FACTORS" CONSIDERED WHEN ESTABLISHING SPECIFIC PRACTITIONER CREDENTIALING CRITERIA

The grid below identifies the Credentialing Factors used in developing credentialing/recredentialing processes for all providers applying to or participating in the MultiPlan Network(s).

Mental Health/Substance Use Disorder

services and MH/SUD services.

Rationale for Applying NQTL Factors	Med/Surg Providers
MultiPlan applies Credentialing Factors to ensure Network Providers meet minimum participation criteria including professional competency.	✓
MultiPlan applies Credentialing Factors to ensure members have access to high quality care and Network Providers that meet minimum professional competency requirements.	✓
MultiPlan applies Credentialing Factors to meet NCQA accreditation requirements.	✓
MultiPlan applies Credentialing Factors to meet state and/or federal requirements.	✓

"CREDENTIALING FACTORS" CONSIDERED WHEN ESTABLISHING SPECIFIC PRACTITIONER CREDENTIALING CRITERIA

The grid below identifies the Credentialing Factors used in developing credentialing/recredentialing processes for all providers applying to or participating in the MultiPlan Network(s).

Medical/Surgical

Mental Health/Substance Use Disorder

Factor	Description	Med/Surg Outpatient (Physician) Services	Factor	Description	MH/ SUD Outpatient (Physician) Services
Credentialing Application/	Credentialing applications are required by the accreditation standards to collect information on a practitioner or facility to determine eligibility for participation in the Network and provide authorization for verification of application contents. All practitioners and specified facilities are required to complete a comprehensive application to verify the applicant is in full compliance with MultiPlan's Network participation criteria.	✓	Credentialing Application/	Credentialing applications are required by the accreditation standards to collect information on a practitioner or facility to determine eligibility for participation in the Network and provide authorization for verification of application contents. All practitioners and specified facilities are required to complete a comprehensive application to verify the applicant is in full compliance with MultiPlan's Network participation criteria.	✓
Credentials Verification	To ensure practitioners and facilities are qualified to provide services and quality care, verification of the application contents is required. Verification of the contents of the provider application is done directly through primary sources or secondary sources, as permitted by the National Accreditation Standards and state laws. Verifications are completed every 36 months or earlier as defined by state laws. Credentials Verifications include the MultiPlan Practitioner Credentialing Criteria and MultiPlan Facility Credentialing Criteria, as defined above in Section 1.	✓	Credentials Verification	To ensure practitioners and facilities are qualified to provide services and quality care, verification of the application contents is required. Verification of the contents of the provider application is done directly through primary sources or secondary sources, as permitted by the National Accreditation Standards and state laws. Verifications are completed every 36 months or earlier as defined by state laws. Credentials Verifications include the MultiPlan Practitioner Credentialing Criteria and MultiPlan Facility Credentialing Criteria, as defined above in Section 1.	✓

Medical/Surgical

Mental Health/Substance Use Disorder

Practitioner Specialty Assignment	Practitioner specialties are verified to ensure practitioners are practicing within the scope of their training and licensing; and to ensure provider directories are consistent with the assigned specialty. Practitioners that do not have a valid state license (or certification) and verifiable training are not eligible for participation in the Network. MultiPlan only accepts the accepted practice standard for certification within a specialty field. In states that do not issue licensure for a specific specialty, MultiPlan accepts the certification that is recognized by most states that do license such specialty. In rare instances, MultiPlan may accept a certification recognized by licensing boards in lieu of licensure. MultiPlan applies this criteria no more stringently to MH/SUD provider specialties as compared to Medical/Surgical provider types.	✓	Practitioner Specialty Assignment	Practitioner specialties are verified to ensure practitioners are practicing within the scope of their training and licensing; and to ensure provider directories are consistent with the assigned specialty. Practitioners that do not have a valid state license (or certification) and verifiable training are not eligible for participation in the Network. MultiPlan only accepts the accepted practice standard for certification within a specialty field. In states that do not issue licensure for a specific specialty, MultiPlan accepts the certification that is recognized by most states that do license such specialty. In rare instances, MultiPlan may accept a certification recognized by licensing boards in lieu of licensure. MultiPlan applies this criteria no more stringently to MH/SUD provider specialties as compared to Medical/Surgical provider types.	✓
Credentialing Decisions	The Credentials Committee makes all credentialing determinations. It is a multidisciplinary committee with representation from different types of practitioners that participate in the Networks, and is composed of the Medical Director and four Network Providers. All clinical aspects of the MultiPlan Credentialing Plan are the responsibility of the Medical Director as dictated by National Accreditation Standards.	✓	Credentialing Decisions	The Credentials Committee makes all credentialing determinations. It is a multidisciplinary committee with representation from different types of practitioners that participate in the Networks, and is composed of the Medical Director and four Network Providers. All clinical aspects of the MultiPlan Credentialing Plan are the responsibility of the Medical Director as dictated by National Accreditation Standards.	✓

Medical/Surgical

Mental Health/Substance Use Disorder

Credentialing Timeframes	Timely credentialing is required to ensure prompt Network participation and access to services in the Network. Credentialing Decisions are made within the timeframes specified by the National Accreditation Standards or as required by law.	✓	Credentialing Timeframes	Timely credentialing is required to ensure prompt Network participation and access to services in the Network. Credentialing Decisions are made within the timeframes specified by the National Accreditation Standards or as required by law.	✓
Monitoring Activities	Performance of monitoring activities is required to ensure that Network Providers continue to meet MultiPlan Practitioner Credentialing Criteria and MultiPlan Facility Credentialing Criteria and have not been the subject of licensing or board actions, as required by the National Accreditation Standards.	✓	Monitoring Activities	Performance of monitoring activities is required to ensure that Network Providers continue to meet MultiPlan Practitioner Credentialing Criteria and MultiPlan Facility Credentialing Criteria and have not been the subject of licensing or board actions, as required by the National Accreditation Standards.	✓
Credentialing Oversight	Credentialing oversight is required to ensure that processes are consistent with National Accreditation Standards and Network Providers meet, and continue to meet, high quality standards to treat members.	✓	Credentialing Oversight	Credentialing oversight is required to ensure that processes are consistent with National Accreditation Standards and Network Providers meet, and continue to meet, high quality standards to treat members.	✓
Hospital-Based Providers	Hospital-Based Providers are providers that solely practice within a facility setting and do not receive direct referrals for care. Verification of Hospital-Based Providers is out-of-scope for the credentialing program, as MultiPlan does not directly credential these practitioners. Facilities that employ Hospital-Based Providers, directly or indirectly, have the sole responsibility of ensuring these providers are appropriately credentialed.	N/A	Hospital-Based Providers	Hospital-Based Providers are providers that solely practice within a facility setting and do not receive direct referrals for care. Verification of Hospital-Based Providers is out-of-scope for the credentialing program, as MultiPlan does not directly credential these practitioners. Facilities that employ Hospital-Based Providers, directly or indirectly, have the sole responsibility of ensuring these providers are appropriately credentialed.	N/A

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical			Mental Health/Substance Use Disorder		
<p>MultiPlan Practitioner Credentialing Criteria, MultiPlan Facility Credentialing Criteria, National Accreditation Standards, and federal/state laws are used by MultiPlan to define the criteria that establish the Credentialing Factors. These evidentiary standards support MultiPlan’s determinations on what constitutes an effective credentialing program.</p> <p><i>EVIDENTIARY STANDARDS FOR EACH FACTOR CONSIDERED WHEN ESTABLISHING SPECIFIC PRACTITIONER AND FACILITY CREDENTIALING CRITERIA</i></p> <p>The grid below identifies the various evidentiary standards for the factors used in developing credentialing/recredentialing processes for all providers applying to, or participating in, the MultiPlan Network(s) as applied to Medical/Surgical providers or to MH/SUD providers.</p>			<p>[MultiPlan Practitioner Credentialing Criteria, MultiPlan Facility Credentialing Criteria, National Accreditation Standards, and federal/state laws are used by MultiPlan to define the criteria that establish the Credentialing Factors. These evidentiary standards support MultiPlan’s determinations on what constitutes an effective credentialing program.</p> <p><i>EVIDENTIARY STANDARDS FOR EACH FACTOR CONSIDERED WHEN ESTABLISHING SPECIFIC PRACTITIONER AND FACILITY CREDENTIALING CRITERIA</i></p> <p>The grid below identifies the various evidentiary standards for the factors used in developing credentialing/recredentialing processes for all providers applying to, or participating in, the MultiPlan Network(s) as applied to Medical/Surgical providers or to MH/SUD providers.</p>		
Factor	Documentation	Medical Surgical Providers	Factor	Documentation	MH/ SUD Providers
Credentialing Application	1. National Accreditation Standards	✓	Credentialing Application	1. National Accreditation Standards	✓

Medical/Surgical			Mental Health/Substance Use Disorder		
	2. State Mandated Applications			2. State Mandated Applications	
Credentials Verification	1. National Accreditation Standards 2. Medicare Managed Care Manual for Government Programs 3. State laws 4. Facility Accreditation/Certification Bodies	✓	Credentials Verification	1. National Accreditation Standards 2. Medicare Managed Care Manual for Government Programs 3. State laws 4. Facility Accreditation/Certification Bodies	✓
Practitioner Specialty Assignment	1. National Accreditation Standards 2. State Licensing Boards	✓	Practitioner Specialty Assignment	1. National Accreditation Standards 2. State Licensing Boards	✓
Facility Type Assignment	1. National Accreditation Standards 2. State Licensing Requirements	✓	Facility Type Assignment	1. National Accreditation Standards 2. State Licensing Requirements	✓
Credentialing Decisions	1. National Accreditation Standards	✓	Credentialing Decisions	1. National Accreditation Standards	✓
Credentialing Timeframes	1. National Accreditation Standards 2. State Laws	✓	Credentialing Timeframes	1. National Accreditation Standards 2. State Laws	✓
Monitoring Activities	1. National Accreditation Standards	✓	Monitoring Activities	1. National Accreditation Standards	✓
Credentialing Oversight	1. National Accreditation Standards	✓	Credentialing Oversight	1. National Accreditation Standards	✓
Hospital-Based Providers	1. National Accreditation Standards	✓	Hospital-Based Providers	1. National Accreditation Standards	✓

Practitioner Credentialing Data - Accept & Reject – 2022						
State	Practitioner Type	Credentialed/ Processed	Accepted	Rejected	Percent Accepted	Percent Rejected
GA	Total Medical/Surgical	643	643	0	100.00%	0.00%
	Total MH/SUD Providers	262	261	1	99.62%	0.38%
	<i>Mental Health Only</i>	91	90	1	98.90%	1.10%
	<i>Substance Use Disorder Only</i>	0	0	0	N/A	N/A
	<i>Both Mental Health/Substance Use Disorder*</i>	171	171	0	100.00%	0.00%
	State Total	905	904	1	99.89%	0.11%

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
<p>The Medical Director oversees and has overall responsibility for the clinical aspects of credentialing network providers and monitors the achievement of quality and outcome measures. The executive committee has delegated the operational responsibility for the credentialing program to the Credentials Committee (the “Committee”), a multidisciplinary committee with representation from different types of practitioners that participate in the networks. The Committee is composed of the Medical Director (non-voting), five network providers (voting), and at least one Credentialing Specialist (nonvoting operational staff member that supports the Committee for the credentialing and recredentialing programs). The Medical Director has the requisite training and qualifications for internal medicine. The five network providers have the requisite training for internal medicine, general surgery, hematology/oncology, psychiatry, and emergency medicine. In instances where matters arise that require subject matter expertise beyond those available from the members of the Committee, the Medical Director seeks consultation from participating network specialists in the same or similar specialty as the practitioner being discussed. The Committee makes decisions based on provider applicants meeting MultiPlan credentialing guidelines. MultiPlan’s credentialing guidelines are comprised of NCQA credentialing criteria and state/federal regulatory obligations. The Committee provides guidance on the overall direction of the credentialing program by overseeing all credentialing policies and procedures. A separate network provider that is not on the Committee audits decisions quarterly to ensure credentialing decisions are not made in a discriminatory manner. The Committee applies the same criteria in its decision-making for MH/SUD practitioners as it does for medical/surgical practitioners.</p>	<p>The Medical Director oversees and has overall responsibility for the clinical aspects of credentialing network providers, and monitors the achievement of quality and outcome measures. The executive committee has delegated the operational responsibility for the credentialing program to the Credentials Committee (the “Committee”), a multidisciplinary committee with representation from different types of practitioners that participate in the networks. The Committee is composed of the Medical Director (non-voting), five network providers (voting), and at least one Credentialing Specialist (nonvoting operational staff member that supports the Committee for the credentialing and recredentialing programs). The Medical Director has the requisite training and qualifications for internal medicine. The five network providers have the requisite training for internal medicine, general surgery, hematology/oncology, psychiatry and emergency medicine. In instances where matters arise that require subject matter expertise beyond those available from the members of the Committee, the Medical Director seeks consultation from participating network specialists in the same or similar specialty as the practitioner being discussed, including but not limited to MH/SUD practitioners. The Committee makes decisions based on provider applicants meeting MultiPlan credentialing guidelines. MultiPlan’s credentialing guidelines are comprised of NCQA credentialing criteria and state/federal regulatory obligations. The Committee provides guidance on the overall direction of the</p>

Medical/Surgical

All applications are reviewed for completeness in accordance with MultiPlan's Complete Applications policy. Practitioners are notified when relevant information is missing and/or if additional information is required to complete the credentialing process. In accordance with National Accreditation Standards and applicable state laws, portions of the application are verified with appropriate sources as specified in MultiPlan policies and procedures. All clean and complete applications that meet MultiPlan Practitioner Credentialing Criteria and/or MultiPlan Facility Credentialing Criteria are reviewed and approved by the Medical Director. All completed applications, including required attachments that do not meet MultiPlan Practitioner Credentialing Criteria and/or MultiPlan Facility Credentialing Criteria are presented to the Credentials Committee. Credentialing decisions are made within one hundred eighty ("180") days of the attestation date on the application. MultiPlan's turn-around times for processing credentialing applications are typically ninety ("90") to one hundred twenty ("120") days from receipt of a complete application. The Credentials Committee consists of MultiPlan clinical and administrative staff, and Network Providers in accordance with MultiPlan's Credentials Committee policy. The Credentials Committee makes Credentialing Decisions related to the acceptance, rejection, continued participation, and termination of practitioners (including Medical/Surgical practitioner specialties), acute care hospitals, home health agencies, skilled nursing facilities, free standing ambulatory surgical centers, inpatient acute physical rehabilitation facilities and behavioral health facilities (all MH/SUD facility types). The Credentials Committee meets in person and/or telephonically on a weekly basis. It is a multidisciplinary committee with representation from different types of practitioners that participate in the MultiPlan Network(s). Specifically, the Credentials Committee is composed of the Medical Director and three Network practitioners. The Credentials Committee reviews and has final authority regarding Network participation for all Network practitioners and facilities. All applicants or Network practitioners under recredentialing review are presented to the committee for consideration and approval.

Providers that do not meet MultiPlan Practitioner Credentialing Criteria or MultiPlan Facility Credentialing Criteria for their discipline are discussed by the Credentials Committee to determine whether they are meeting reasonable standards of care. After review, the committee votes on all applicants and determines whether to accept or reject the applicants. Cases are presented by the Medical Director or Credentialing Specialist to the Credentials Committee. In instances where matters arise that require subject matter expertise beyond that available from the members of the committee, the Medical Director seeks consultation from participating MultiPlan Network(s) provider specialists in the same or similar specialty as the practitioner being discussed (including MH/SUD providers as needed). This information is made available to the other members of the committee prior to a deciding vote being taken.

All Credentials Committee actions are documented. The committee maintains meeting minutes for each meeting. The Quality

Mental Health/Substance Use Disorder

credentialing program by overseeing all credentialing policies and procedures. A separate network provider that is, not on the Committee audits decisions quarterly to ensure credentialing decisions are not made in a discriminatory manner. The Committee applies the same criteria in its decision-making for MH/SUD practitioners as it does for medical/surgical practitioners.

All applications are reviewed for completeness in accordance with MultiPlan's Complete Applications policy. Practitioners are notified when relevant information is missing and/or if additional information is required to complete the credentialing process. In accordance with National Accreditation Standards and applicable state laws, portions of the application are verified with appropriate sources as specified in MultiPlan policies and procedures. All clean and complete applications that meet MultiPlan Practitioner Credentialing Criteria and/or MultiPlan Facility Credentialing Criteria are reviewed and approved by the Medical Director. All completed applications, including required attachments that do not meet MultiPlan Practitioner Credentialing Criteria and/or MultiPlan Facility Credentialing Criteria are presented to the Credentials Committee. Credentialing decisions are made within one hundred eighty ("180") days of the attestation date on the application. MultiPlan's turn-around times for processing credentialing applications are typically ninety ("90") to one hundred twenty ("120") days from receipt of a complete application. The Credentials Committee consists of MultiPlan clinical and administrative staff, and Network Providers in accordance with MultiPlan's Credentials Committee policy. The Credentials Committee makes Credentialing Decisions related to the acceptance, rejection, continued participation, and termination of practitioners (including MH/SUD practitioner specialties), acute care hospitals, home health agencies, skilled nursing facilities, free standing ambulatory surgical centers, inpatient acute physical rehabilitation facilities and behavioral health facilities (all MH/SUD facility types).

The Credentials Committee meets in person and/or telephonically on a weekly basis. It is a multidisciplinary committee with representation from different types of practitioners that participate in the MultiPlan Network(s). Specifically, the Credentials Committee is composed of the Medical Director and three Network practitioners. The Credentials Committee may invite an MH/SUD practitioner to participate on the committee, as needed, for review of MH/SUD provider applicants. The Credentials Committee reviews and has final authority regarding Network participation for all Network practitioners and facilities. All applicants or Network practitioners under recredentialing review are presented to the committee for consideration and approval.

Providers that do not meet MultiPlan Practitioner Credentialing Criteria or MultiPlan Facility Credentialing Criteria for their discipline are discussed by the Credentials Committee to determine whether they are meeting reasonable standards of care. After review, the committee votes on all applicants and determines whether to accept or reject the

Medical/Surgical

Management Committee receives a quarterly report of credentialing metrics, including but not limited to, the number of credentialed/recredentialed practitioners, delegation oversight results, and sanctions monitoring results. Information presented by the Manager of Credentialing Operations/PNQ in these quarterly reports is used to measure the overall effectiveness of the credentialing program.

All rejected and terminated practitioners (inclusive of MH/SUD providers) are informed of their right to a two level appeal process. This process is detailed within MultiPlan's Network Provider Appeal policy, and conforms to National Accreditation Standards, and applicable state and federal laws.

Formal recredentialing occurs on a thirty-six (36) month cycle and is conducted in accordance with MultiPlan's Credentialing policies. All policies are structured to be in full compliance with National Accreditation Standards and state and federal laws. In addition, MultiPlan will initiate off-cycle recredentialing of practitioners as a result of complaints and grievances received through Corporate Quality Management or as a result of information obtained from our ongoing monitoring process.

Mental Health/Substance Use Disorder

applicants. Cases are presented by the Medical Director or Credentialing Specialist to the Credentials Committee. In instances where matters arise that require subject matter expertise beyond that available from the members of the committee, the Medical Director seeks consultation from participating MultiPlan Network(s) provider specialists in the same or similar specialty as the practitioner being discussed (including MH/SUD providers as needed). This information is made available to the other members of the committee prior to a deciding vote being taken.

All Credentials Committee actions are documented. The committee maintains meeting minutes for each meeting. The Quality Management Committee receives a quarterly report of credentialing metrics, including but not limited to, the number of credentialed/recredentialed practitioners, delegation oversight results, and sanctions monitoring results. Information presented by the Manager of Credentialing Operations/PNQ in these quarterly reports is used to measure the overall effectiveness of the credentialing program.

All rejected and terminated practitioners (inclusive of MH/SUD providers) are informed of their right to a two level appeal process. This process is detailed within MultiPlan's Network Provider Appeal policy, and conforms to National Accreditation Standards, and applicable state and federal laws.

Formal recredentialing occurs on a thirty-six (36) month cycle and is conducted in accordance with MultiPlan's Credentialing policies. All policies are structured to be in full compliance with National Accreditation Standards and state and federal laws. In addition, MultiPlan will initiate off-cycle recredentialing of practitioners as a result of complaints and grievances received through Corporate Quality Management or as a result of information obtained from our ongoing monitoring process.

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical

MultiPlan's credentialing guidelines are comprised of NCQA credentialing criteria and state/federal regulatory obligations. The Committee provides guidance on the overall direction of the credentialing program by overseeing all credentialing policies and procedures. A separate network provider that is, not on the

Mental Health/Substance Use Disorder

MultiPlan's credentialing guidelines are comprised of NCQA credentialing criteria and state/federal regulatory obligations. The Committee provides guidance on the overall direction of the credentialing program by overseeing all credentialing policies and procedures. A separate network provider that is, not on the

Medical/Surgical

Committee audits decisions quarterly to ensure credentialing decisions are not made in a discriminatory manner. The Committee applies the same criteria in its decision-making for MH/SUD practitioners as it does for medical/surgical practitioners. MultiPlan's Credentialing Comparative Analysis shows how review of provider credentials for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing NQTL for medical surgical benefits. The rejection percentage is 0.19% for medical/surgical providers. Upon quarterly non-discrimination audits, zero instances of discrimination were found. Credentialing decisions for medical/surgical providers are made within an average of 18.04 business days.

Mental Health/Substance Use Disorder

Committee audits decisions quarterly to ensure credentialing decisions are not made in a discriminatory manner. The Committee applies the same criteria in its decision-making for MH/SUD practitioners as it does for medical/surgical practitioners. MultiPlan's Credentialing Comparative Analysis shows how review of provider credentials for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing NQTL for medical surgical benefits. The rejection percentage is 0.10% for MH/SUD providers. Upon quarterly non-discrimination audits, zero instances of discrimination were found. Credentialing decisions for MH/SUD providers are made within an average of 16.18 business days.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Multiplan applies Facility Credentialing Criteria to both Medical/Surgical and MH/SUD providers in the same manner, as written and in operation. The same set of policies and procedures are utilized to process and make Credentialing Decisions regarding Network participation for all provider applications, and the same staff members process MH/SUD provider files and Medical/Surgical provider files. As evidenced by the data and policy review depicted above, no criteria are applied more stringently to MH/SUD providers than Medical/Surgical providers.

MultiPlan also conducts discrimination audits on a quarterly basis. An impartial physician reviewer audits a sample of credentialing rejections/terminations for any evidence of potential discrimination, including any bias based on specialty or area of practice as well as any other form of discrimination. These findings, along with data on all credentialing outcomes, are reported to MultiPlan's Quality Management Committee where the information is reviewed to ensure quality and the equal application of policies and procedures.

The Credentialing Factors defined above are reflective of the credentialing process for all MultiPlan Network practitioners and facilities including both inpatient and outpatient services. All practitioners are credentialed to the same standard regardless of practice setting with the exception of Hospital Based Providers which are out of scope for credentialing in accordance with National Accreditation Standards. The MultiPlan Practitioner Credentialing Criteria and MultiPlan Facility Credentialing Criteria are not more stringently applied to any one provider population over another as evidenced by the credentialing outcome data, which shows no marked disparities between MH/SUD providers and Medical/Surgical providers. In fact, the data shows that, on average, the network rejects 0.21% of Medical/Surgical providers and only rejects 0.08% of MH/SUD providers. Although the volume of Medical/Surgical applicants is much larger than the MH/SUD providers, many more specialty categories fall into the Medical/Surgical category, which may explain the deviation.

Based on the above analysis, MultiPlan's processes, as applied in writing and operation, are comparable to and no more stringently applied to MH/SUD providers than to Medical/Surgical providers.

Benefit Classification 4: Outpatient – Out-of-Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – There is no credentialing of out of network providers	N/A – There is no credentialing of out of network providers

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – There is no credentialing of out of network providers	N/A – There is no credentialing of out of network providers

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – There is no credentialing of out of network providers	N/A – There is no credentialing of out of network providers

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical

Mental Health/Substance Use Disorder

N/A – There is no credentialing of out of network providers

N/A – There is no credentialing of out of network providers

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical

Mental Health/Substance Use Disorder

N/A – There is no credentialing of out of network providers

N/A – There is no credentialing of out of network providers

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical

Mental Health/Substance Use Disorder

N/A – There is no credentialing of out of network providers

N/A – There is no credentialing of out of network providers

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

There is no credentialing of out of network providers

Benefit Classification 5: Emergency Services

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – There is no credentialing for emergency services.	N/A – There is no credentialing for emergency services.

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – There is no credentialing for emergency services.	N/A – There is no credentialing for emergency services.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – There is no credentialing for emergency services.	N/A – There is no credentialing for emergency services.

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – There is no credentialing for emergency services.	N/A – There is no credentialing for emergency services.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – There is no credentialing for emergency services.	N/A – There is no credentialing for emergency services.

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – There is no credentialing for emergency services.	N/A – There is no credentialing for emergency services.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Emergency services provided by physicians are out-of-scope for the credentialing program, as this practitioner type is considered a Hospital-Based Provider, and does not receive direct referrals for care. In certain circumstance, emergency service providers may be subject to the credentialing program, if they have an independent practice location outside of a facility setting (Hospital-Based Provider) contracted with MultiPlan. In this instance, emergency service providers follow the same credentialing criteria required for out-patient physician services. Emergency services for facility services are not differentiated from the standard facility type factors defined above.

Benefit Classification 6: Pharmacy Services

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- There is no credentialing for Pharmacy Services.	N/A- There is no credentialing for Pharmacy Services.

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- There is no credentialing for Pharmacy Services.	N/A- There is no credentialing for Pharmacy Services.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- There is no credentialing for Pharmacy Services.	N/A- There is no credentialing for Pharmacy Services.

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- There is no credentialing for Pharmacy Services.	N/A- There is no credentialing for Pharmacy Services.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- There is no credentialing for Pharmacy Services.	N/A- There is no credentialing for Pharmacy Services.

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- There is no credentialing for Pharmacy Services.	N/A- There is no credentialing for Pharmacy Services.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion
There is no credentialing for Pharmacy Services.

Kaiser Foundation Health Plan
National Claims Administration
Non-Quantitative Treatment Limits (NQTL)



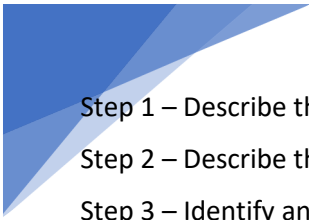
NQTL: Retrospective Financial Claims Review

Last Reviewed: April 19, 2022



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Benefits		Classifications					
Is NQTL applied to Medical/Surgical benefits?	Is NQTL applied to Mental Health/Substance Use Disorder benefits?	Is NQTL applied to In Network Inpatient classification?	Is NQTL applied to Out of Network Inpatient classification?	Is NQTL applied to In Network Outpatient classification?	Is NQTL applied to Out of Network Outpatient classification?	Is NQTL applied to Emergency classification?	Is NQTL applied to Prescription classification?
Yes	No	Yes	Yes	Yes	Yes	Yes	No

Benefit Classification 1: Inpatient – In Network

Prompt – Benefit / Service(s) to which the NQTL applies

Medical/Surgical	Mental Health/Substance Use Disorder
Hospital stays- Med/Surg Long-Term Acute Care (LTAC) - KPWA 2 specific facilities only ETOH (Ethanol Alcohol related care /OD Overdose for Substance abuse. An overdose is always an emergency, however each person's history and presenting problems could result in potential inpatient case.	National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.

Step 1 – Describe the NQTL's requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
1. When a claim for a Kaiser Permanente member is received within the claim processing area and meets Payment Integrity Clinical Review (CR) Criteria, tapestry will apply the appropriate pend/hold code based on systemic criteria to route the claim to Clinical Review for review. Upon review if a Registered Nurse (RN) determines the service(s) listed on the claim, or a portion of the claim are not medically necessary or may be cosmetic; or may be experimental/ investigational then the RN will provide the narrative which includes claim details, history, and direction on where to find medical documentation in the system and route the claim to a Physician Advisor (PA) to review for the final decision. If there is	National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.

not a finding or full authorization for the services billed, Clinical Review would review for any additional clinical review capability that is in scope prior to sending back to claims operations.

2. Cases that require retrospective review are completed by a Retrospective RN reviewer in National Claims Administration for Med/Surg only.

3. A retrospective review is completed using medical necessity criteria consistent with prior authorization.

4. Physician Advisor (PA) will review claims for what may not be medically necessary or may be cosmetic; or may be experimental/ investigational based off RN assessment and make decision to deny or allow charges. The decision to approve or deny these services are based on the following:

- Member benefits
- Input from Evidence based Medicine Team.
- Additional applicable resources:

Georgia	MCG (Milliman Care Guidelines) National Coverage Decisions - NCD (These guidelines are determined by CMS) Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC) National Uniform Billing Committee (NUBC) standards Established Kaiser Permanente Policy's
Mid-Atlantic States (Wash. DC/ Virginia/ Maryland)	MCG (Milliman Care Guidelines) National Coverage Decisions - NCD (These guidelines are determined by CMS) Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC) National Uniform Billing Committee (NUBC) standards Established Kaiser Permanente Policy's

Southern California	<p>InterQual</p> <p>National Coverage Decisions - NCD (These guidelines are determined by CMS)</p> <p>Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC)</p> <p>National Uniform Billing Committee (NUBC) standards</p> <p>Established Kaiser Permanente Policy's</p>
Northern California	<p>InterQual</p> <p>National Coverage Decisions - NCD (These guidelines are determined by CMS)</p> <p>Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC)</p> <p>National Uniform Billing Committee (NUBC) standards</p> <p>Established Kaiser Permanente Policy's</p>
Hawaii	<p>MCG (Milliman Care Guidelines)</p> <p>National Coverage Decisions - NCD (These guidelines are determined by CMS)</p> <p>Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC)</p> <p>National Uniform Billing Committee (NUBC) standards</p> <p>Established Kaiser Permanente Policy's</p>
Northwest	<p>MCG (Milliman Care Guidelines)</p> <p>National Coverage Decisions - NCD (These guidelines are determined by CMS)</p> <p>Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC)</p> <p>National Uniform Billing Committee (NUBC) standards</p> <p>Established Kaiser Permanente Policy's</p>

Colorado

MCG
(Milliman Care Guidelines)
National Coverage Decisions - NCD (These
guidelines are determined by CMS)
Local Coverage Decisions - LCD (These
guidelines will vary by Medicare
Administrative Contractor (MAC)
National Uniform Billing Committee
(NUBC) standards
Established Kaiser Permanente Policy's

5. Decision is then sent back to RN via PA packet with decision and then updated in our tracking tool and complete any other reviews within our scope prior to sending the claim back to Claims operations with instructions.

Step 2 – Describe the reason for applying to the NQTL

Provide comparative analysis demonstrating that comparable factors are used to determine the applicability of the **NQTL** for MH/SUD benefits and for medical/surgical benefits.

Medical/Surgical	Mental Health/Substance Use Disorder
In review of Medical/Surgical inpatient admission processes, the factors used to determine applicability of retrospective review are based on inpatient services that; contractually require health plan prior authorization for coverage, care, service, procedure, admission, or equipment that is a higher cost than other acceptable alternatives.	National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.
Factors Examples:	
<ul style="list-style-type: none"> ☐ Market price ☐ Volume of service capacity ☐ Geographic location ☐ Disability accommodations ☐ Community reputation 	<ul style="list-style-type: none"> ☐ Value-added services ☐ Languages spoken ☐ multi-specialty co-location ☐ Additional training/skills
Factors used to determine the need for inpatient retrospective review include: -Delivery of medically necessary services to our members. -Physician Review -Payment meets contract and/or provider manual requirements -Compliance with billing and coding standards -Level of care effectiveness and/or appropriateness (excluding California)	National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.

- Appropriate level of care (excluding California)
- Mis or over-utilization -This could fall into our 30-day readmission review criteria for example: Poor discharge planning
- Lack of prior authorization

Sources

Examples of sources for data to identify factors:

- ☐ Internal claims analyses
- ☐ Internal quality standard studies
- ☐ Expert medical review

Policies guiding retrospective review cover med/surg and are reviewed annually by Permanente Utilization Review Oversight Committee (UROC) to support administration of evidence-based medicine in the retrospective review process. In addition, Clinical Review partners with compliance, legal, operations, and our internal Medical Director to review and approve our established Kaiser Permanente Policy whenever there are new additions or changes to the Policy.

National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Examples of evidentiary standards, their sources, and other evidence considered include:

- ☐ Patient experience surveys
- ☐ Provider professional profiles
- ☐ Provider rating services
- ☐ Word of mouth/reputation

Medical/Surgical	Mental Health/Substance Use Disorder
The evidentiary standards relied upon when defining the factors above are embedded in the National Payment Integrity (NPI) Clinical Review processes for determining payment for claims under review.	National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.

Nationally Clinical Review References established Kaiser Permanente Policies, MCG Criteria (Regions outside of California), and InterQual (California).

These policies support the factors with evidence from commonly accepted standards including CMS guidelines, National Uniform Billing Committee (NUBC) standards, professional and academic journals, and publications.

Retrospective medical necessity determinations consider whether the care and treatment were:

- Appropriate for the symptoms and diagnosis or treatment of the member's condition, illness, disease, or injury.
- Provide for the diagnosis, direct care, and treatment of the medical condition.
- Meet the standard of good medical practice and is not mainly for the convenience of the provider or patient.

Nationally recognized medical criteria such as MCG or Kaiser Permanente medical policy criteria that has been thoroughly reviewed against evidence based medical research (reviewed by PMG) are used when reviewing retrospective cases for medical necessity.

Diagnosis Related Group (DRG) are also used to ensure diagnostic and procedural information and discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician's description and the information contained in the beneficiary's medical records.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical

Mental Health/Substance Use Disorder

Clinical Review is an essential part of the Claims organization and is an industry standard that Kaiser established to ensure fair and appropriate reimbursement.

All Medical/Surgical reviews follow the organization's utilization review policy which is regulated by Kaiser Permanente NCQA accreditation as well as our Kaiser Permanente Clinical Review Payment Policy. The Utilization Review policy provides the framework for adding, revising, or removing criteria.

The Clinical Review Payment Policy was designed to incorporate CMS criteria and regulations.

The RNs who complete these reviews have clinical experience in the med surgery areas. If there is a finding by a clinical review RN, the next step would be to have a PA with clinical experience and with the appropriate licensure review the findings and make a final determination.

In addition to the use of the policies mentioned above, Kaiser Permanente also maintains compliance with state insurance regulations and turnaround times for retrospective review.

NW Only: The Inter-Rater Reliability (IRR) process provides Kaiser Permanente with oversight to retrospective review standards, accountabilities with a process. This ensures consistent application of medical necessity criteria by all utilization review staff (listed above) when making determinations regarding covered services or items.

National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
<p>All regions (including NW): The RNs who complete these Medical Necessity reviews have clinical experience in the med surgery areas. If there is a finding by a clinical review RN, the next step would be to have a PA with clinical experience with the appropriate licensure review the findings and make a final determination.</p> <p>Clinical Review completes an internal Quality Assessment (QA) review based on Payment Policy Standards to ensure compliance. The target is to hit a 98% quality rating monthly. These reviews are completed on a weekly basis for all staff (Support and Clinical Staff). Clinical Review has Quality Criteria to measure accuracy and quality. The QA review is performed by the team lead and managers.</p> <p>NW Only: Medical/Surgical utilize the same framework in operationalizing the retrospective review process that is guided by the Kaiser Permanente Utilization Review Oversight Committee (UROC) and the Behavioral Health Utilization Review Committee, respectively</p> <p>To ensure consistent use of criteria, all licensed healthcare providers for medical are required to complete an annual evaluation; called Inter-Rater Reliability. This process requires the staff to apply medical necessity criteria for fictional patients. The results of these tests are reviewed and discussed within the department to ensure consistent, and application of criteria are maintained.</p> <p>The Inter-Rater Reliability study is an annual study utilized to evaluate the proper and consistent application of criteria.</p>	<p>National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.</p>

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

NCA's Clinical Review Team utilizes evidence from nationally recognized studies for Medical Surgical Services only. Clinical review utilizes medical necessity criteria from either nationally recognized organizations like MCG, and

InterQual as well as established Kaiser Permanente Policies or internally by our Practice Leader in Evidence Based Medicine with oversight from Medical Director.

The application of these guidelines/criteria are audited regularly and in accordance with our NCQA Accreditation process. Our NCQA Accreditation has provided a very clear and regimented process when designing/reviewing the plans medical necessity criteria.

The application of retrospective review process is carried out in the same manner; from receipt of the request, application of the medical necessity criteria, to the requirement of a Medical Doctor to be the only person that can deny a prior authorization request. Clinical Review applies these checks and balances only for Med Surg services.

Benefit Classification 2: Inpatient – Out-of-Network

Prompt – Benefit / Service(s) to which the NQTL applies

Medical/Surgical	Mental Health/Substance Use Disorder
Hospital stays- Med/Surg Long-Term Acute Care (LTAC) - KPWA 2 specific facilities only ETOH (Ethanol Alcohol related care /OD Overdose for Substance abuse. An overdose is always an emergency, however each person's history and presenting problems could result in potential inpatient case.	National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.

Step 1 – Describe the NQTL's requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
1. When a claim for a Kaiser Permanente member is received within the claim processing area and meets Payment Integrity Clinical Review (CR) Criteria, tapestry will apply the appropriate pend/hold code based on systemic criteria to route the claim to Clinical Review for review. Upon review if a Registered Nurse (RN) determines the service(s) listed on the claim, or a portion of the claim are not medically necessary or may be cosmetic; or may be experimental/ investigational then the RN will provide the narrative which includes claim details, history, and direction on where to find medical documentation in the system and route the claim to a Physician Advisor (PA) to review for the final decision. If there is not a finding or full authorization for the services billed, Clinical	National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.

Review would review for any additional clinical review capability that is in scope prior to sending back to claims operations.

2. Cases that require retrospective review are completed by a Retrospective RN reviewer in National Claims Administration for Med/Surg only.

3. A retrospective review is completed using medical necessity criteria consistent with prior authorization.

4. Physician Advisor (PA) will review claims for what may not be medically necessary or may be cosmetic; or may be experimental/ investigational based off RN assessment and make decision to deny or allow charges. The decision to approve or deny these services are based on the following:

- Member benefits
- Input from Evidence based Medicine Team.
- Additional applicable resources:

Georgia	MCG (Milliman Care Guidelines) National Coverage Decisions - NCD (These guidelines are determined by CMS) Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC) National Uniform Billing Committee (NUBC) standards Established Kaiser Permanente Policy's
Mid-Atlantic States (Wash. DC/ Virginia/ Maryland)	MCG (Milliman Care Guidelines) National Coverage Decisions - NCD (These guidelines are determined by CMS) Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC) National Uniform Billing Committee (NUBC) standards Established Kaiser Permanente Policy's
Southern California	InterQual National Coverage Decisions - NCD (These guidelines are determined by CMS) Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC) National Uniform Billing Committee (NUBC) standards Established Kaiser Permanente Policy's

Northern California	<p>InterQual</p> <p>National Coverage Decisions - NCD (These guidelines are determined by CMS)</p> <p>Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC)</p> <p>National Uniform Billing Committee (NUBC) standards</p> <p>Established Kaiser Permanente Policy's</p>
Hawaii	<p>MCG (Milliman Care Guidelines)</p> <p>National Coverage Decisions - NCD (These guidelines are determined by CMS)</p> <p>Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC)</p> <p>National Uniform Billing Committee (NUBC) standards</p> <p>Established Kaiser Permanente Policy's</p>
Northwest	<p>MCG (Milliman Care Guidelines)</p> <p>National Coverage Decisions - NCD (These guidelines are determined by CMS)</p> <p>Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC)</p> <p>National Uniform Billing Committee (NUBC) standards</p> <p>Established Kaiser Permanente Policy's</p>
Colorado	<p>MCG (Milliman Care Guidelines)</p> <p>National Coverage Decisions - NCD (These guidelines are determined by CMS)</p> <p>Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC)</p> <p>National Uniform Billing Committee (NUBC) standards</p> <p>Established Kaiser Permanente Policy's</p>

5. Decision is then sent back to RN via PA packet with decision and then updated in our tracking tool and complete any other reviews within our scope prior to sending the claim back to Claims operations with instructions.

Step 2 – Describe the reason for applying to the NQTL

Provide comparative analysis demonstrating that comparable factors are used to determine the applicability of the **NQTL** for MH/SUD benefits and for medical/surgical benefits.

Medical/Surgical	Mental Health/Substance Use Disorder
In review of Medical/Surgical inpatient admission processes, the factors used to determine applicability of retrospective review are based on inpatient services that; contractually require health plan prior authorization for coverage, care, service, procedure, admission, or equipment that is a higher cost than other acceptable alternatives.	National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.
<p>Factors Examples:</p> <div> <div> <input type="checkbox"/> Market price <input type="checkbox"/> Volume of service capacity <input type="checkbox"/> Geographic location <input type="checkbox"/> Disability accommodations <input type="checkbox"/> Community reputation </div> <div> <input type="checkbox"/> Value-added services <input type="checkbox"/> Languages spoken <input type="checkbox"/> multi-specialty co-location <input type="checkbox"/> Additional training/skills </div> </div>	
<p>Factors used to determine the need for inpatient retrospective review include:</p> <ul style="list-style-type: none"> -Delivery of medically necessary services to our members. -Physician Review -Payment meets contract and/or provider manual requirements -Compliance with billing and coding standards -Level of care effectiveness and/or appropriateness (excluding California) -Appropriate level of care (excluding California) -Mis or over-utilization -This could fall into our 30-day readmission review criteria for example: Poor discharge planning -Lack of prior authorization 	National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.
<p>Sources</p> <p>Examples of sources for data to identify factors:</p> <div> <input type="checkbox"/> Internal claims analyses <input type="checkbox"/> Internal quality standard studies <input type="checkbox"/> Expert medical review </div>	
Policies guiding retrospective review cover med/surg and are reviewed annually by Permanente Utilization Review Oversight Committee (UROC) to support administration of evidence-based medicine in the retrospective review process. In addition, Clinical Review partners with compliance, legal, operations, and our internal Medical Director to review and approve our	National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.

established Kaiser Permanente Policy whenever there are new additions or changes to the Policy.

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Examples of evidentiary standards, their sources, and other evidence considered include:

- ☐ Patient experience surveys
- ☐ Provider professional profiles
- ☐ Provider rating services
- ☐ Word of mouth/reputation

Medical/Surgical	Mental Health/Substance Use Disorder
<p>The evidentiary standards relied upon when defining the factors above are embedded in the National Payment Integrity (NPI) Clinical Review processes for determining payment for claims under review.</p> <p>Nationally Clinical Review References established Kaiser Permanente Policies, MCG Criteria (Regions outside of California), and InterQual (California).</p> <p>These policies support the factors with evidence from commonly accepted standards including CMS guidelines, National Uniform Billing Committee (NUBC) standards, professional and academic journals, and publications.</p> <p>Retrospective medical necessity determinations consider whether the care and treatment were:</p> <ul style="list-style-type: none">- Appropriate for the symptoms and diagnosis or treatment of the member's condition, illness, disease, or injury.- Provide for the diagnosis, direct care, and treatment of the medical condition.	<p>National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.</p>

- Meet the standard of good medical practice and is not mainly for the convenience of the provider or patient.

Nationally recognized medical criteria such as MCG or Kaiser Permanente medical policy criteria that has been thoroughly reviewed against evidence based medical research (reviewed by PMG) are used when reviewing retrospective cases for medical necessity.

Diagnosis Related Group (DRG) are also used to ensure diagnostic and procedural information and discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician's description and the information contained in the beneficiary's medical records.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
<p>Clinical Review is an essential part of the Claims organization and is an industry standard that Kaiser established to ensure fair and appropriate reimbursement.</p> <p>All Medical/Surgical reviews follow the organization's utilization review policy which is regulated by Kaiser Permanente NCQA accreditation as well as our Kaiser Permanente Clinical Review Payment Policy. The Utilization Review policy provides the framework for adding, revising, or removing criteria.</p> <p>The Clinical Review Payment Policy was designed to incorporate CMS criteria and regulations.</p>	<p>National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.</p>

The RNs who complete these reviews have clinical experience in the med surgery areas. If there is a finding by a clinical review RN, the next step would be to have a PA with clinical experience and with the appropriate licensure review the findings and make a final determination.

In addition to the use of the policies mentioned above, Kaiser Permanente also maintains compliance with state insurance regulations and turnaround times for retrospective review.

NW Only: The Inter-Rater Reliability (IRR) process provides Kaiser Permanente with oversight to retrospective review standards, accountabilities with a process. This ensures consistent application of medical necessity criteria by all utilization review staff (listed above) when making determinations regarding covered services or items.

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
<p>All regions (including NW): The RNs who complete these Medical Necessity reviews have clinical experience in the med surgery areas. If there is a finding by a clinical review RN, the next step would be to have a PA with clinical experience with the appropriate licensure review the findings and make a final determination.</p> <p>Clinical Review completes an internal Quality Assessment (QA) review based on Payment Policy Standards to ensure compliance. The target is to hit a 98% quality rating monthly. These reviews are completed on a weekly basis for all staff (Support and Clinical Staff). Clinical Review has Quality Criteria to measure accuracy and quality. The QA review is performed by the team lead and managers.</p>	<p>National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.</p>

NW Only: Medical/Surgical utilize the same framework in operationalizing the retrospective review process that is guided by the Kaiser Permanente Utilization Review Oversight Committee (UROC) and the Behavioral Health Utilization Review Committee, respectively

To ensure consistent use of criteria, all licensed healthcare providers for medical are required to complete an annual evaluation; called Inter-Rater Reliability. This process requires the staff to apply medical necessity criteria for fictional patients. The results of these tests are reviewed and discussed within the department to ensure consistent, and application of criteria are maintained.

The Inter-Rater Reliability study is an annual study utilized to evaluate the proper and consistent application of criteria.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

NCA's Clinical Review Team utilizes evidence from nationally recognized studies for Medical Surgical Services only. Clinical review utilizes medical necessity criteria from either nationally recognized organizations like MCG, and InterQual as well as established Kaiser Permanente Policies or internally by our Practice Leader in Evidence Based Medicine with oversight from Medical Director.

The application of these guidelines/criteria are audited regularly and in accordance with our NCQA Accreditation process. Our NCQA Accreditation has provided a very clear and regimented process when designing/reviewing the plans medical necessity criteria.

The application of retrospective review process is carried out in the same manner; from receipt of the request, application of the medical necessity criteria, to the requirement of a Medical Doctor to be the only person that can deny a prior authorization request. Clinical Review applies these checks and balances only for Med Surg services.

Benefit Classification 3: Outpatient – In Network

Prompt – Benefit / Service(s) to which the NQTL applies

Medical/Surgical	Mental Health/Substance Use Disorder
<p>Clinic Visits (Only when there is no authorization) - NW only</p> <p>Urgent Care (NW only out of service area)</p> <p>Laboratory Service (NW only when no authorization on file)</p> <p>Hospital OP Visits/Procedures (with exception of TPMG claims)</p> <p>Procedural OP (Facility bill only)</p>	<p>National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.</p>

Step 1 – Describe the NQTL's requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
<p>1. When a claim for a Kaiser Permanente member is received within the claim processing area and meets Payment Integrity Clinical Review (CR) Criteria, tapestry will apply the appropriate pend/hold code based on systemic criteria to route the claim to Clinical Review for review. Upon review if a Registered Nurse (RN) determines the service(s) listed on the claim, or a portion of the claim are not medically necessary or may be cosmetic; or may be experimental/ investigational then the RN will provide the narrative which includes claim details, history, and direction on where to find medical documentation in the system and route the claim to a Physician Advisor (PA) to review for the final decision. If there is not a finding or full authorization for the services billed, Clinical Review would review for any additional clinical review capability that is in scope prior to sending back to claims operations.</p> <p>2. Cases that require retrospective review are completed by a Retrospective RN reviewer in National Claims Administration for Med/Surg only.</p> <p>3. A retrospective review is completed using medical necessity criteria consistent with prior authorization.</p> <p>4. Physician Advisor (PA) will review claims for what may not be medically necessary or may be cosmetic; or may be experimental/ investigational based off RN assessment and make decision to deny or allow charges. The decision to approve or deny these services are based on the following:</p> <ul style="list-style-type: none"> - Member benefits - Input from Evidence based Medicine Team. 	<p>National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.</p>

- Additional applicable resources:

Georgia	<p>MCG (Milliman Care Guidelines) National Coverage Decisions - NCD (These guidelines are determined by CMS) Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC) National Uniform Billing Committee (NUBC) standards Established Kaiser Permanente Policy's</p>
Mid-Atlantic States (Wash. DC/ Virginia/ Maryland)	<p>MCG (Milliman Care Guidelines) National Coverage Decisions - NCD (These guidelines are determined by CMS) Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC) National Uniform Billing Committee (NUBC) standards Established Kaiser Permanente Policy's</p>
Southern California	<p>InterQual National Coverage Decisions - NCD (These guidelines are determined by CMS) Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC) National Uniform Billing Committee (NUBC) standards Established Kaiser Permanente Policy's</p>
Northern California	<p>InterQual National Coverage Decisions - NCD (These guidelines are determined by CMS) Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC) National Uniform Billing Committee (NUBC) standards Established Kaiser Permanente Policy's</p>

Hawaii	MCG (Milliman Care Guidelines) National Coverage Decisions - NCD (These guidelines are determined by CMS) Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC) National Uniform Billing Committee (NUBC) standards Established Kaiser Permanente Policy's
Northwest	MCG (Milliman Care Guidelines) National Coverage Decisions - NCD (These guidelines are determined by CMS) Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC) National Uniform Billing Committee (NUBC) standards Established Kaiser Permanente Policy's
Colorado	MCG (Milliman Care Guidelines) National Coverage Decisions - NCD (These guidelines are determined by CMS) Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC) National Uniform Billing Committee (NUBC) standards Established Kaiser Permanente Policy's

5. Decision is then sent back to RN via PA packet with decision and then updated in our tracking tool and complete any other reviews within our scope prior to sending the claim back to Claims operations with instructions.

Step 2 – Describe the reason for applying to the NQTL

Provide comparative analysis demonstrating that comparable factors are used to determine the applicability of the **NQTL** for MH/SUD benefits and for medical/surgical benefits.

Medical/Surgical	Mental Health/Substance Use Disorder
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<p>In review of Medical/Surgical outpatient processes, the factors used to determine applicability of retrospective review are based on outpatient services that; contractually require health plan prior authorization for coverage, care, service, procedure, or equipment that is a higher cost than other acceptable alternatives.</p>	<p>National Claims Administration’s (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.</p>
<p style="text-align: center;">Factors Examples:</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <ul style="list-style-type: none"> ☐ Market price ☐ Volume of service capacity ☐ Geographic location ☐ Disability accommodations ☐ Community reputation </div> <div style="width: 45%;"> <ul style="list-style-type: none"> ☐ Value-added services ☐ Languages spoken ☐ multi-specialty co-location ☐ Additional training/skills </div> </div>	
<p>Factors used to determine the need for outpatient retrospective review include:</p> <ul style="list-style-type: none"> -Delivery of medically necessary services to our members. -Physician Review -Payment meets contract and/or provider manual requirements -Compliance with billing and coding standards -Level of care effectiveness and/or appropriateness (excluding California) -Appropriate level of care (excluding California) -Mis or over-utilization -Lack of prior authorization 	<p>National Claims Administration’s (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.</p>
<p style="text-align: center;">Sources</p> <p style="text-align: center;">Examples of sources for data to identify factors:</p> <ul style="list-style-type: none"> ☐ Internal claims analyses ☐ Internal quality standard studies ☐ Expert medical review 	
<p>Policies guiding retrospective review cover med/surg are reviewed annually by Permanente Utilization Review Oversight Committee (UROC) to support administration of evidence-based medicine in the retrospective review process. In addition, Clinical Review partners with compliance, legal, operations, and our internal Medical Director to review and approve our established Kaiser Permanente Policy whenever there are new additions or changes to the Policy.</p>	<p>National Claims Administration’s (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.</p>

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Examples of evidentiary standards, their sources, and other evidence considered include:

- ☐ Patient experience surveys
- ☐ Provider professional profiles
- ☐ Provider rating services
- ☐ Word of mouth/reputation

Medical/Surgical	Mental Health/Substance Use Disorder
<p>The evidentiary standards relied upon when defining the factors above are embedded in the National Payment Integrity (NPI) Clinical Review processes for determining payment for claims under review.</p> <p>Nationally Clinical Review References established Kaiser Permanente Policies, MCG Criteria (Regions outside of California), and InterQual (California).</p> <p>These policies support the factors with evidence from commonly accepted standards including CMS guidelines, National Uniform Billing Committee (NUBC) standards, professional and academic journals, and publications.</p> <p>Retrospective medical necessity determinations consider whether the care and treatment were:</p> <ul style="list-style-type: none"> - Appropriate for the symptoms and diagnosis or treatment of the member's condition, illness, disease, or injury. - Provide for the diagnosis, direct care, and treatment of the medical condition. - Meet the standard of good medical practice and is not mainly for the convenience of the provider or patient. <p>Nationally recognized medical criteria such as MCG or Kaiser Permanente medical policy criteria that has been thoroughly reviewed against evidence based medical research (reviewed by PMG) are used when reviewing retrospective cases for medical necessity.</p>	<p>National Claims Administration’s (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.</p>

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
<p>Clinical Review is an essential part of the Claims organization and is an industry standard that Kaiser established to ensure fair and appropriate reimbursement.</p> <p>All Medical/Surgical reviews follow the organization's utilization review policy which is regulated by Kaiser Permanente NCQA accreditation as well as our Kaiser Permanente Clinical Review Payment Policy. The Utilization Review policy provides the framework for adding, revising, or removing criteria.</p> <p>The Clinical Review Payment Policy was designed to incorporate CMS criteria and regulations.</p> <p>The RNs who complete these reviews have clinical experience in the med surgery areas. If there is a finding by a clinical review RN, the next step would be to have a PA with clinical experience and with the appropriate licensure review the findings and make a final determination.</p> <p>In addition to the use of the policies mentioned above, Kaiser Permanente also maintains compliance with state insurance regulations and turnaround times for retrospective review.</p> <p>NW Only: The Inter-Rater Reliability (IRR) process provides Kaiser Permanente with oversight to retrospective review standards, accountabilities with a process. This ensures consistent application of medical necessity criteria by all utilization review staff (listed above) when making determinations regarding covered services or items.</p>	<p>National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.</p>



Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
<p>All regions (including NW): The RNs who complete these Medical Necessity reviews have clinical experience in the med surgery areas. If there is a finding by a clinical review RN, the next step would be to have a PA with clinical experience with the appropriate licensure review the findings and make a final determination.</p> <p>Clinical Review completes an internal Quality Assessment (QA) review based on Payment Policy Standards to ensure compliance. The target is to hit a 98% quality rating monthly. These reviews are completed on a weekly basis for all staff (Support and Clinical Staff). Clinical Review has Quality Criteria to measure accuracy and quality. The QA review is performed by the team lead and managers.</p> <p>NW Only: Medical/Surgical utilize the same framework in operationalizing the retrospective review process that is guided by the Kaiser Permanente Utilization Review Oversight Committee (UROC) and the Behavioral Health Utilization Review Committee, respectively</p> <p>To ensure consistent use of criteria, all licensed healthcare providers for medical are required to complete an annual evaluation; called Inter-Rater Reliability. This process requires the staff to apply medical necessity criteria for fictional patients. The results of these tests are reviewed and discussed within the department to ensure consistent, and application of criteria are maintained.</p> <p>The Inter-Rater Reliability study is an annual study utilized to evaluate the proper and consistent application of criteria.</p>	<p>National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.</p>

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

NCA's Clinical Review Team utilizes evidence from nationally recognized studies for Medical Surgical Services only. Clinical review utilizes medical necessity criteria from either nationally recognized organizations like MCG, and InterQual as well as established Kaiser Permanente Policies or internally by our Practice Leader in Evidence Based Medicine with oversight from Medical Director.

The application of these guidelines/criteria are audited regularly and in accordance with our NCQA Accreditation process. Our NCQA Accreditation has provided a very clear and regimented process when designing/reviewing the plans medical necessity criteria.

The application of retrospective review process is carried out in the same manner; from receipt of the request, application of the medical necessity criteria, to the requirement of a Medical Doctor to be the only person that can deny a prior authorization request. Clinical Review applies these checks and balances only for Med Surg services.

Benefit Classification 4: Outpatient – Out-of-Network

Prompt – Benefit / Service(s) to which the NQTL applies

Medical/Surgical	Mental Health/Substance Use Disorder
Clinic Visits (Only when there is no authorization) - NW only Urgent Care (NW only out of service area) Laboratory Service (NW only when no auth on file) Hospital OP Visits/Procedures (with exception of TPMG claims) Procedural OP (Facility bill only)	National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.

Step 1 – Describe the NQTL's requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
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1. When a claim for a Kaiser Permanente member is received within the claim processing area and meets Payment Integrity Clinical Review (CR) Criteria, tapestry will apply the appropriate pend/hold code based on systemic criteria to route the claim to Clinical Review for review. Upon review if a Registered Nurse (RN) determines the service(s) listed on the claim, or a portion of the claim are not medically necessary or may be cosmetic; or may be experimental/ investigational then the RN will provide the narrative which includes claim details, history, and direction on where to find medical documentation in the system and route the claim to a Physician Advisor (PA) to review for the final decision. If there is not a finding or full authorization for the services billed, Clinical Review would review for any additional clinical review capability that is in scope prior to sending back to claims operations.

2. Cases that require retrospective review are completed by a Retrospective RN reviewer in National Claims Administration for Med/Surg only.

3. A retrospective review is completed using medical necessity criteria consistent with prior authorization.

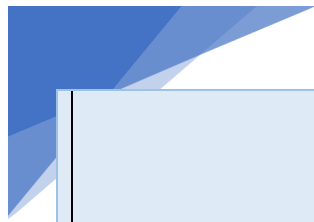
4. Physician Advisor (PA) will review claims for what may not be medically necessary or may be cosmetic; or may be experimental/ investigational based off RN assessment and make decision to deny or allow charges. The decision to approve or deny these services are based on the following:

- Member benefits
- Input from Evidence based Medicine Team.
- Additional applicable resources:

Georgia	MCG (Milliman Care Guidelines) National Coverage Decisions - NCD (These guidelines are determined by CMS) Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC) National Uniform Billing Committee (NUBC) standards Established Kaiser Permanente Policy's
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National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.

Mid-Atlantic States (Wash. DC/ Virginia/ Maryland)	<p>MCG (Milliman Care Guidelines) National Coverage Decisions - NCD (These guidelines are determined by CMS) Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC) National Uniform Billing Committee (NUBC) standards Established Kaiser Permanente Policy's</p>		
Southern California	<p>InterQual National Coverage Decisions - NCD (These guidelines are determined by CMS) Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC) National Uniform Billing Committee (NUBC) standards Established Kaiser Permanente Policy's</p>		
Northern California	<p>InterQual National Coverage Decisions - NCD (These guidelines are determined by CMS) Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC) National Uniform Billing Committee (NUBC) standards Established Kaiser Permanente Policy's</p>		
Hawaii	<p>MCG (Milliman Care Guidelines) National Coverage Decisions - NCD (These guidelines are determined by CMS) Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC) National Uniform Billing Committee (NUBC) standards Established Kaiser Permanente Policy's</p>		



Northwest	MCG (Milliman Care Guidelines) National Coverage Decisions - NCD (These guidelines are determined by CMS) Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC) National Uniform Billing Committee (NUBC) standards Established Kaiser Permanente Policy's
Colorado	MCG (Milliman Care Guidelines) National Coverage Decisions - NCD (These guidelines are determined by CMS) Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC) National Uniform Billing Committee (NUBC) standards Established Kaiser Permanente Policy's

5. Decision is then sent back to RN via PA packet with decision and then updated in our tracking tool and complete any other reviews within our scope prior to sending the claim back to Claims operations with instructions.

Step 2 – Describe the reason for applying to the NQTL

Provide comparative analysis demonstrating that comparable factors are used to determine the applicability of the **NQTL** for MH/SUD benefits and for medical/surgical benefits.

Medical/Surgical	Mental Health/Substance Use Disorder
In review of Medical/Surgical outpatient processes, the factors used to determine applicability of retrospective review are based on outpatient services that; contractually require health plan prior authorization for coverage, care, service, procedure, or equipment that is a higher cost than other acceptable alternatives.	National Claims Administration’s (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.
Factors Examples:	

<ul style="list-style-type: none"> ☐ Market price ☐ Volume of service capacity ☐ Geographic location ☐ Disability accommodations ☐ Community reputation 	<ul style="list-style-type: none"> ☐ Value-added services ☐ Languages spoken ☐ multi-specialty co-location ☐ Additional training/skills
<p>Factors used to determine the need for outpatient retrospective review include:</p> <ul style="list-style-type: none"> -Delivery of medically necessary services to our members. -Physician Review -Payment meets contract and/or provider manual requirements -Compliance with billing and coding standards -Level of care effectiveness and/or appropriateness (excluding California) -Appropriate level of care (excluding California) -Mis or over-utilization -Lack of prior authorization 	<p>National Claims Administration’s (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.</p>
<p style="text-align: center;">Sources</p> <p style="text-align: center;">Examples of sources for data to identify factors:</p> <ul style="list-style-type: none"> ☐ Internal claims analyses ☐ Internal quality standard studies ☐ Expert medical review 	
<p>Policies guiding retrospective review cover med/surg are reviewed annually by Permanente Utilization Review Oversight Committee (UROC) to support administration of evidence-based medicine in the retrospective review process. In addition, Clinical Review partners with compliance, legal, operations, and our internal Medical Director to review and approve our established Kaiser Permanente Policy whenever there are new additions or changes to the Policy.</p>	<p>National Claims Administration’s (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.</p>

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Examples of evidentiary standards, their sources, and other evidence considered include:

- ☐ Patient experience surveys

- ☐ Provider professional profiles
- ☐ Provider rating services
- ☐ Word of mouth/reputation

Medical/Surgical	Mental Health/Substance Use Disorder
<p>The evidentiary standards relied upon when defining the factors above are embedded in the National Payment Integrity (NPI) Clinical Review processes for determining payment for claims under review.</p> <p>Nationally Clinical Review References established Kaiser Permanente Policies, MCG Criteria (Regions outside of California), and InterQual (California).</p> <p>These policies support the factors with evidence from commonly accepted standards including CMS guidelines, National Uniform Billing Committee (NUBC) standards, professional and academic journals, and publications.</p> <p>Retrospective medical necessity determinations consider whether the care and treatment were:</p> <ul style="list-style-type: none"> - Appropriate for the symptoms and diagnosis or treatment of the member's condition, illness, disease, or injury. - Provide for the diagnosis, direct care, and treatment of the medical condition. - Meet the standard of good medical practice and is not mainly for the convenience of the provider or patient. <p>Nationally recognized medical criteria such as MCG or Kaiser Permanente medical policy criteria that has been thoroughly reviewed against evidence based medical research (reviewed by PMG) are used when reviewing retrospective cases for medical necessity.</p>	<p>National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.</p>

Step 4 – Processes and strategies used to design NQTL as written

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

These processes may include, but are not limited to, the composition and deliberations of decision-making staff, e.g., the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence

considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations.

Medical/Surgical	Mental Health/Substance Use Disorder
<p>Clinical Review is an essential part of the Claims organization and is an industry standard that Kaiser established to ensure fair and appropriate reimbursement.</p> <p>All Medical/Surgical reviews follow the organization's utilization review policy which is regulated by Kaiser Permanente NCQA accreditation as well as our Kaiser Permanente Clinical Review Payment Policy. The Utilization Review policy provides the framework for adding, revising, or removing criteria.</p> <p>The Clinical Review Payment Policy was designed to incorporate CMS criteria and regulations.</p> <p>The RNs who complete these reviews have clinical experience in the med surgery areas. If there is a finding by a clinical review RN, the next step would be to have a PA with clinical experience and with the appropriate licensure review the findings and make a final determination.</p> <p>In addition to the use of the policies mentioned above, Kaiser Permanente also maintains compliance with state insurance regulations and turnaround times for retrospective review.</p> <p>NW Only: The Inter-Rater Reliability (IRR) process provides Kaiser Permanente with oversight to retrospective review standards, accountabilities with a process. This ensures consistent application of medical necessity criteria by all utilization review staff (listed above) when making determinations regarding covered services or items.</p>	<p>National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.</p>

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
<p>All regions (including NW): The RNs who complete these Medical Necessity reviews have clinical experience in the med surgery areas. If there is a finding by a clinical review RN, the next step would be to have a PA with clinical experience with the appropriate licensure review the findings and make a final determination.</p> <p>Clinical Review completes an internal Quality Assessment (QA) review based on Payment Policy Standards to ensure compliance. The target is to hit a 98% quality rating monthly. These reviews are completed on a weekly basis for all staff (Support and Clinical Staff). Clinical Review has Quality Criteria to measure accuracy and quality. The QA review is performed by the team lead and managers.</p> <p>NW Only: Medical/Surgical utilize the same framework in operationalizing the retrospective review process that is guided by the Kaiser Permanente Utilization Review Oversight Committee (UROC) and the Behavioral Health Utilization Review Committee, respectively</p> <p>To ensure consistent use of criteria, all licensed healthcare providers for medical are required to complete an annual evaluation; called Inter-Rater Reliability. This process requires the staff to apply medical necessity criteria for fictional patients. The results of these tests are reviewed and discussed within the department to ensure consistent, and application of criteria are maintained.</p> <p>The Inter-Rater Reliability study is an annual study utilized to evaluate the proper and consistent application of criteria.</p>	<p>National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.</p>

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

NCA's Clinical Review Team utilizes evidence from nationally recognized studies for Medical Surgical Services only. Clinical review utilizes medical necessity criteria from either nationally recognized organizations like MCG, and InterQual as well as established Kaiser Permanente Policies or internally by our Practice Leader in Evidence Based Medicine with oversight from Medical Director.

The application of these guidelines/criteria are audited regularly and in accordance with our NCQA Accreditation process. Our NCQA Accreditation has provided a very clear and regimented process when designing/reviewing the plans medical necessity criteria.

The application of retrospective review process is carried out in the same manner; from receipt of the request, application of the medical necessity criteria, to the requirement of a Medical Doctor to be the only person that can deny a prior authorization request. Clinical Review applies these checks and balances only for Med Surg services.

Benefit Classification 5: Emergency Services

Prompt – Benefit / Service(s) to which the NQTL applies

Medical/Surgical	Mental Health/Substance Use Disorder
Emergency visits Medical/Surgical and Behavioral Health (In regard to Behavioral Health we may review the medical portion of the Emergency (ED) bill ONLY) Emergency Observation Medical/Surgical and Behavioral Health includes psychiatric crisis stabilization (In regard to Behavioral Health we may review the medical portion of the ED bill ONLY)	National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.

Step 1 – Describe the NQTL's requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
1. When a claim for a Kaiser Permanente member is received within the claim processing area and meets Payment Integrity Clinical Review (CR) Criteria, tapestry will apply the appropriate pend/hold code based on systemic criteria to route the claim to Clinical Review for review. Upon review if a Registered Nurse (RN) determines the service(s) listed on the claim, or a portion of the claim are not medically necessary or may be cosmetic; or may be experimental/ investigational then the RN will provide the narrative which includes claim details, history, and direction on where to find	National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.

medical documentation in the system and route the claim to a Physician Advisor (PA) to review for the final decision. If there is not a finding or full authorization for the services billed, Clinical Review would review for any additional clinical review capability that is in scope prior to sending back to claims operations.

2. Cases that require retrospective review are completed by a Retrospective RN reviewer in National Claims Administration for Med/Surg only.

3. A retrospective review is completed using medical necessity criteria

4. Physician Advisor (PA) will review claims for what may not be medically necessary or may be cosmetic; or may be experimental/ investigational based off RN assessment and make decision to deny or allow charges. The decision to approve or deny these services are based on the following:

- Member benefits
- Input from Evidence based Medicine Team.
- Additional applicable resources:

Georgia	MCG (Milliman Care Guidelines) National Coverage Decisions - NCD (These guidelines are determined by CMS) Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC) National Uniform Billing Committee (NUBC) standards Established Kaiser Permanente Policy's
Mid-Atlantic States (Wash. DC/ Virginia/ Maryland)	MCG (Milliman Care Guidelines) National Coverage Decisions - NCD (These guidelines are determined by CMS) Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC) National Uniform Billing Committee (NUBC) standards Established Kaiser Permanente Policy's

Southern California	<p>InterQual</p> <p>National Coverage Decisions - NCD (These guidelines are determined by CMS)</p> <p>Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC)</p> <p>National Uniform Billing Committee (NUBC) standards</p> <p>Established Kaiser Permanente Policy's</p>
Northern California	<p>InterQual</p> <p>National Coverage Decisions - NCD (These guidelines are determined by CMS)</p> <p>Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC)</p> <p>National Uniform Billing Committee (NUBC) standards</p> <p>Established Kaiser Permanente Policy's</p>
Hawaii	<p>MCG (Milliman Care Guidelines)</p> <p>National Coverage Decisions - NCD (These guidelines are determined by CMS)</p> <p>Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC)</p> <p>National Uniform Billing Committee (NUBC) standards</p> <p>Established Kaiser Permanente Policy's</p>
Northwest	<p>MCG (Milliman Care Guidelines)</p> <p>National Coverage Decisions - NCD (These guidelines are determined by CMS)</p> <p>Local Coverage Decisions - LCD (These guidelines will vary by Medicare Administrative Contractor (MAC)</p> <p>National Uniform Billing Committee (NUBC) standards</p> <p>Established Kaiser Permanente Policy's</p>

Colorado

MCG
(Milliman Care Guidelines)
National Coverage Decisions - NCD (These
guidelines are determined by CMS)
Local Coverage Decisions - LCD (These
guidelines will vary by Medicare
Administrative Contractor (MAC)
National Uniform Billing Committee
(NUBC) standards
Established Kaiser Permanente Policy's

5. Decision is then sent back to RN via PA packet with decision and then updated in our tracking tool and complete any other reviews within our scope prior to sending the claim back to Claims operations with instructions.

Step 2 – Describe the reason for applying to the NQTL

Provide comparative analysis demonstrating that comparable factors are used to determine the applicability of the **NQTL** for MH/SUD benefits and for medical/surgical benefits.

Medical/Surgical	Mental Health/Substance Use Disorder
We will review for the medical portion of the ED bill that could include behavioral health services in the ED.	National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.
Factors Examples:	
<ul style="list-style-type: none"> ☐ Market price ☐ Volume of service capacity ☐ Geographic location ☐ Disability accommodations ☐ Community reputation 	<ul style="list-style-type: none"> ☐ Value-added services ☐ Languages spoken ☐ multi-specialty co-location ☐ Additional training/skills
Factors used to determine the need for ED review include: -Delivery of medically necessary services to our members. -Physician Review -Payment meets contract and/or provider manual requirements -Compliance with billing and coding standards -Level of care effectiveness and/or appropriateness (excluding California) -Appropriate level of care (excluding California) -Mis or over-utilization	National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.
Sources	
Examples of sources for data to identify factors:	

- ☑ Internal claims analyses
- ☑ Internal quality standard studies
- ☑ Expert medical review

Policies guiding retrospective review cover med/surg are reviewed annually by Permanente Utilization Review Oversight Committee (UROC) to support administration of evidence-based medicine in the retrospective review process. In addition, Clinical Review partners with compliance, legal, operations, and our internal Medical Director to review and approve our established Kaiser Permanente Policy whenever there are new additions or changes to the Policy.

National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Examples of evidentiary standards, their sources, and other evidence considered include:

- ☐ Patient experience surveys
- ☐ Provider professional profiles
- ☐ Provider rating services
- ☐ Word of mouth/reputation

Medical/Surgical	Mental Health/Substance Use Disorder
<p>We will review for the medical portion of the ED bill that could include behavioral health services in the ED.</p> <p>The evidentiary standards relied upon when defining the factors above are embedded in the National Payment Integrity (NPI) Clinical Review processes for determining payment for claims under review.</p> <p>Nationally Clinical Review References established Kaiser Permanente Policies, MCG Criteria (Regions outside of California), and InterQual (California).</p>	<p>National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.</p>

These policies support the factors with evidence from commonly accepted standards including CMS guidelines, National Uniform Billing Committee (NUBC) standards, professional and academic journals, and publications.

Retrospective medical necessity determinations consider whether the care and treatment were:

- Appropriate for the symptoms and diagnosis or treatment of the member's condition, illness, disease, or injury.
- Provide for the diagnosis, direct care, and treatment of the medical condition.
- Meet the standard of good medical practice and is not mainly for the convenience of the provider or patient.

Nationally recognized medical criteria such as MCG or Kaiser Permanente medical policy criteria that has been thoroughly reviewed against evidence based medical research (reviewed by PMG) are used when reviewing retrospective cases for medical necessity.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
<p>Clinical Review is an essential part of the Claims organization and is an industry standard that Kaiser established to ensure fair and appropriate reimbursement.</p> <p>All Medical/Surgical reviews follow the organization's utilization review policy which is regulated by Kaiser Permanente NCQA accreditation as well as our Kaiser Permanente Clinical Review Payment Policy. The</p>	<p>National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.</p>

Utilization Review policy provides the framework for adding, revising, or removing criteria.

The Clinical Review Payment Policy was designed to incorporate CMS criteria and regulations.

The RNs who complete these reviews have clinical experience in the med surgery areas. If there is a finding by a clinical review RN, the next step would be to have a PA with clinical experience and with the appropriate licensure review the findings and make a final determination.

In addition to the use of the policies mentioned above, Kaiser Permanente also maintains compliance with state insurance regulations and turnaround times for retrospective review.

NW Only: The Inter-Rater Reliability (IRR) process provides Kaiser Permanente with oversight to retrospective review standards, accountabilities with a process. This ensures consistent application of medical necessity criteria by all utilization review staff (listed above) when making determinations regarding covered services or items.

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
<p>All regions (including NW): The RNs who complete these Medical Necessity reviews have clinical experience in the med surgery areas. If there is a finding by a clinical review RN, the next step would be to have a PA with clinical experience with the appropriate licensure review the findings and make a final determination.</p> <p>Clinical Review completes an internal Quality Assessment (QA) review based on Payment Policy Standards to ensure compliance. The target is to hit a 98% quality rating</p>	<p>National Claims Administration's (NCA) Clinical Review Team does not include Mental Health/Substance Use Disorder services in the criteria for retrospective financial claims review.</p>

monthly. These reviews are completed on a weekly basis for all staff (Support and Clinical Staff). Clinical Review has Quality Criteria to measure accuracy and quality. The QA review is performed by the team lead and managers.

NW Only: Medical/Surgical utilize the same framework in operationalizing the retrospective review process that is guided by the Kaiser Permanente Utilization Review Oversight Committee (UROC) and the Behavioral Health Utilization Review Committee, respectively

To ensure consistent use of criteria, all licensed healthcare providers for medical are required to complete an annual evaluation; called Inter-Rater Reliability. This process requires the staff to apply medical necessity criteria for fictional patients. The results of these tests are reviewed and discussed within the department to ensure consistent, and application of criteria are maintained.

The Inter-Rater Reliability study is an annual study utilized to evaluate the proper and consistent application of criteria.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

NCA's Clinical Review Team utilizes evidence from nationally recognized studies for Medical Surgical Services only. Clinical review utilizes medical necessity criteria from either nationally recognized organizations like MCG, and InterQual as well as established Kaiser Permanente Policies or internally by our Practice Leader in Evidence Based Medicine with oversight from Medical Director.

The application of these guidelines/criteria are audited regularly and in accordance with our NCQA Accreditation process. Our NCQA Accreditation has provided a very clear and regimented process when designing/reviewing the plans medical necessity criteria.

The application of retrospective review process is carried out in the same manner; from receipt of the request, application of the medical necessity criteria, to the requirement of a Medical Doctor to be the only person that can deny a prior authorization request. Clinical Review applies these checks and balances only for Med Surg services.

Benefit Classification 6: Pharmacy Services

Prompt – Benefit / Service(s) to which the NQTL applies

Medical/Surgical	Mental Health/Substance Use Disorder
NCA's Clinical Review Team does not review Pharmacy Services	NCA's Clinical Review Team does not review Pharmacy Services

Step 1 – Describe the NQTL's requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

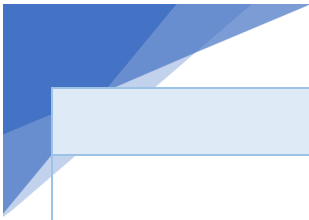
Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
NCA's Clinical Review Team does not review Pharmacy Services	NCA's Clinical Review Team does not review Pharmacy Services

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors are used to determine the applicability of the **NQTL** for MH/SUD benefits and for medical/surgical benefits.

Medical/Surgical	Mental Health/Substance Use Disorder
NCA's Clinical Review Team does not review Pharmacy Services	NCA's Clinical Review Team does not review Pharmacy Services
Factors Examples:	
<input type="checkbox"/> Market price <input type="checkbox"/> Volume of service capacity <input type="checkbox"/> Geographic location <input type="checkbox"/> Disability accommodations <input type="checkbox"/> Community reputation	<input type="checkbox"/> Value-added services <input type="checkbox"/> Languages spoken <input type="checkbox"/> multi-specialty co-location <input type="checkbox"/> Additional training/skills
NCA's Clinical Review Team does not review Pharmacy Services	NCA's Clinical Review Team does not review Pharmacy Services



Sources	
Examples of sources for data to identify factors: <ul style="list-style-type: none">☑ Internal claims analyses☑ Internal quality standard studies☑ Expert medical review	
NCA's Clinical Review Team does not review Pharmacy Services	NCA's Clinical Review Team does not review Pharmacy Services

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Examples of evidentiary standards, their sources, and other evidence considered include:

- ☐ Patient experience surveys
- ☐ Provider professional profiles
- ☐ Provider rating services
- ☐ Word of mouth/reputation

Medical/Surgical	Mental Health/Substance Use Disorder
NCA's Clinical Review Team does not review Pharmacy Services	NCA's Clinical Review Team does not review Pharmacy Services

Step 4 – Processes and strategies used to design NQTL as written

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

These processes may include, but are not limited to, the composition and deliberations of decision-making staff, e.g., the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence

considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations.

Medical/Surgical	Mental Health/Substance Use Disorder
NCA's Clinical Review Team does not review Pharmacy Services	NCA's Clinical Review Team does not review Pharmacy Services

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
NCA's Clinical Review Team does not review Pharmacy Services	NCA's Clinical Review Team does not review Pharmacy Services

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion
NCA's Clinical Review Team does not review Pharmacy Services



Date: December 19, 2023

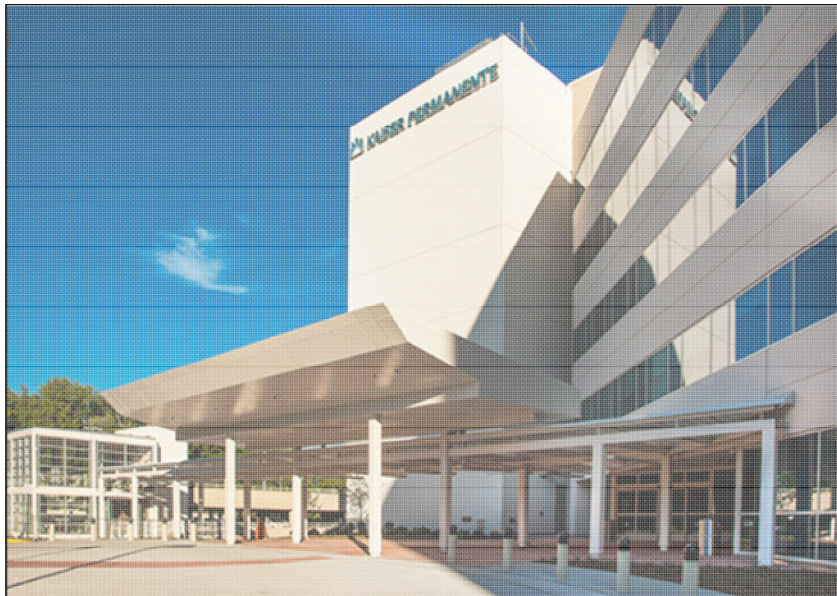
NQTL- Exclusions Based on Failure to Complete a Course of Treatment NQTL

Kaiser Permanente Insurance Company (KPIC) Georgia acknowledges the Exclusions Based on Failure to Complete a Course of Treatment NQTL. KPIC plans do not make any determinations for a course or episode of treatment based on failure to complete any previous treatments. KPIC conducts a medical necessity review utilizing applicably nationally recognized criteria such as American Society of Addiction Medicine (ASAM) guidelines/criteria for Substance Use Disorders, Milliman Care Guidelines (MCG™) for Medical / Surgical, as well as, Mental Health services and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people to ensure that the patient's current clinical condition is reviewed in the determination. This process is applied to Medical / Surgical, Mental Health and Substance Use Disorder classifications. Pharmacy Benefit Manager (PBM), MedImpact does not exclude pharmacy benefits based on failure to complete any previous treatments.

Source(s): Certificate of Insurance (COI) - Medical Necessity

Kaiser Permanente Insurance Company (KPIC) Georgia Region

Non-Quantitative Treatment Limits (NQTL)



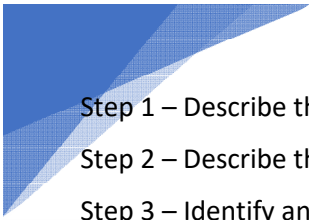
NQTL: First Fail/Step Therapy Georgia (PPO/POS)

Last Reviewed: 12/19/2023



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Benefits		Classifications					
Is NQTL applied to Medical/Surgical benefits?	Is NQTL applied to Mental Health/Substance Use Disorder benefits?	Is NQTL applied to In Network Inpatient classification?	Is NQTL applied to Out of Network Inpatient classification?	Is NQTL applied to In Network Outpatient classification?	Is NQTL applied to Out of Network Outpatient classification?	Is NQTL applied to Emergency classification?	Is NQTL applied to Prescription classification?
Y	Y	N	N	Y	Y	N	Y

Benefit Classification 1: Inpatient – In Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- Please refer to response in step 1.	N/A- Please refer to response in step 1.

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- Fail-first and step-therapy protocols are not required for inpatient in-network or inpatient out-of-network, Medical/Surgical, Mental Health, Behavioral Health or Substance Use Disorder services when utilized under the medical benefit.	N/A- Fail-first and step-therapy protocols are not required for inpatient in-network or inpatient out-of-network Medical/Surgical, Mental Health, Behavioral Health or Substance Use Disorder services when utilized under the medical benefit.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- Please refer to response in step 1.	N/A- Please refer to response in step 1.

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- Please refer to response in step 1.	N/A- Please refer to response in step 1.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- Please refer to response in step 1.	N/A- Please refer to response in step 1.

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- Please refer to response in step 1.	N/A- Please refer to response in step 1.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer’s conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes,

strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

N/A- Please refer to response in step 1.

Benefit Classification 2: Inpatient – Out-of-Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- Please refer to response in step 1.	N/A- Please refer to response in step 1.

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- Fail-first and step-therapy protocols are not required for inpatient in-network or inpatient out-of-network Medical/Surgical, Mental Health, Behavioral Health or Substance Use Disorder services when utilized under the medical benefit.	N/A- Fail-first and step-therapy protocols are not required for inpatient in-network or inpatient out-of-network Medical/Surgical, Mental Health, Behavioral Health or Substance Use Disorder services when utilized under the medical benefit.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- Please refer to response in step 1.	N/A- Please refer to response in step 1.

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- Please refer to response in step 1.	N/A- Please refer to response in step 1.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- Please refer to response in step 1.	N/A- Please refer to response in step 1.

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- Please refer to response in step 1.	N/A- Please refer to response in step 1.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer’s conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion
N/A- Please refer to response in step 1.

Benefit Classification 3: Outpatient – In Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage POS:</u> N/A	<u>Permanente Advantage POS:</u> N/A
<u>Permanente Advantage PPO:</u> Clinically Administered Prescriptions/Medications	<u>Permanente Advantage PPO:</u> N/A- Please refer to response in step 1.

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage PPO:</u> <u>Step Therapy</u> Selected prescription drugs require step therapy. Step therapy defines how and when a particular outpatient prescription drug can be dispensed and establishes the specific sequence in which prescription drugs for a specified condition are deemed medically appropriate. Step therapy requires the use of one or more prerequisite drugs (first line agents), as identified through a member’s drug history, prior to the use of another drug (second line agent) when prescribed for their condition. The step therapy process encourages safe and cost-effective medication use. Under this process, a “step” approach is required to receive coverage for certain medications. This means that to receive coverage the member may first need to try a proven, cost-effective medication different than the one prescribed. A member’s prescribing Provider should prescribe a first-line medication appropriate for their condition. If the member’s prescribing Provider determines that a first-line drug is not appropriate or effective for them, a second line drug may be covered if they qualify for a step therapy exception. Treatment decisions are always between the member and their Prescribing Provider. <u>Step Therapy Exception and Appeals Process</u> A step therapy exception may be granted if the member’s prescribing Provider submits justification and supporting clinical documentation that meets Medically Necessary criteria. The	N/A- Fail-first and step-therapy protocols are not required for outpatient in-network or outpatient out-of-network Mental Health, Behavioral Health or Substance Use Disorder services when utilized under the medical benefit.

exception process may be initiated by contacting KPIC. This exception process only applies to prescription drugs that are covered under this Plan.

Medically Necessary means the service that, in the judgement of KPIC are:

1. Essential for the diagnosis and treatment of Covered Person's injury or sickness;
2. In accord with generally accepted medical practice and professional recognized standards in the community;
3. Appropriate with regard to standards of medical care;
4. Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;
5. Not provided solely for the convenience of the covered person or the convenience of the healthcare provider or facility;
6. Not primarily custodial care; and
7. Provided at the most appropriate supply, level and facility.

When applied to confinement in a hospital or other facility, this test means the Covered Person needs to be confined to as an inpatient due to the nature of the services rendered or due to the Covered Person's condition and that the Covered Person cannot receive safe and adequate care through outpatient treatment.

The fact that a physician may prescribe, authorize, or direct a service, does not in itself make it Medically Necessary or covered by the Group Policy

Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person's health care needs; and (3) manages Your plan of care.

Precertification/Precertified means the required assessment of the necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review Program. If the Medical Review Program determines that the care is not Medically Necessary, Precertification will be denied. The Medical Review Program may be contacted twenty-four (24) hours per day, seven days per week. Precertification must be obtained for all Hospital stays and certain other services and procedures. Request for Precertification must be made by the Covered Person, the Covered Person's attending Physician, or the Covered Person's authorized representative prior to the commencement of any service or treatment. If Your services are provided by a Kaiser Permanente Provider, the Kaiser Permanente Provider will arrange for any necessary Precertification on Your behalf. If Precertification is required, it must be obtained to avoid a reduction in benefits. It is important to work with your provider to be certain services are Precertified when required or you will pay for the cost of the service.

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage completes the medical necessity reviews for KPIC Plans. Medical necessity Review is required for some outpatient medications / prescriptions that are administered in the clinic / outpatient setting which are covered under the member's medical benefit. Per nationally recognized evidence-based medical necessity criteria these medications may require other types, or levels of treatment to be completed before the requested medication / treatment can be approved which is step therapy. For example, with Botox for Migraines the use of a preventative medication (beta-blocker, tricyclic antidepressant, or anticonvulsant) must be ineffective or not tolerated for a trial of at least 3 months (per MCG A-0296 Onabotulinumtoxin A).

Permanente Advantage utilizes the same Medical Necessity Review procedures and forms for all types of requests. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. Permanente Advantage applies relevant Utilization Management (UM) criteria to make medical necessity decisions. This 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 approved by the Utilization Management and Quality Management Committee. Permanente Advantage utilizes evidence-based criteria/guidelines, such as Milliman Care Guidelines (MCG™) for Med/Surg. Medical Necessity decisions are based on sound clinical evidence to make utilization decisions and specifies procedures for appropriately applying the criteria. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Medical Necessity cases are reviewed and processed within the regulatory turnaround times.

Qualifications/Training:

The UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing Medical Necessity Reviews are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each Medical Necessity Review. If any of the attributes indicate that the UM criteria are not appropriate, the case is referred to the UM Physician Reviewer for discussion, and final decision. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage PPO:</u></p> <p>Factors</p> <p>Variability and/or lack of adherence to criteria Provider discretion and variation in determining medical necessity Clinical effectiveness of the treatment or service Appropriate level of care Severity or chronicity of medical surgical (M/S)</p> <p>Sources</p> <p>National Accreditation standards Electronic medical record Internal and external medical necessity requirements Certification of Insurance</p>	<p><u>Permanente Advantage PPO:</u> N/A- Please refer to response in step 1.</p>

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage PPO:</u></p> <p>The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services.</p> <p>Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as Milliman Care Guidelines (MCG™) are utilized for M/S services. This standard applies to the following factors:</p>	<p><u>Permanente Advantage PPO:</u> N/A- Please refer to response in step 1.</p>

Medical/Surgical

Mental Health/Substance Use Disorder

1. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity:
 - a. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards.
2. Effectiveness of the treatment or service:
 - a. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes.
3. Severity or chronicity of the M/S conditions:
 - a. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.
4. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, effectiveness of the treatment or service, severity or and chronicity of the M/S conditions.
5. Claim cost if the utilization of services or treatment is in-network utilizing direct contracts (per diem), rental network and/or letter of agreements (% of billed charges); out-of-network (100%) billed charges for facilities. This standard applies to the following factors: High variability of cost of care per episode.
 - a. Utilization Management (pre-certification / concurrent review) assists in managing costs, ensure medical necessity, and reducing unnecessary services. Our ability to encourage or channel patient's to in-network providers or obtain letter of agreement for out-of-network providers (continuity of care, network inadequacy, transition of care) reduces variability in cost of care and reduces cost share of Covered Persons and reduces the cost of care. Improving quality of care by using evidence-based criteria reduces variability or reduction of cost of care.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage PPO:</u> Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.	<u>Permanente Advantage PPO:</u> N/A- Please refer to response in step 1.

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage PPO:</u> Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.	<u>Permanente Advantage PPO:</u> N/A- Please refer to response in step 1.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion
<u>Permanente Advantage PPO:</u> Permanente Advantage reviewed the clinically administered medications that require step therapy that are covered under the medical benefit and there are none for MH/SUD medications. Therefore, Permanente Advantage concludes that as written and in operation, the UM policies, process, factors, and evidentiary standards used to develop and apply Medical Necessity Review for the Step Therapy NQTL for all MH/SUD In Network Outpatient services is less stringent than M/S for the KPIC plans, and therefore are compliant with the final regulation of the Mental Health Parity and Addiction Equity Act.

Benefit Classification 4: Outpatient – Out-of-Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage PPO & POS:</u> Clinically Administered Prescriptions/Medications	<u>Permanente Advantage PPO & POS:</u> N/A- Please refer to response in step 1.

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage PPO & POS:</u> <u>Step Therapy</u> Selected prescription drugs require step therapy. Step therapy defines how and when a particular outpatient prescription drug can be dispensed and establishes the specific sequence in which prescription drugs for a specified condition are deemed medically appropriate. Step therapy requires the use of one or more prerequisite drugs (first line agents), as identified through a member’s drug history, prior to the use of another drug (second line agent) when prescribed for their condition. The step therapy process encourages safe and cost-effective medication use. Under this process, a “step” approach is required to receive coverage for certain medications. This means that to receive coverage the member may first need to try a proven, cost-effective medication different than the one prescribed. A member’s prescribing Provider should prescribe a first-line medication appropriate for their condition. If the member’s prescribing Provider determines that a first-line drug is not appropriate or effective for them, a second line drug may be covered if they qualify for a step therapy exception. Treatment decisions are always between the member and their Prescribing Provider. <u>Step Therapy Exception and Appeals Process</u> A step therapy exception may be granted if the member’s prescribing Provider submits justification and supporting clinical documentation that meets Medically Necessary criteria. The exception process may be initiated by contacting KPIC. This exception process only applies to prescription drugs that are covered under this Plan.	<u>Permanente Advantage PPO & POS:</u> N/A- Fail-first and step-therapy protocols are not required for outpatient in-network or outpatient out-of-network Mental Health, Behavioral Health or Substance Use Disorder services when utilized under the medical benefit.

Medically Necessary means the service that, in the judgement of KPIC are:

1. Essential for the diagnosis and treatment of Covered Person's injury or sickness;
2. In accord with generally accepted medical practice and professional recognized standards in the community;
3. Appropriate with regard to standards of medical care;
4. Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;
5. Not provided solely for the convenience of the covered person or the convenience of the healthcare provider or facility;
6. Not primarily custodial care; and
7. Provided at the most appropriate supply, level and facility.

When applied to confinement in a hospital or other facility, this test means the Covered Person needs to be confined to as an inpatient due to the nature of the services rendered or due to the Covered Person's condition and that the Covered Person cannot receive safe and adequate care through outpatient treatment.

The fact that a physician may prescribe, authorize, or direct a service, does not in itself make it Medically Necessary or covered by the Group Policy

Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person's health care needs; and (3) manages Your plan of care.

Precertification/Precertified means the required assessment of the necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review Program. If the Medical Review Program determines that the care is not Medically Necessary, Precertification will be denied. The Medical Review Program may be contacted twenty-four (24) hours per day, seven days per week. Precertification must be obtained for all Hospital stays and certain other services and procedures. Request for Precertification must be made by the Covered Person, the Covered Person's attending Physician, or the Covered Person's authorized representative prior to the commencement of any service or treatment. If Your services are provided by a Kaiser Permanente Provider, the Kaiser Permanente Provider will arrange for any necessary Precertification on Your behalf. If Precertification is required, it must be obtained to avoid a reduction in benefits. It is important to work with your provider to be certain services are Precertified when required or you will pay for the cost of the service.

Permanente Advantage completes the medical necessity reviews for KPIC Plans. Medical necessity Review is required for some outpatient medications / prescriptions that are administered in the clinic / outpatient setting which are covered

Medical/Surgical

Mental Health/Substance Use Disorder

under the member's medical benefit. Per nationally recognized evidence-based medical necessity criteria these medications may require other types, or levels of treatment to be completed before the requested medication / treatment can be approved which is step therapy. For example, with Botox for Migraines the use of a preventative medication (beta-blocker, tricyclic antidepressant, or anticonvulsant) must be ineffective or not tolerated for a trial of at least 3 months (per MCG A-0296 Onabotulinumtoxin A).

Permanente Advantage utilizes the same Medical Necessity Review procedures and forms for all types of requests. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. Permanente Advantage applies relevant Utilization Management (UM) criteria to make medical necessity decisions. This 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 approved by the Utilization Management and Quality Management Committee. Permanente Advantage utilizes evidence-based criteria/guidelines, such as Milliman Care Guidelines (MCG™) for Med/Surg. Medical Necessity decisions are based on sound clinical evidence to make utilization decisions and specifies procedures for appropriately applying the criteria. For approved services written notification is provided to the member; both verbal and written notifications are provided to the referring provider/facility. For denied services both verbal and written notification are provided to both the referring provider/facility and the member/member's representative. The denial letter will include information on how to file for an appeal. Medical Necessity cases are reviewed and processed within the regulatory turnaround times.

Qualifications/Training:

The UM team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing Medical Necessity Reviews are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each Medical Necessity Review. If any of the attributes indicate that the UM criteria are not appropriate, the case is referred to the UM Physician Reviewer for discussion, and final decision. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a

definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage PPO & POS:</u></p> <p>Factors</p> <p>Variability and/or lack of adherence to criteria</p> <p>Provider discretion and variation in determining medical necessity</p> <p>Clinical effectiveness of the treatment or service</p> <p>Appropriate level of care</p> <p>Severity or chronicity of medical surgical (M/S)</p> <p>Sources</p> <p>National Accreditation standards</p> <p>Electronic medical record</p> <p>Internal and external medical necessity requirements</p> <p>Certification of Insurance</p>	<p><u>Permanente Advantage PPO & POS:</u></p> <p>N/A- Please refer to response in step 1.</p>

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage PPO & POS:</u></p> <p>The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services.</p> <p>Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as Milliman Care Guidelines (MCG™) are utilized for M/S services. This standard applies to the following factors:</p> <ol style="list-style-type: none"> 1. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity: <ol style="list-style-type: none"> a. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care 	<p><u>Permanente Advantage PPO & POS:</u></p> <p>N/A- Please refer to response in step 1.</p>

Medical/Surgical

Mental Health/Substance Use Disorder

guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards.

2. Effectiveness of the treatment or service:

a. MCG is the gold standard guidelines in eliminating redundant or unnecessary services, provides the right treatment, the right care, the right cost, and right level of care. Analysis of data and benchmarking regional and national outcomes, length of stay, utilization rates, and assists in clinical improvement opportunities to improve effectiveness of care and outcomes.

3. Severity or chronicity of the M/S conditions:

a. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.

4. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, effectiveness of the treatment or service, severity or and chronicity of the M/S conditions.

5. Claim cost if the utilization of services or treatment is in-network utilizing direct contracts (per diem), rental network and/or letter of agreements (% of billed charges); out-of-network (100%) billed charges for facilities. This standard applies to the following factors: High variability of cost of care per episode.

a. Utilization Management (pre-certification / concurrent review) assists in managing costs, ensure medical necessity, and reducing unnecessary services. Our ability to encourage or channel patient's to in-network providers or obtain letter of agreement for out-of-network providers (continuity of care, network inadequacy, transition of care) reduces variability in cost of care and reduces cost share of Covered Persons and reduces the cost of care. Improving quality of care by using evidence-based criteria reduces variability or reduction of cost of care.

Step 4 – Processes and strategies used to design NQTL as written

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

These processes may include, but are not limited to, the composition and deliberations of decision-making staff, e.g., the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence

considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations.

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage PPO & POS:</u> Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.	<u>Permanente Advantage PPO & POS:</u> N/A- Please refer to response in step 1.

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage PPO & POS:</u> Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.	<u>Permanente Advantage PPO & POS:</u> N/A- Please refer to response in step 1.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion
<u>Permanente Advantage PPO & POS:</u> Permanente Advantage reviewed the clinically administered medications that require step therapy that are covered under the medical benefit and there are none for MH/SUD medications. Therefore, Permanente Advantage concludes that as written and in operation, the UM policies, process, factors, and evidentiary standards used to develop and apply Medical Necessity Review for the Step Therapy NQTL for all MH/SUD In Network Outpatient services is less stringent than M/S for the KPIC plans, and therefore are compliant with the final regulation of the Mental Health Parity and Addiction Equity Act.

Benefit Classification 5: Emergency Services

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- Please refer to response in step 1.	N/A- Please refer to response in step 1.

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- Fail-first and step-therapy protocols are not required for Emergency Services Medical/Surgical, Mental Health, Behavioral Health or Substance Use Disorder services when utilized under the medical benefit.	N/A- Fail-first and step-therapy protocols are not required for Emergency Services Medical/Surgical, Mental Health, Behavioral Health or Substance Use Disorder services when utilized under the medical benefit.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- Please refer to response in step 1.	N/A- Please refer to response in step 1.

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- Please refer to response in step 1.	N/A- Please refer to response in step 1.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- Please refer to response in step 1.	N/A- Please refer to response in step 1.

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- Please refer to response in step 1.	N/A- Please refer to response in step 1.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion
N/A- Please refer to response in step 1.

Benefit Classification 6: Pharmacy Services

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
<u>POS</u>	<u>POS</u>

Medical/Surgical	Mental Health/Substance Use Disorder
Kaiser does not utilize First Fail/Step Therapy for this plan for prescription drugs (self-administered)	Kaiser does not utilize First Fail/Step Therapy for this plan for prescription drugs (self-administered)
<u>PPO</u> Prescription drugs (self-administered)	<u>PPO</u> Prescription drugs (self-administered)

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>POS:</u> N/A</p> <p><u>PPO</u> Step Therapy (ST) is the practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug and progressing to other more costly or risky therapy, only if necessary (i.e., patients must try drug "A" before they can get drug "B").</p> <p>Step Therapy includes coverage determinations that can be made appropriately through auto-adjudication as well as coverage determinations that require manual authorizations pursuant to clinical review. Step Therapy criteria require information that are retrievable by the pharmacy claims adjudication system. Such information typically includes drug use history and age.</p> <p>This process of approving secondary agents may involve information from prescribers, according to factors and processes set forth in the Prior Authorization analysis or may be automated by computer review of a patient drug history of which drug(s) had been tried previously.</p> <p><u>Drugs subject to ST:</u></p> <ul style="list-style-type: none"> Formulary drugs by formulary tier are in the formulary. The formulary is made available to members in the KPIC Regional Microsite. The formulary is updated periodically for members to access the most current information. Drugs subject to Step Therapy are listed on the formulary print 	<p><u>POS:</u> N/A</p> <p><u>PPO</u> Step Therapy (ST) is the practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug and progressing to other more costly or risky therapy, only if necessary (i.e., patients must try drug "A" before they can get drug "B").</p> <p>Step Therapy includes coverage determinations that can be made appropriately through auto-adjudication as well as coverage determinations that require manual authorizations pursuant to clinical review. Step Therapy criteria require information that are retrievable by the pharmacy claims adjudication system. Such information typically includes drug use history and age.</p> <p>This process of approving secondary agents may involve information from prescribers, according to factors and processes set forth in the Prior Authorization analysis or may be automated by computer review of a patient drug history of which drug(s) had been tried previously.</p> <p><u>Drugs subject to ST:</u> Currently no drugs for the treatment of mental health or substance use disorder are restricted to Step Therapy. The majority of behavioral health medications that require step therapy are used to treat attention deficit hyperactivity disorder (ADHD). The step requirements is that a patient try a short acting agent prior to receiving a long-acting agent.</p>

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Process for obtaining a Step Therapy exception:</u></p> <p>If a patient or prescriber wishes to obtain a Step Exception to the formulary's existing step therapy requirements, the patient or the prescriber must supply MedImpact with a clinical reason why the preferred formulary drug(s) will cause harm or be less effective than the requested drug or reasons why the guideline criteria cannot be applied to the particular patient, as described above.</p> <p>In the event that MedImpact does not have all the necessary information needed to make an exception based on medical necessity, MedImpact shall make reasonable and diligent efforts to obtain all necessary information, including medical records and other pertinent documentation, from the patient's Prescribing Physician. All exception decisions based upon medical necessity are rendered by appropriate pharmacists and practitioners in a timely fashion as outlined in the Prior Authorization NQTL analysis.</p> <p>The plan's Step Therapy exceptions process is the same as the prior authorization (PA) process.</p>	

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>POS:</u> N/A</p> <p><u>PPO</u></p> <p>For formulary drugs, the following factors are applied by each named committee to determine whether to apply step therapy:</p> <p><u>Pharmacy & Therapeutics (P&T) Committee</u></p> <ul style="list-style-type: none"> Where there is a logical succession of drug therapy for a particular medical condition, and Where there are medically appropriate alternatives. In such a succession of agents, the most cost-effective preferred agent might be required to be used first with the prescriber moving to another agent next if the first drug was not successful or the patient was an 	<p><u>POS:</u> N/A</p> <p><u>PPO</u></p> <p>For formulary drugs, the following factors are applied by each named committee to determine whether to apply step therapy:</p> <p>All drugs (medical, mental health, and substance use disorder) are treated equally and follow the same process as outlined under Med/Surg</p> <p><u>Pharmacy & Therapeutics (P&T) Committee</u></p> <ul style="list-style-type: none"> Where there is a logical succession of drug therapy for a particular medical condition, and

Medical/Surgical

inappropriate candidate or the patient had adverse effects.

Formulary Business Review Committee (FBRC)

Formulary Business Review Committee (FBRC) abides by all Step Therapy recommendations approved by the P&T, and evaluates the following factors for drugs identified by the P&T Committee as appropriate for consideration for step therapy:

- Net cost
- Terms of a negotiated manufacturer rebate contract

FACTORS

POS: N/A

PPO

The P&T Committee members evaluate the following factors based on the identified evidentiary standards and sources to arrive at a determination based on the totality of the evidence. All factors are assessed on a qualitative basis and are balanced according to the professional judgment of the member.

- Relative therapeutic efficacy
 - Definition: Efficacy is defined as the potential outcome of treatment under optimal circumstances. Relative therapeutic efficacy is defined as the efficacy of a drug compared to other medications that are determined to be therapeutically equivalent.
 - Evidentiary standard: The medication (or class) does not have significant therapeutic advantage over existing medication classes but a select population may require the new therapy be prescribed first line, as determined by the P&T Committee applying professional judgment to the sources cited below.
 - Sources: see below
- Drug safety and relative risks of drug versus alternatives

Mental Health/Substance Use Disorder

- Where there are medically appropriate alternatives.
- In such a succession of agents, the most cost-effective preferred agent might be required to be used first with the prescriber moving to another agent next if the first drug was not successful or the patient was an inappropriate candidate or the patient had adverse effects.

Formulary Business Review Committee (FBRC)

Formulary Business Review Committee (FBRC) abides by all Step Therapy recommendations approved by the P&T, and evaluates the following factors for drugs identified by the P&T Committee as appropriate for consideration for step therapy:

- Net cost
- Terms of a negotiated manufacturer rebate contract

FACTORS

POS: N/A

PPO

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

The P&T Committee members evaluate the following factors based on the identified evidentiary standards and sources to arrive at a determination based on the totality of the evidence. All factors are assessed on a qualitative basis and are balanced according to the professional judgment of the member.

- Relative therapeutic efficacy
 - Definition: Efficacy is defined as the potential outcome of treatment under optimal circumstances. Relative therapeutic efficacy is defined as the efficacy of a drug compared to other medications that are determined to be therapeutically equivalent.
 - Evidentiary standard: The medication (or class) does not have significant therapeutic advantage over existing medication classes but a select population may require the new therapy be prescribed first line, as determined

Medical/Surgical

- Definition: drug safety and relative risks are defined as the potential for patient harm or adverse outcomes.
- Evidentiary standard: Careful patient selection is needed in order to achieve the best therapeutic outcome or because of medication safety implications, relative to alternatives within the same therapeutic class, as determined by the P&T Committee applying professional judgment to the sources cited below.
- Sources: see below
- Cost-effectiveness
 - Definition: The medication is associated with a high net cost when compared to accepted alternative therapies that are effective, and safe, and associated with lower net cost in most patients
 - Evidentiary standard: Cost-effectiveness is evaluated through utilization of pharmacoeconomic principles and/or published pharmacoeconomic or outcomes research evaluations where available (such as reports by the U.S. Institute for Clinical and Economic Review or the International Society for Pharmacoeconomics and Outcomes Research), to determine whether the drug offers an acceptable cost-effectiveness ratio comparative to therapeutic alternatives, as determined by the P&T Committee applying professional judgment to the sources cited below.
 - Sources: see below
- Risk for off-label or experimental use
 - Definition: Off-label Use means use of an FDA-approved medication that has been prescribed by a provider for treatment of a condition or disease other than for an indication specifically designated in the product's FDA-approved labeling. Experimental use is defined according to the factors set forth in the Experimental and Investigational NQTL analysis
 - Evidentiary standard: risk is evaluated in the judgment the P&T Committee based on professional knowledge and experience. This factor is given extra weight for drugs with

Mental Health/Substance Use Disorder

- by the P&T Committee applying professional judgment to the sources cited below.
- Sources: see below
- Drug safety and relative risks of drug versus alternatives
 - Definition: drug safety and relative risks are defined as the potential for patient harm or adverse outcomes.
 - Evidentiary standard: Careful patient selection is needed in order to achieve the best therapeutic outcome or because of medication safety implications, relative to alternatives within the same therapeutic class, as determined by the P&T Committee applying professional judgment to the sources cited below.
 - Sources: see below
- Cost-effectiveness
 - Definition: The medication is associated with a high net cost when compared to accepted alternative therapies that are effective, and safe, and associated with lower net cost in most patients
 - Evidentiary standard: Cost-effectiveness is evaluated through utilization of pharmacoeconomic principles and/or published pharmacoeconomic or outcomes research evaluations where available (such as reports by the U.S. Institute for Clinical and Economic Review or the International Society for Pharmacoeconomics and Outcomes Research), to determine whether the drug offers an acceptable cost-effectiveness ratio comparative to therapeutic alternatives, as determined by the P&T Committee applying professional judgment to the sources cited below.
 - Sources: see below
- Risk for off-label or experimental use
 - Definition: Off-label Use means use of an FDA-approved medication that has been prescribed by a provider for treatment of a condition or disease other than for an indication specifically designated in the product's FDA-approved labeling. Experimental use is defined according to the factors set forth in the Experimental and Investigational NQTL analysis

Medical/Surgical	Mental Health/Substance Use Disorder
<p>higher-than-average costs, but no quantitative threshold is applied for cost.</p> <ul style="list-style-type: none"> ○ Sources: see below <p>SOURCES</p> <p><u>POS:</u> N/A</p> <p><u>PPO</u></p> <p>All drugs or drug classes are reviewed using evidence-based criteria from credible sources including:</p> <ul style="list-style-type: none"> -Peer-reviewed medical literature -Accepted national treatment guidelines -Drug compendia in common use -Other authoritative medical sources -ICER analyses -MediSpan data -Expert opinion where necessary -Prescribing guidelines 	<ul style="list-style-type: none"> ○ Evidentiary standard: risk is evaluated in the judgment the P&T Committee based on professional knowledge and experience. This factor is given extra weight for drugs with higher-than-average costs, but no quantitative threshold is applied for cost. ○ Sources: see below <p>SOURCES</p> <p><u>POS:</u> N/A</p> <p><u>PPO</u></p> <p>All drugs (medical, mental health, and substance use disorder) are treated equally and follow the same process as outlined under Med/Surg</p> <p>Sources: All drugs or drug classes are reviewed using evidence-based criteria from credible sources including:</p> <ul style="list-style-type: none"> -Peer-reviewed medical literature -Accepted national treatment guidelines -Drug compendia in common use -Other authoritative medical sources -ICER analyses -MediSpan data -Expert opinion where necessary -Prescribing guidelines

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
<u>POS:</u> N/A	<u>POS:</u> N/A
<u>PPO</u>	<u>PPO</u>

Medical/Surgical

- There is a logical succession of drug therapy for a particular medical condition
 - Evidentiary standard: widely accepted national treatment guidelines identify first-line and subsequent treatment options
- There are medically appropriate alternatives
 - Evidentiary standard: The P&T Committee determines that multiple covered drugs are medically appropriate for a condition and may be considered treatment alternatives, based on the standard of care in the community as determined by the P&T Committee members, based on the sources below
- At least one agent is significantly more cost-effective than the alternatives
 - Evidentiary standard: Cost-effectiveness is evaluated through utilization of pharmacoeconomic principles and/or published pharmacoeconomic or outcomes research evaluations where available (such as reports by the U.S. Institute for Clinical and Economic Review or the International Society for Pharmacoeconomics and Outcomes Research), to determine whether the drug offers an acceptable cost-effectiveness ratio comparative to therapeutic alternatives, as evaluated by the P&T Committee pursuant to the sources below.

Sources: For all factors, drug classes are reviewed using evidence-based criteria from credible sources including:

- Peer-reviewed medical literature
- Accepted national treatment guidelines
- Drug compendia in common use
- Other authoritative medical sources
- ICER analyses
- MediSpan
- Expert opinion where necessary
- FDA-approved REMS program

FBRC

- Net cost
 - Definition: net cost is defined to mean the total projected cost after rebates
 - Evidentiary standard: Step Therapy is applied to require a trial of a lower costing generic

Mental Health/Substance Use Disorder

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

- There is a logical succession of drug therapy for a particular medical condition
 - Evidentiary standard: widely accepted national treatment guidelines identify first-line and subsequent treatment options
- There are medically appropriate alternatives
 - Evidentiary standard: The P&T Committee determines that multiple covered drugs are medically appropriate for a condition and may be considered treatment alternatives, based on the standard of care in the community as determined by the P&T Committee members, based on the sources below
- At least one agent is significantly more cost-effective than the alternatives
 - Evidentiary standard: Cost-effectiveness is evaluated through utilization of pharmacoeconomic principles and/or published pharmacoeconomic or outcomes research evaluations where available (such as reports by the U.S. Institute for Clinical and Economic Review or the International Society for Pharmacoeconomics and Outcomes Research), to determine whether the drug offers an acceptable cost-effectiveness ratio comparative to therapeutic alternatives, as evaluated by the P&T Committee pursuant to the sources below.

Sources: For all factors, drug classes are reviewed using evidence-based criteria from credible sources including:

- Peer-reviewed medical literature
- Accepted national treatment guidelines
- Drug compendia in common use
- Other authoritative medical sources
- ICER analyses
- MediSpan
- Expert opinion where necessary
- FDA-approved REMS program

FBRC

- Net cost

Medical/Surgical	Mental Health/Substance Use Disorder
<p>and/or lower costing preferred brand drug net of rebates. Non-preferred drugs will require a trial of preferred drugs that have a net cost that is lower after rebates.</p> <ul style="list-style-type: none"> ○ Sources: First Data Bank, MedOptimize© <ul style="list-style-type: none"> • Terms of a negotiated manufacturer rebate contract <ul style="list-style-type: none"> ○ Evidentiary standard: Step Therapy is recommended where the manufacturer contract terms require non-preferred drugs within the same therapeutic classification to have a trial of first line drugs. <p>Sources: Pharmaceutical manufacturer rebate contract agreements</p>	<ul style="list-style-type: none"> ○ Definition: net cost is defined to mean the total projected cost after rebates ○ Evidentiary standard: Step Therapy is applied to require a trial of a lower costing generic and/or lower costing preferred brand drug net of rebates. Non-preferred drugs will require a trial of preferred drugs that have a net cost that is lower after rebates. ○ Sources: First Data Bank, MedOptimize© <ul style="list-style-type: none"> • Terms of a negotiated manufacturer rebate contract <ul style="list-style-type: none"> ○ Evidentiary standard: Step Therapy is recommended where the manufacturer contract terms require non-preferred drugs within the same therapeutic classification to have a trial of first line drugs. <p>Sources: Pharmaceutical manufacturer rebate contract agreements</p>

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>POS</u>: N/A</p> <p><u>PPO</u> Process for creating a Step Therapy policy: Same as for Prior Authorization.</p> <p>Exception to Step Therapy requirements:</p> <p>Exceptions to a Step Therapy requirement may be granted based on medical necessity and a clinically valid explanation if:</p> <ol style="list-style-type: none"> The prescription drug that is the subject of the exception request is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen; 	<p><u>POS</u>: N/A</p> <p><u>PPO</u> All drugs (medical, mental health, and substance use disorder) are treated equally and follow the same process as outlined under Med/Surg.</p> <p>Process for creating a Step Therapy policy: Same as for Prior Authorization.</p> <p>Exception to Step Therapy requirements:</p> <p>Exceptions to a Step Therapy requirement may be granted based on medical necessity and a clinically valid explanation if:</p> <ol style="list-style-type: none"> The prescription drug that is the subject of the exception request is expected to be ineffective

Medical/Surgical

- b. The patient has tried the prescription drug that is the subject of the exception request, or another prescription drug in the same pharmacologic class or with the same mechanism of action as the
- c. prescription drug that is the subject of the exception request, and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event;
- d. The prescription drug required pursuant to the step therapy protocol is not in the best interest of the patient, based on clinical appropriateness, because the patient's use of the prescription drug is expected to:
- e. Cause a significant barrier to the patient's adherence to or compliance with the patient's plan of care;
- f. Worsen a comorbid condition of the patient; or
- g. Cause a clinically predictable negative drug interaction; or
- h. Decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities.
- i. The patient is currently experiencing a positive therapeutic outcome on a prescription drug recommended by the patient's provider for the medical condition under consideration while on his or her current or immediately preceding health plan and changing to the required prescription drug may cause clinically predictable adverse reactions, or physical or mental harm to, the patient.

Mental Health/Substance Use Disorder

- based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen;
 - b. The patient has tried the prescription drug that is the subject of the exception request, or another prescription drug in the same pharmacologic class or with the same mechanism of action as the
 - c. prescription drug that is the subject of the exception request, and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect or an adverse event;
 - d. The prescription drug required pursuant to the step therapy protocol is not in the best interest of the patient, based on clinical appropriateness, because the patient's use of the prescription drug is expected to:
 - e. Cause a significant barrier to the patient's adherence to or compliance with the patient's plan of care;
 - f. Worsen a comorbid condition of the patient; or
 - g. Cause a clinically predictable negative drug interaction; or
 - h. Decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities.
- The patient is currently experiencing a positive therapeutic outcome on a prescription drug recommended by the patient's provider for the medical condition under consideration while on his or her current or immediately preceding health plan and changing to the required prescription drug may cause clinically predictable adverse reactions, or physical or mental harm to, the patient.

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical

Mental Health/Substance Use Disorder

POS: N/A

POS: N/A

Medical/Surgical

Mental Health/Substance Use Disorder

PPO

The comparative analysis conducted included review of the prior authorization review process for medications included within the GA Dual Choice PPO formulary that contain a Step Therapy parameter. MedImpact utilizes the same processes for application of Step Therapy and other forms of Utilization Management (UM) for both MH/SUD and M/S prescription drug benefits. All processes rely on evidence-based clinical guidelines to determine whether the requested medication is medically necessary. The same methodology is utilized to develop prior authorization criteria and utilization management parameters. Thus, the NQTLs that are in place with respect to prior authorization criteria for MH/SUD benefits are the same and applied no more stringently than those applied to M/S benefits.

PPO

The comparative analysis conducted included review of the prior authorization review process for medications included within the GA Dual Choice PPO formulary that contain a Step Therapy parameter. MedImpact utilizes the same processes for application of Step Therapy and other forms of Utilization Management (UM) for both MH/SUD and M/S prescription drug benefits. All processes rely on evidence-based clinical guidelines to determine whether the requested medication is medically necessary. The same methodology is utilized to develop prior authorization criteria and utilization management parameters. Thus, the NQTLs that are in place with respect to prior authorization criteria for MH/SUD benefits are the same and applied no more stringently than those applied to M/S benefits.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

POS: N/A

PPO

- MedImpact utilizes the same processes, strategies, evidentiary standards, and other factors to apply Step Therapy to both MH/SUD and M/S drugs.
- The same process and staff are used to review Step Therapy exception requests regardless of whether the requested drug is prescribed to treat a M/S or MH/SUD condition. Reviewers do not differentiate or apply any review factors differently based on the drug's primary indication or utilization. All drugs are reviewed and follow the same processes without regard to their primary indication.
- The proportion of MH/SUD drugs that are subject to Step Therapy is comparable to the proportion of M/S drugs that are subject to Step Therapy.
- Thus MedImpact concludes that the processes, strategies, evidentiary standards, and other factors used to apply PA to MH/SUD drugs are comparable to and no more stringent than the processes, strategies, evidentiary standards, and other factors used to apply PA to M/S drugs, as written and in operation.

Kaiser Permanente Insurance Company (KPIC)

Non-Quantitative Treatment Limits (NQTL)



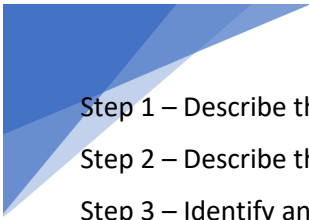
NQTL: Formulary Design for Prescriptions Drugs (PPO/POS)

Last Reviewed: December 4, 2023



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Benefits		Classifications					
Is NQTL applied to Medical/Surgical benefits?	Is NQTL applied to Mental Health/Substance Use Disorder benefits?	Is NQTL applied to In Network Inpatient classification?	Is NQTL applied to Out of Network Inpatient classification?	Is NQTL applied to In Network Outpatient classification?	Is NQTL applied to Out of Network Outpatient classification?	Is NQTL applied to Emergency classification?	Is NQTL applied to Prescription classification?
Y	Y	N	N	N	N	N	Y

Benefit Classification 1: Inpatient – In Network

Prompt – Benefit / Service(s) to which the NQTL applies

Medical/Surgical	Mental Health/Substance Use Disorder
Pharmacy POS: N/A Pharmacy PPO: N/A- Pharmacy Benefit Manager (PBM), MedImpact does not administer pharmacy benefit for in-patient prescription drugs.	Pharmacy POS: N/A Pharmacy PPO: N/A- Pharmacy Benefit Manager (PBM), MedImpact does not administer pharmacy benefit for in-patient prescription drugs.

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors are used to determine the applicability of the **NQTL** for MH/SUD benefits and for medical/surgical benefits. Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of retrospective review for the identified MH/SUD benefits as were used for medical/surgical benefits, including the sources for ascertaining each of these factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors. Examples of factors for determining that retrospective review is appropriate include (these examples are merely illustrative and not exhaustive):
☐ Excessive utilization ☐ Recent medical cost escalation ☐ Lack of adherence to quality standards ☐ High levels of variation in length of stay ☐ High variability in cost per episode of care ☐ Clinical efficacy of the proposed treatment or service ☐ Provider discretion in determining diagnoses ☐ Claims associated with a high percentage of fraud ☐ Severity or chronicity of the MH/SUD condition • Examples of sources for data to identify factors: ☐ Internal claims analyses ☐ Internal quality standard studies ☐ Expert medical review

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Examples of evidentiary standards, their sources, and other evidence considered include:

- ☐ Patient experience surveys
- ☐ Provider professional profiles
- ☐ Provider rating services
- ☐ Word of mouth/reputation

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

N/A

Benefit Classification 2: Inpatient – Out-of-Network

Prompt – Benefit / Service(s) to which the NQTL applies

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Pharmacy POS:</u> N/A	<u>Pharmacy POS:</u> N/A
<u>Pharmacy PPO:</u> PBM, MedImpact does not administer pharmacy benefit for in-patient prescription drugs.	<u>Pharmacy PPO:</u> PBM, MedImpact does not administer pharmacy benefit for in-patient prescription drugs.

Step 1 – Describe the NQTL's requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors are used to determine the applicability of the **NQTL** for MH/SUD benefits and for medical/surgical benefits.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A
Factors Examples:	
<input type="checkbox"/> Market price <input type="checkbox"/> Volume of service capacity <input type="checkbox"/> Geographic location <input type="checkbox"/> Disability accommodations <input type="checkbox"/> Community reputation	<input type="checkbox"/> Value-added services <input type="checkbox"/> Languages spoken <input type="checkbox"/> Multi-specialty co-location <input type="checkbox"/> Additional training/skills
N/A	N/A
Sources	

Examples of sources for data to identify factors:

- ☐ Internal claims analyses
- ☐ Internal quality standard studies
- ☐ Expert medical review

N/A

N/A

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Examples of evidentiary standards, their sources, and other evidence considered include:

- ☐ Patient experience surveys
- ☐ Provider professional profiles
- ☐ Provider rating services
- ☐ Word of mouth/reputation

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion
N/A

Benefit Classification 3: Outpatient – In Network

Prompt – Benefit / Service(s) to which the NQTL applies

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Pharmacy POS:</u> N/A <u>Pharmacy PPO:</u> PBM, MedImpact does not administer pharmacy benefit for out-patient prescription drugs (physician administered).	<u>Pharmacy POS:</u> N/A <u>Pharmacy PPO:</u> PBM, MedImpact does not administer pharmacy benefit for out-patient prescription drugs (physician administered).

Step 1 – Describe the NQTL's requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors are used to determine the applicability of the **NQTL** for MH/SUD benefits and for medical/surgical benefits. Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of retrospective review for the identified MH/SUD benefits as were used for medical/surgical benefits, including the sources for ascertaining each of these factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors. Examples of factors for

determining that retrospective review is appropriate include (these examples are merely illustrative and not exhaustive):

☐ Excessive utilization ☐ Recent medical cost escalation ☐ Lack of adherence to quality standards ☐ High levels of variation in length of stay ☐ High variability in cost per episode of care ☐ Clinical efficacy of the proposed treatment or service ☐ Provider discretion in determining diagnoses ☐ Claims associated with a high percentage of fraud ☐ Severity or chronicity of the MH/SUD condition • Examples of sources for data to identify factors: ☐ Internal claims analyses ☐ Internal quality standard studies ☐ Expert medical review

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A
<p>Factors Examples:</p> <div> <div> ☐ Market price☐ Volume of service capacity ☐ Geographic location ☐ Disability accommodations ☐ Community reputation </div> <div> ☐ Value-added services ☐ Languages spoken ☐ Multi-specialty co-location ☐ Additional training/skills </div> </div>	
N/A	N/A
<p>Sources Examples of sources for data to identify factors:</p> <div> ☐ Internal claims analyses ☐ Internal quality standard studies ☐ Expert medical review </div>	
N/A	N/A

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Examples of evidentiary standards, their sources, and other evidence considered include:

- ☐ Patient experience surveys
- ☐ Provider professional profiles
- ☐ Provider rating services
- ☐ Word of mouth/reputation

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion
N/A

Benefit Classification 4: Outpatient – Out-of-Network

Prompt – Benefit / Service(s) to which the NQTL applies

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Pharmacy POS:</u> N/A	<u>Pharmacy POS:</u> N/A
<u>Pharmacy PPO:</u> PBM, MedImpact does not administer pharmacy benefit for out-patient prescription drugs (physician administered).	<u>Pharmacy PPO:</u> PBM, MedImpact does not administer pharmacy benefit for out-patient prescription drugs (physician administered).

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors are used to determine the applicability of the **NQTL** for MH/SUD benefits and for medical/surgical benefits.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A
Factors Examples:	
<input type="checkbox"/> Market price <input type="checkbox"/> Volume of service capacity <input type="checkbox"/> Geographic location <input type="checkbox"/> Disability accommodations <input type="checkbox"/> Community reputation	<input type="checkbox"/> Value-added services <input type="checkbox"/> Languages spoken <input type="checkbox"/> Multi-specialty co-location <input type="checkbox"/> Additional training/skills
N/A	N/A
Sources Examples of sources for data to identify factors:	
<input type="checkbox"/> Internal claims analyses <input type="checkbox"/> Internal quality standard studies <input type="checkbox"/> Expert medical review	
N/A	N/A

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Examples of evidentiary standards, their sources, and other evidence considered include:

- ☐ Patient experience surveys
- ☐ Provider professional profiles
- ☐ Provider rating services
- ☐ Word of mouth/reputation

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion
N/A

Benefit Classification 5: Emergency Services

Prompt – Benefit / Service(s) to which the NQTL applies

Medical/Surgical	Mental Health/Substance Use Disorder
Pharmacy POS: N/A	Pharmacy POS: N/A
Pharmacy PPO: PBM, MedImpact does not administer pharmacy benefit for emergency services	Pharmacy PPO: PBM, MedImpact does not administer pharmacy benefit for emergency services

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors are used to determine the applicability of the **NQTL** for MH/SUD benefits and for medical/surgical benefits. Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of retrospective review for the identified MH/SUD benefits as were used for medical/surgical benefits, including the sources for ascertaining each of these factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors. Examples of factors for determining that retrospective review is appropriate include (these examples are merely illustrative and not exhaustive):
☐ Excessive utilization ☐ Recent medical cost escalation ☐ Lack of adherence to quality standards ☐ High levels of variation in length of stay ☐ High variability in cost per episode of care ☐ Clinical efficacy of the proposed treatment or service ☐ Provider discretion in determining diagnoses ☐ Claims associated with a high percentage of fraud ☐ Severity or chronicity of the MH/SUD condition • Examples of sources for data to identify factors: ☐ Internal claims analyses ☐ Internal quality standard studies ☐ Expert medical review

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A
Factors Examples:	
☐ Market price ☐ Volume of service capacity ☐ Geographic location ☐ Disability accommodations ☐ Community reputation	☐ Value-added services ☐ Languages spoken ☐ Multi-specialty co-location ☐ Additional training/skills
N/A	N/A
Sources Examples of sources for data to identify factors:	



<input type="checkbox"/> Internal claims analyses <input type="checkbox"/> Internal quality standard studies <input type="checkbox"/> Expert medical review	
N/A	N/A

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Examples of evidentiary standards, their sources, and other evidence considered include:

- ☐ Patient experience surveys
- ☐ Provider professional profiles
- ☐ Provider rating services
- ☐ Word of mouth/reputation

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion
N/A

Benefit Classification 6: Pharmacy Services

Prompt – Benefit / Service(s) to which the NQTL applies

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Pharmacy POS:</u> Prescription drugs (self-administered) <u>Pharmacy PPO:</u> Prescription drugs (self-administered)	<u>Pharmacy POS:</u> Prescription drugs (self-administered) <u>Pharmacy PPO:</u> Prescription drugs (self-administered)

Step 1 – Describe the NQTL's requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Pharmacy POS:</u> These procedures are related to the Kaiser Permanente Georgia open commercial formulary which includes step therapy and prior authorization. <ul style="list-style-type: none"> The Pharmacy and Therapeutics Committee (PTC), with expert guidance from various specialists, evaluates, appraises, and selects from available drugs those considered to be the most appropriate for patient care and general use within the Kaiser Permanente Georgia region. The Formulary is published under authority of the PTC. (See 	<u>Pharmacy POS:</u> These procedures are related to the Kaiser Permanente Georgia open commercial formulary which includes step therapy and prior authorization. <ul style="list-style-type: none"> The Pharmacy and Therapeutics Committee (PTC), with expert guidance from various specialists, evaluates, appraises, and selects from available drugs those considered to be the most appropriate for patient care and general use within the Kaiser Permanente Georgia region. The Formulary is published under authority of the PTC. (See below for the

below for the required qualifications/training of members serving the PTC.)

Drug selection decisions are made primarily based on safety and effectiveness. Safety and effectiveness are determined by a thorough review of pertinent medical evidence, incorporating expert opinion and relevant findings from appropriate external organizations (e.g., Centers for Disease Control, National Institutes of Health, American Academy of Pediatrics, etc.). After safety and effectiveness are investigated, cost is considered.

- All therapeutic classes of medications are reviewed on an annual basis. The review includes current Formulary products and drugs which have recently been introduced into the market.
- The PTC is comprised of the following:

A. The Physician Program Director of Pharmacy and Therapeutics/Medication Safety serves as Chairperson and serves unlimited terms as deemed appropriate by the Medical Director and President,

B. Two actively practicing physicians representing Adult Primary Care (Internal Medicine/Family Medicine), two actively practicing physicians representing Pediatrics, at least one actively practicing physician representing Obstetrics and Gynecology, Behavioral Health, Hospitalists, Hematology/Oncology, and Infectious Disease. Members from other disciplines may be added as determined appropriate by the Chairperson

C. At least one actively practicing dispensing and clinical pharmacist selected by the Committee Chairperson and Executive Director of Pharmacy

D. One pharmacist member and one physician member are expert in care of the elderly and disabled.

E. The Executive Director of Pharmacy shall serve as secretary or shall appoint a suitable designee and serve unlimited terms as deemed appropriate by the Medical Director and President

F. The Sr. Manager of Clinical Pharmacy Operations shall serve unlimited terms as deemed appropriate by the Medical Director and President

G. A representative from the Department of Nursing, nominated by Nursing, the Chairperson, and the Executive Director of Pharmacy

H. Ex-officio Members:
Ex-officio members include: The Physician Lead, Pharmacy Initiatives; Manager, Clinical Pharmacy; and Manager, Drug Utilization.

- Expert opinion is obtained from specialty practitioners serving as consultants to the PTC

required qualifications/training of members serving the PTC.)

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A. The Physician Program Director of Pharmacy and Therapeutics/Medication Safety serves as Chairperson and serves unlimited terms as deemed appropriate by the Medical Director and President,

B. Two actively practicing physicians representing Adult Primary Care (Internal Medicine/Family Medicine), two actively practicing physicians representing Pediatrics, at least one actively practicing physician representing Obstetrics and Gynecology, Behavioral Health, Hospitalists, Hematology/Oncology, and Infectious Disease. Members from other disciplines may be added as determined appropriate by the Chairperson

C. At least one actively practicing dispensing and clinical pharmacist selected by the Committee Chairperson and Executive Director of Pharmacy

D. One pharmacist member and one physician member are expert in care of the elderly and disabled.

E. The Executive Director of Pharmacy shall serve as secretary or shall appoint a suitable designee and serve unlimited terms as deemed appropriate by the Medical Director and President

F. The Sr. Manager of Clinical Pharmacy Operations shall serve unlimited terms as deemed appropriate by the Medical Director and President

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Ex-officio members include: The Physician Lead, Pharmacy Initiatives; Manager, Clinical Pharmacy; and Manager, Drug Utilization.

- Expert opinion is obtained from specialty practitioners serving as consultants to the PTC

Pharmacy PPO:

Definition:

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

In Georgia, the Dual Choice PPO utilizes a 5 Tier formulary. However, the number of tiers and cost-share is flexible and may vary based on copay structure and level of desired control. Higher tiers indicate a higher level of cost-sharing.

5 Tier Design:

Tier	Tier Description
1	Zero Cost Share Preventative Drug List
2	Generics
3	Preferred Brands
4	Non- Preferred Brands
5	Specialty
10 (EHB)	Zero Cost Share Essential Health Benefits

- EHB - Preventative Drug Products: No copayment for those drugs that are used for prevention and are mandated by the Affordable Care Act. Select oral contraceptives, vitamin D, folic acid for women of childbearing age, over-the-counter (OTC) aspirin, and smoking cessation products may be covered under this tier. Certain age limits apply.
- Generics: Lowest copayment for those drugs that offer the greatest value compared to other drugs used to treat similar conditions.
- Preferred Brand: Medium copayment covers brand name drugs that are generally more affordable or may be preferred compared to other drugs to treat the same conditions.
- Non-Preferred Brand: Highest copayment covers higher cost brand name drugs.
- Specialty: Coverage for this tier is for “specialty” drugs. Specialty drugs are used to treat complex, chronic conditions and may require special handling, storage, or clinical management. Prescription drugs covered under the specialty tier require fulfillment at a pharmacy that participates in the plan’s “specialty” or “hemophilia” networks. For some formularies, the specialty tier is subdivided among specialty generics, specialty preferred brands, and specialty non-preferred brands according to the same logic set forth above for non-specialty drugs.

Pharmacy PPO:

Definition:

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

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- Preferred Brand: Medium copayment covers brand name drugs that are generally more affordable or may be preferred compared to other drugs to treat the same conditions.
- Non-Preferred Brand: Highest copayment covers higher cost brand name drugs.
- Specialty: Coverage for this tier is for “specialty” drugs. Specialty drugs are used to treat complex, chronic conditions and may require special handling, storage, or clinical management. Prescription drugs covered under the specialty tier require fulfillment at a pharmacy that participates in the plan’s “specialty” or “hemophilia” networks. For some formularies, the specialty tier is subdivided among specialty generics, specialty preferred brands, and specialty non-preferred brands according to the same logic set forth above for non-specialty drugs.

Formulary drugs by formulary tier are in the formulary. The formulary for the POS and PPO plan is made available to members in the KPIC Regional Microsite. The formulary is updated on a quarterly basis for members to access the most current information.

Formulary drugs by formulary tier are in the formulary. The formulary for the POS and PPO plan is made available to members in the KPIC Regional Microsite. The formulary is updated on a quarterly basis for members to access the most current information.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors are used to determine the applicability of the **NQTL** for MH/SUD benefits and for medical/surgical benefits.

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Pharmacy POS:</u> Factors used to determine formulary tier placement of prescription drugs within the plan's drug coverage formulary design are determined based on a review of Pharmacy policies and procedures:</p> <p>Factors:</p> <p>Safety and effectiveness as determined by:</p> <ul style="list-style-type: none"> -Medical evidence -Expert opinion -Relevant findings of appropriate external organizations <p>-Additional information considered in making decisions include:</p> <ul style="list-style-type: none"> i. Availability of current formulary drugs to meet the therapeutic need ii. Reliability and quality control of the drug manufacturer iii. Current utilization of the drug by practitioners within the program iv. Comparative cost of alternative equivalent therapy v. Utilization of the Non-formulary Exception Process for closed formularies vi. Other unique attributes which may warrant inclusion of the drug. <p>Factors rejected: KPGA does not employ incentives or penalties in order to influence clinician prescribing. KPGA does employ formulary education to encourage and support formulary prescribing.</p> <p><u>Pharmacy PPO:</u> Formulary tiering determinations start with a clinical determination of Therapeutic Designation and Therapeutic Caveats, as well as the maximum-allowable utilization management criteria for each drug by the Pharmacy and Therapeutics Committee (P&T) Committee. The Drug Information (DI) Department and the MedImpact Direct</p>	<p><u>Pharmacy POS:</u> Factors used to determine formulary tier placement of prescription drugs within the plan's drug coverage formulary design are determined based on a review of Pharmacy policies and procedures:</p> <p>Factors:</p> <p>Safety and effectiveness as determined by:</p> <ul style="list-style-type: none"> -Medical evidence -Expert opinion -Relevant findings of appropriate external organizations <p>-Additional information considered in making decisions include:</p> <ul style="list-style-type: none"> i. Availability of current formulary drugs to meet the therapeutic need ii. Reliability and quality control of the drug manufacturer iii. Current utilization of the drug by practitioners within the program iv. Comparative cost of alternative equivalent therapy v. Utilization of the Non-formulary Exception Process for closed formularies vi. Other unique attributes which may warrant inclusion of the drug. <p>Factors rejected: KPGA does not employ incentives or penalties in order to influence clinician prescribing. KPGA does employ formulary education to encourage and support formulary prescribing.</p> <p><u>Pharmacy PPO:</u> All drugs (medical, mental health, and substance use disorder) are treated equally and follow the same process as outlined under Med/Surg</p> <p>Formulary tiering determinations start with a clinical determination of Therapeutic Designation and Therapeutic Caveats, as well as the maximum-allowable utilization management criteria for each drug</p>

Specialty (MIDS) Department collaborate to determine a drug's commercial specialty status. The Trade Relations (TR) department establishes rebate strategies through the Formulary Business Review Committee (FBRC), consistent with P&T-approved standards. Finally, the Formulary Administration & Strategy team (FAS) integrates P&T criteria, FBRC strategy, and business strategy to make final formulary tiering and UM determinations.

by the Pharmacy and Therapeutics Committee (P&T) Committee. The Drug Information (DI) Department and the MedImpact Direct Specialty (MIDS) Department collaborate to determine a drug's commercial specialty status. The Trade Relations (TR) department establishes rebate strategies through the Formulary Business Review Committee (FBRC), consistent with P&T-approved standards. Finally, the Formulary Administration & Strategy team (FAS) integrates P&T criteria, FBRC strategy, and business strategy to make final formulary tiering and UM determinations.

**Factors
Examples:**

- ☐ Market price
- ☐ Volume of service capacity
- ☐ Geographic location
- ☐ Disability accommodations
- ☐ Community reputation

- ☐ Value-added services
- ☐ Languages spoken
- ☐ Multi-specialty co-location
- ☐ Additional training/skills

Pharmacy POS:

Factors used to determine formulary drug tier placement within the drug benefit design are determined based on a review of Pharmacy policies and procedures:

Factors:

Safety and effectiveness as determined by:

- Medical evidence
- Expert opinion
- Relevant findings of appropriate external organizations

-Additional information considered in making decisions include:

- i. Availability of current formulary drugs to meet the therapeutic need
- ii. Reliability and quality control of the drug manufacturer
- iii. Current utilization of the drug by practitioners within the program
- iv. Comparative cost of alternative equivalent therapy
- v. Utilization of Step Therapy and prior authorization for open formulary

Other unique attributes which may warrant inclusion of the drug.

Factors rejected:

KPGA does not employ incentives or penalties in order to influence clinician prescribing. KPGA does employ formulary education to encourage and support formulary prescribing.

Pharmacy PPO:

The P&T Committee recommends therapeutic designations and appropriate prescribing guidelines for formulary placement based on the following factors:

- Relative therapeutic efficacy
- Cost-effectiveness
- Multi-source brand status

Pharmacy POS:

Factors used to determine formulary drug tier placement within the drug benefit design are determined based on a review of Pharmacy policies and procedures:

Factors:

Safety and effectiveness as determined by:

- Medical evidence
- Expert opinion
- Relevant findings of appropriate external organizations

-Additional information considered in making decisions include:

- i. Availability of current formulary drugs to meet the therapeutic need
- ii. Reliability and quality control of the drug manufacturer
- iii. Current utilization of the drug by practitioners within the program
- iv. Comparative cost of alternative equivalent therapy
- v. Utilization of Step Therapy and prior authorization for open formulary

Other unique attributes which may warrant inclusion of the drug.

Factors rejected:

KPGA does not employ incentives or penalties in order to influence clinician prescribing. KPGA does employ formulary education to encourage and support formulary prescribing.

Pharmacy PPO:

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

The P&T Committee recommends therapeutic designations and appropriate prescribing guidelines for formulary placement based on the following factors:

- Relative therapeutic efficacy

The DI and the MIDS teams collaborate to determine a drug's commercial specialty status based on the following factors:

- High cost
- Complex clinical conditions
- Drug availability only through a specialty pharmacy (i.e. Limited Distribution Drugs (LDD))
- Complex Monitoring Requirements (e.g., Risk Evaluation and Mitigation Strategies (REMS) which may require provider and/or patient registries along with laboratory or diagnostic testing).

To be considered a specialty drug, a drug must meet at least one of the four previously described factors. However, in some circumstances multiple factors may be needed to make a determination. LDDs will generally always be designated as specialty.

Specialty drugs are further sub-classified into specialty generics, specialty preferred brand, specialty non-preferred brand, and specialty multi-source brand drugs.

- Cost-effectiveness
- Multi-source brand status

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- High cost
- Complex clinical conditions
- Drug availability only through a specialty pharmacy (i.e. Limited Distribution Drugs (LDD))
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Specialty drugs are further sub-classified into specialty generics, specialty preferred brand, specialty non-preferred brand, and specialty multi-source brand drugs.

Sources

Examples of sources for data to identify factors:

- ☑ Internal claims analyses
- ☑ Internal quality standard studies
- ☑ Expert medical review

Pharmacy POS:

N/A

Pharmacy PPO:

FBRC Review

The Formulary Business Review Committee (FBRC) abides by all recommended Therapeutic Designations and Prescribing Guidelines of the P&T Committee. FBRC will recommend preferred formulary status for reviewed drugs pursuant to an analysis that balances findings for the following factors:

- Drug cost, net of rebates, is less than other drugs in the same therapeutic classification
- Drug utilization is anticipated to grow

Formulary Administration and Strategy (FAS) Review

FAS integrates the P&T standards, FBRC strategy, and business strategy to make final formulary tiering and UM recommendations. FAS first applies tiering by status as generic or brand products. Where a preferred tier exists for generic and/or brand drugs, the FAS reviews and approves the recommendations developed by the P&T and FBRC based on the factors, sources, and evidentiary standards

Pharmacy POS:

N/A

Pharmacy PPO:

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

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identified above and presented to the FAS. Where P&T and FBRC recommendations do not fully align, FAS may request more information to support the committees' recommendations, and ultimately exercises professional judgment to make tiering determinations based on their evaluation of the weight of the evidence presented. All formulary decisions are also ultimately approved by the P&T Committee.

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Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Examples of evidentiary standards, their sources, and other evidence considered include:

- ☐ Patient experience surveys
- ☐ Provider professional profiles
- ☐ Provider rating services
- ☐ Word of mouth/reputation

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Pharmacy POS:</u> Drug selection decisions are made primarily based on safety and effectiveness. Safety and effectiveness are determined by a thorough review of pertinent medical evidence, incorporating expert opinion and relevant findings from appropriate external organizations (e.g., Centers for Disease Control, National Institutes of Health, American Academy of Pediatrics, etc.). After safety and effectiveness are investigated, cost is considered.</p> <p>a. Medical evidence can include peer reviewed journal articles obtained through library searches and on-line search engines, as well as Kaiser Permanente Drug Information Services in other Kaiser Permanente regions. Medical evidence provides insight into the following:</p> <ul style="list-style-type: none"> i. Documentation of effectiveness ii. Results and extent of clinical investigation iii. Severity and incidence of toxicity and side effects <p>b. Expert opinion is obtained from practitioners who serve as consultants to the PTC. Consultants may be invited to a PTC meeting to present their</p>	<p><u>Pharmacy POS:</u> Drug selection decisions are made primarily based on safety and effectiveness. Safety and effectiveness are determined by a thorough review of pertinent medical evidence, incorporating expert opinion and relevant findings from appropriate external organizations (e.g., Centers for Disease Control, National Institutes of Health, American Academy of Pediatrics, etc.). After safety and effectiveness are investigated, cost is considered.</p> <p>a. Medical evidence can include peer reviewed journal articles obtained through library searches and on-line search engines, as well as Kaiser Permanente Drug Information Services in other Kaiser Permanente regions. Medical evidence provides insight into the following:</p> <ul style="list-style-type: none"> i. Documentation of effectiveness ii. Results and extent of clinical investigation iii. Severity and incidence of toxicity and side effects <p>b. Expert opinion is obtained from practitioners who serve as consultants to the PTC. Consultants may be invited to a PTC meeting to present their opinions regarding the inclusion of certain medications on the formulary, or they</p>

opinions regarding the inclusion of certain medications on the formulary, or they may present their opinions in writing or verbally communicate with a PTC member.

c. Relevant findings of appropriate external organizations are included in the monographs presented to the PTC for consideration.

Information is usually obtained via reliable sites on the internet or from peer reviewed journals.

d. Additional information considered in making decisions include:

- i. Availability of current formulary drugs to meet the therapeutic need
- ii. Reliability and quality control of the drug manufacturer
- iii. Current utilization of the drug by practitioners within the program
- iv. Comparative cost of alternative equivalent therapy
- v. Utilization of Step Therapy for open Formulary
- vi. Other unique attributes which may warrant inclusion of the drug.

Pharmacy PPO:

1. Evidentiary standards and sources for factors applied by the P&T Committee

The P&T Committee members evaluate the following factors based on the identified evidentiary standards and sources to arrive at a determination based on the totality of the evidence. All factors are assessed and balanced on a qualitative basis according to the professional judgment of the P&T members to create a therapeutic designation, as further defined below, based on the totality of the evidence.

- Relative therapeutic efficacy:
 - Definition: Efficacy is defined as the potential outcome of treatment under optimal circumstances. Relative therapeutic efficacy is defined as the efficacy of a drug compared to other medications that are determined to be therapeutically equivalent.
 - Evidentiary standard: therapeutic designation (superior, novel, equivalent, or non-essential, as defined below), as determined in the professional judgment of the P&T members pursuant to the sources cited below
 - Sources: see below
- Cost-effectiveness:
 - Definition: Where sufficient cost and effectiveness data are available, Cost-Effectiveness is defined to mean a qualitative

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 - Sources: see below
- Cost-effectiveness:
 - Definition: Where sufficient cost and effectiveness data are available, Cost-Effectiveness is defined to mean a qualitative evaluation of the relative

evaluation of the relative magnitudes and balance between the following factors:

- Cost: AWP or MAC, where those prices are available
- Relative patient outcome: Strength of the actual outcome of treatment under real life conditions, including the impact on patient compliance when compared to alternative products, due to criteria including the dosage form and route of administration (tablet, liquid, injectable), palatability, ease of use, and/or other relevant benefits relative to current formulary agents of similar use, and potential duplication of similar drugs currently on formulary
- Cost-effectiveness is evaluated as a qualitative balancing of cost and relative patient outcomes, in the subjective professional judgment of the P&T Committee members, relying on pharmacoeconomic principles and/or published pharmacoeconomic or outcomes research evaluations where available (such as reports by the U.S. Institute for Clinical and Economic Review or the International Society for Pharmacoeconomics and Outcomes Research), to determine whether the drug offers an acceptable balance of cost and effectiveness compared to therapeutic alternatives
 - Evidentiary standard: therapeutic designation (superior, novel, equivalent, or non-essential, as defined below), as determined in the professional judgment of the P&T members pursuant to the sources cited below
 - Sources: see below

- Multi-Source Brand status:

- Definition: Multi-Source Brand (MSB) drugs are drugs marketed as brands that have at least one FDA-approved interchangeable generic available on the market (e.g., drugs for which FDA has given an “AB” rating to at least one generic alternative based on the FDA’s determination of bioequivalence).
- Evidentiary standard: MSB drugs shall be considered by default to have a Therapeutic Designation as “Equivalent” with their interchangeable generics.
 - In certain instances, a Therapeutic Caveat will be provided to indicate

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- Evidentiary standard: MSB drugs shall be considered by default to have a Therapeutic Designation as “Equivalent” with their interchangeable generics.
 - In certain instances, a Therapeutic Caveat will be provided to indicate that MSB coverage is required. For example, Narrow Therapeutic Index MSBs, and drugs with a clinical rationale to be an exception will have a mechanism in place to allow access to the MSB drug in addition to coverage for the generic alternative.
 - Source: FDA Orange Book

that MSB coverage is required. For example, Narrow Therapeutic Index MSBs, and drugs with a clinical rationale to be an exception will have a mechanism in place to allow access to the MSB drug in addition to coverage for the generic alternative.

- Source: FDA Orange Book

Therapeutic Designations: *

- **Superior** – Following evidence-based review outlined above, it is determined that the drug provides a significant therapeutic advantage, in terms of safety, efficacy, and/or cost effectiveness over other available products within the same treatment modality. Products with this designation are not placed into disadvantaged tiers.
- **Novel** - Following evidence-based review outlined above, it is determined that the drug represents a new and/or advanced therapeutic option that expands the treatment modality. Products in this tier are not excluded from closed formularies.
- **Equivalent** – Following evidence-based review outlined above, it is determined that the drug is relatively equivalent in terms of safety, efficacy, and/or cost effectiveness to other available products within the same treatment modality. The drug has not established itself as offering a significant therapeutic advantage that would require it to hold a preferred formulary position.
- **Not Essential** – Following evidence-based review outlined above, it is determined that the drug is therapeutically disadvantageous, due to either reduced safety, efficacy, and/or cost effectiveness over other available products within the same treatment modality. (usually excluded or disadvantaged)

* In addition to applying a therapeutic designation to each drug, the P&T Committee may elect to apply a “therapeutic caveat,” which is a clinical comment that provides further direction to the FBRC and FAS Department when making formulary placement determinations. Caveats are provided, as applicable, to note where other factors are identified that are determined to be significant enough that they may create exceptions to the tiering determination suggested by efficacy and cost-effectiveness alone (e.g., with regard to patient safety considerations for pregnant women). These caveats serve as instructions and are intended to provide more detailed guidance than can be conveyed in a simple therapeutic designation.

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Product Placement on Formulary.

- For products with the “Superior” designation, a minimum of one drug per therapeutic drug category will be preferred on all MedImpact Healthcare Systems, Inc. (MedImpact) National Drug Formularies.
- All products with the “Not Essential” designation will not be added to any MedImpact National Drug Formularies.
- Products with the “Equivalent” and “Novel” designations may be added to MedImpact National Drug Formularies as determined by the Formulary Administration and Strategy (FAS) Department or FBRC.

Prior to submission to regulator, Portfolio formularies are included as applicable.

Sources: All drugs or drug classes are reviewed using evidence-based criteria from credible sources including:

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Prior to submission to regulator, Portfolio formularies are included as applicable.

Sources: All drugs or drug classes are reviewed using evidence-based criteria from credible sources including:

- Peer-reviewed medical literature
- Accepted national treatment guidelines
- Drug compendia in common use
- ICER analyses
- MediSpan data
- Expert opinion where necessary
- Prescribing guidelines

2. Evidentiary standards and sources applied by DI/MIDS for Specialty determination factors:

DI/MIDS members evaluate the following factors based on the identified evidentiary standards and sources to arrive at a determination based on the totality of the evidence. All factors are assessed on a qualitative basis and are balanced to arrive at an overall determination based on the totality of the evidence according to the professional judgment of the members.

To be considered a specialty drug, a drug must meet at least one of the four factors described below. However, in some circumstances multiple factors may be needed to make a determination. LDDs will generally always be designated as specialty. The following factors are considered to designate a drug as “Specialty”:

- High cost
 - Evidentiary standard: \$2,000/month, with weight for this factor assigned based on proximity to the threshold
 - Sources: Average Wholesale Price (AWP)
- Complexity of clinical condition
 - Evidentiary standard: MedImpact identified a set of complex clinical conditions based on the professional experience and judgment of the P&T Committee members. (Note that no

- Peer-reviewed medical literature
- Accepted national treatment guidelines
- Drug compendia in common use
- ICER analyses
- MediSpan data
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 - Sources: Average Wholesale Price (AWP)
- Complexity of clinical condition
 - Evidentiary standard: MedImpact identified a set of complex clinical conditions based on the professional experience and judgment of the P&T Committee members. (Note that no MH/SUD conditions are included in this list, meaning that it is not used to subject any MH/SUD drugs to the higher cost-sharing applied in the specialty tier. Thus, this factor is applied less stringently to MH/SUD benefits than it is to M/S benefits.)
 - Sources: Professional judgment of the P&T Committee members
- Drug availability only through a specialty pharmacy (i.e. Limited Distribution Drug, or “LDD”)
 - Evidentiary standard: drugs that are available only through a specialty pharmacy are identified based on negotiation between manufacturer and pharmacies
 - Sources: manufacturer LDD lists
- Clinical utility of monitoring by specialty pharmacy due to Complex Monitoring Requirements (e.g., Risk Evaluation and Mitigation Strategies (REMS) which may require provider and/or patient registries along with laboratory or diagnostic testing).
 - Evidentiary standard: existence of a complex monitoring requirement as set forth by the FDA or other regulator
 - Sources: FDA labeling

MH/SUD conditions are included in this list, meaning that it is not used to subject any MH/SUD drugs to the higher cost-sharing applied in the specialty tier. Thus, this factor is applied less stringently to MH/SUD benefits than it is to M/S benefits.)

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 - Sources: manufacturer LDD lists
- Clinical utility of monitoring by specialty pharmacy due to Complex Monitoring Requirements (e.g., Risk Evaluation and Mitigation Strategies (REMS) which may require provider and/or patient registries along with laboratory or diagnostic testing).
 - Evidentiary standard: existence of a complex monitoring requirement as set forth by the FDA or other regulator
 - Sources: FDA labeling

3. Evidentiary standards and sources for factors applied by the FBRC

FBRC members accept the clinical evaluation by the P&T Committee and provide a recommendation regarding preferred, non-preferred, or excluded status for reviewed drugs. FBRC members evaluate the following factors based on the identified evidentiary standards and sources to arrive at a determination based on the totality of the evidence. All factors are assessed on a qualitative basis and are balanced to arrive at an overall determination based on the totality of the evidence according to the professional judgment of the members.

FBRC evaluates preferred or non-preferred status. FBRC evaluates preferred status based on the factors listed below.

- Drug cost, net of any rebates that are negotiated with the manufacturer, is less than other drugs within the same therapeutic classification
 - Drug cost, net of any rebates that are negotiated with the manufacturer, is less than other drugs within the same therapeutic classification
 - The therapeutic classification is determined by First Data Bank. Drugs belong to a Generic Therapeutic Category (GTC) and a Specific Therapeutic Class (STC). For example:

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 - Drug cost, net of any rebates that are negotiated with the manufacturer, is less than other drugs within the same therapeutic classification
 - The therapeutic classification is determined by First Data Bank. Drugs belong to a Generic Therapeutic Category (GTC) and a Specific Therapeutic Class (STC). For example: Insulin drugs are in a STC of the Diabetes GTC.
 - Cost is evaluated on the ingredient cost minus rebate earned.
 - Rebate is the amount negotiated with a drug manufacturer that is supplied to the payer after a drug is sold.
 - Evidentiary standard: Preferred status is recommended if cost of the drug after rebates is less than most nonpreferred drugs within the therapeutic class, unless:
 - There is insufficient evidence to support effectiveness compared to other drugs in the therapeutic class, making it less likely that physicians will prescribe these agents
 - There are access barriers such as FDA auto-substitutions rules, making it more likely that patients will stay on their current medication rather than switch to a new medication
 - Source(s): First Data Bank, **MedOptimize®**, drug compendia, FDA auto-substitutions rules, national treatment guidelines
- Drug utilization is anticipated to grow
 - Definitions:
 - Drug utilization is calculated by prescription claims adjudicated at point of sale. The reports generated are out of **MedOptimize®**. All analyses are conducted utilizing retrospective data.
 - Anticipated utilization is determined by one or more of the following:

<ul style="list-style-type: none"> <ul style="list-style-type: none"> Insulin drugs are in a STC of the Diabetes GTC. ▪ Cost is evaluated on the ingredient cost minus rebate earned. ▪ Rebate is the amount negotiated with a drug manufacturer that is supplied to the payer after a drug is sold. ○ Evidentiary standard: Preferred status is recommended if cost of the drug after rebates is less than most nonpreferred drugs within the therapeutic class, unless: <ul style="list-style-type: none"> ▪ There is insufficient evidence to support effectiveness compared to other drugs in the therapeutic class, making it less likely that physicians will prescribe these agents ▪ There are access barriers such as FDA auto-substitutions rules, making it more likely that patients will stay on their current medication rather than switch to a new medication ○ Source(s): First Data Bank, MedOptimize®, drug compendia, FDA auto-substitutions rules, national treatment guidelines • Drug utilization is anticipated to grow <ul style="list-style-type: none"> ○ Definitions: <ul style="list-style-type: none"> ▪ Drug utilization is calculated by prescription claims adjudicated at point of sale. The reports generated are out of MedOptimize®. All analyses are conducted utilizing retrospective data. ▪ Anticipated utilization is determined by one or more of the following: <ul style="list-style-type: none"> • Generic release version of the branded agent • Breakthrough treatment option • Drugs anticipating expanded FDA indications • AB Rating ○ Evidentiary standard: Preferred status is recommended if the therapeutic class is anticipated to grow. Growth is determined by prevalence of the disease state that the drug is indicated for and whether the drug provides breakthrough treatment option or an added option. By adding the drug to preferred status and meeting rebate contract terms, will allow the drug to earn rebates, which helps manage drug spend. ○ Source(s): MedOptimize®, IPD Analytics, Orange Book, FDA labeling 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> • Generic release version of the branded agent • Breakthrough treatment option • Drugs anticipating expanded FDA indications • AB Rating ○ Evidentiary standard: Preferred status is recommended if the therapeutic class is anticipated to grow. Growth is determined by prevalence of the disease state that the drug is indicated for and whether the drug provides breakthrough treatment option or an added option. By adding the drug to preferred status and meeting rebate contract terms, will allow the drug to earn rebates, which helps manage drug spend. ○ Source(s): MedOptimize®, IPD Analytics, Orange Book, FDA labeling <p>4. Evidentiary standards and sources for factors applied by the FAS</p> <ul style="list-style-type: none"> ▪ The FAS considers reviews and integrates the recommendations developed by the P&T and FBRC based on the factors, sources, and evidentiary standards identified above and presented to the FAS. FAS recommendations align with P&T recommendations, and the FAS exercises discretion for tiering only within limits defined by the P&T Committee. FAS may request more information from the P&T to support the committees' recommendations, and ultimately exercises professional judgment to make tiering determinations based on their evaluation of the weight of the evidence presented.
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4. Evidentiary standards and sources for factors applied by the FAS

The FAS considers reviews and integrates the recommendations developed by the P&T and FBRC based on the factors, sources, and evidentiary standards identified above and presented to the FAS. FAS recommendations align with P&T recommendations, and the FAS exercises discretion for tiering only within limits defined by the P&T Committee. FAS may request more information from the P&T to support the committees' recommendations, and ultimately exercises professional judgment to make tiering determinations based on their evaluation of the weight of the evidence presented.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Pharmacy POS:</u> Drug Coverage Plan establishes Formulary Tier design. The Pharmacy and Therapeutics committee aligns with the plan's drug coverage formulary design when placing drugs on each established formulary tier:</p> <p>Drugs are chosen for formulary review based on one or all of the following:</p> <ol style="list-style-type: none"> A practitioner requests review of a certain drug via form "Drug Formulary Change Request Form." The drug represents a therapeutic class of drugs reviewed during an annual review of all formulary drugs. The drug becomes generically available. High rate of appropriate prior authorization or step therapy use. New information is available to support a change in current formulary. <p>All therapeutic classes of medications are reviewed on an annual basis.</p> <p>The PTC evaluates the medical and pharmaceutical literature, discusses use of the drug with experts in the appropriate area of specialty, and may contact the requesting practitioner or pharmacist for additional information before discussing data</p>	<p><u>Pharmacy POS:</u> Drug Coverage Plan establishes Formulary Tier design. The Pharmacy and Therapeutics committee aligns with the plan's drug coverage formulary design when placing drugs on each established formulary tier:</p> <p>Drugs are chosen for formulary review based on one or all of the following:</p> <ol style="list-style-type: none"> A practitioner requests review of a certain drug via form "Drug Formulary Change Request Form." The drug represents a therapeutic class of drugs reviewed during an annual review of all formulary drugs. The drug becomes generically available. High rate of appropriate prior authorization or step therapy use. New information is available to support a change in current formulary. <p>All therapeutic classes of medications are reviewed on an annual basis.</p> <p>The PTC evaluates the medical and pharmaceutical literature, discusses use of the drug with experts in the appropriate area of specialty, and may contact the requesting practitioner or pharmacist for additional information before discussing data and recommendations at the PTC</p>

and recommendations at the PTC meeting.

After the PTC has reviewed the clinical evidence, expert opinion and other relevant information, a motion is made to add the drug to the Formulary, not add to the Formulary, to defer the decision awaiting further clinical information or, if applicable, to delete a drug from the Formulary. The decision is carried forth via parliamentary procedure and simple majority vote of the PTC.

The PTC Staff communicates the committee's decision to the requesting practitioner or pharmacist within thirty days after the decision is made.

The internal PTC Actions document specifies effective dates for all formulary changes. This document provides guidance for changes to KP HealthConnect, ePIMS, Lexicomp, and the PBMs.

Application of the formulary:

All KPGA affiliated Physicians and Allied Health providers who are licensed to prescribe pharmaceuticals in the state of Georgia and an affiliated care provider with Kaiser Permanente may prescribe Formulary drugs without restriction. Plan coverage determination will be administered. Prior authorization medications are labeled as such in the Formulary and may be eligible for coverage when prescribed in alignment with coverage criteria.

Formulary Drugs are covered under the prescription drug benefit and are available to members when prescribed according to their specific plan coverage criteria and co-pay or coinsurance (after the deductible is met, if applicable). See the section under Procedure: A. Formulary Drugs above for additional clarification.

If the medication is covered under the drug benefit, the prescription is filled, and pharmacy staff collects the appropriate co-pay or coinsurance amount, as appropriate.

If the medication is not covered under the drug benefit and is available through the pharmacy, the prescription is filled, and pharmacy staff collects the full retail price for the medication.

Pharmacy PPO:

The standard commercial formulary is developed and managed by Formulary Administration & Strategy (FAS) department (FAS) and approved by the MedImpact P&T Committee.

FAS acts as the decision-making body for formulary placement with support from the Drug Information (DI), MedImpact

meeting.

After the PTC has reviewed the clinical evidence, expert opinion and other relevant information, a motion is made to add the drug to the Formulary, not add to the Formulary, to defer the decision awaiting further clinical information or, if applicable, to delete a drug from the Formulary. The decision is carried forth via parliamentary procedure and simple majority vote of the PTC.

The PTC Staff communicates the committee's decision to the requesting practitioner or pharmacist within thirty days after the decision is made.

The internal PTC Actions document specifies effective dates for all formulary changes. This document provides guidance for changes to KP HealthConnect, ePIMS, Lexicomp, and the PBMs.

Application of the formulary:

All KPGA affiliated Physicians and Allied Health providers who are licensed to prescribe pharmaceuticals in the state of Georgia and an affiliated care provider with Kaiser Permanente may prescribe Formulary drugs without restriction. Plan coverage determination will be administered. Prior authorization medications are labeled as such in the Formulary and may be eligible for coverage when prescribed in alignment with coverage criteria.

Formulary Drugs are covered under the prescription drug benefit and are available to members when prescribed according to their specific plan coverage criteria and co-pay or coinsurance (after the deductible is met, if applicable). See the section under Procedure: A. Formulary Drugs above for additional clarification.

If the medication is covered under the drug benefit, the prescription is filled, and pharmacy staff collects the appropriate co-pay or coinsurance amount, as appropriate.

If the medication is not covered under the drug benefit and is available through the pharmacy, the prescription is filled, and pharmacy staff collects the full retail price for the medication.

Pharmacy PPO:

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

Direct Specialty (MIDS), and Formulary Business Review Committee (FBRC, also known as Trade Relations) departments. The roles of each committee/departments in the formulary management process are as follows:

Pharmacy & Therapeutics Committee purpose, composition, and process:

Purpose:

The Pharmacy & Therapeutics (P&T) Committee is a standing committee of MedImpact and is responsible for review, guidance, and clinical recommendations for the therapeutic use of drugs as contained within the MedImpact National Formularies.

The P&T Committee serves in an advisory capacity to MedImpact management and to the medical and clinical professionals of MedImpact clients on matters pertaining to the clinical management of drug use, including recommendations pertaining to drug selection (e.g., specific agents, or classes of agents, clinical practice guidelines, prior authorization guidelines, or coverage of specific drug therapies as they relate to appropriateness of use). The P&T Committee may serve as a delegated Pharmacy & Therapeutics committee for client organizations after proper documentation. In furtherance of these responsibilities, the P&T Committee:

1. Recommends therapeutic designations and appropriate prescribing guidelines to assist with the placement of products on Drug Formulary(ies) by the Formulary Administration and Strategy (FAS) Department and the Formulary Business Review Committee (FBRC). FAS and the FBRC will abide by all recommended Therapeutic Designations and Prescribing Guidelines of the P&T Committee.
2. Fulfills the CMS-specified functions as the P&T and Formulary decision-making body for Medicare Part D purposes.
3. Interfaces with other MedImpact quality and utilization management committees as appropriate.
4. Provides ongoing review and monitoring of the safety, effectiveness, and quality of care of drugs contained within the MedImpact and/or client formularies and in the pharmacy benefits management programs of MedImpact as needed and specified by the P&T Committee.
5. Reviews and approves drug use review and drug use evaluation programs.
6. Reviews and approves prior authorization guidelines.
7. Reviews and approves drug products for inclusion on MedImpact MAC list(s).
8. Advises MedImpact on suitable informational programs (e.g., for provider networks, clients benefit plan enrollees, and pharmacy chains).
9. Makes recommendations for the implementation of effective drug utilization control procedures.

The standard commercial formulary is developed and managed by Formulary Administration & Strategy (FAS) department (FAS) and approved by the MedImpact P&T Committee.

FAS acts as the decision-making body for formulary placement with support from the Drug Information (DI), MedImpact Direct Specialty (MIDS), and Formulary Business Review Committee (FBRC, also known as Trade Relations) departments. The roles of each committee/departments in the formulary management process are as follows:

Pharmacy & Therapeutics Committee purpose, composition, and process:

Purpose:

The Pharmacy & Therapeutics (P&T) Committee is a standing committee of MedImpact and is responsible for review, guidance, and clinical recommendations for the therapeutic use of drugs as contained within the MedImpact National Formularies.

The P&T Committee serves in an advisory capacity to MedImpact management and to the medical and clinical professionals of MedImpact clients on matters pertaining to the clinical management of drug use, including recommendations pertaining to drug selection (e.g., specific agents, or classes of agents, clinical practice guidelines, prior authorization guidelines, or coverage of specific drug therapies as they relate to appropriateness of use). The P&T Committee may serve as a delegated Pharmacy & Therapeutics committee for client organizations after proper documentation. In furtherance of these responsibilities, the P&T Committee:

1. Recommends therapeutic designations and appropriate prescribing guidelines to assist with the placement of products on Drug Formulary(ies) by the Formulary Administration and Strategy (FAS) Department and the Formulary Business Review Committee (FBRC). FAS and the FBRC will abide by all recommended Therapeutic Designations and Prescribing Guidelines of the P&T Committee.
2. Fulfills the CMS-specified functions as the P&T and Formulary decision-making body for Medicare Part D purposes.
3. Interfaces with other MedImpact quality and utilization management committees as appropriate.
4. Provides ongoing review and monitoring of the safety, effectiveness, and quality of care of drugs contained within the MedImpact and/or client formularies and in the pharmacy benefits management programs of MedImpact as needed and specified by the P&T Committee.
5. Reviews and approves drug use review and drug use evaluation programs.
6. Reviews and approves prior authorization guidelines.

Composition:

The P&T Committee is comprised of at least ten, but not more than fifteen voting members, all of whom are healthcare professionals with unrestricted licenses to practice in their professions in a state or territory of the United States, and whose training and expertise materially contributes to the goals of the P&T Committee; all of whom are physicians or pharmacists, and a majority of whom are actively practicing in their professions. A practicing physician or pharmacist is defined to be an individual who has an active professional license to practice in the United States or one of its Territories and is currently practicing in the U.S. or one of its Territories. A maximum of two MedImpact employees may be voting members. The Vice President, Medical Director (VP/Medical Director) acts as Chairperson and the Director of Drug Information acts as Co-Chairperson of the Committee. The duties of Co-Chair may be delegated to the Manager of Drug Information. The P&T Committee includes at least one actively practicing physician and at least one actively practicing pharmacist who are experts, defined as a person who has training and/or ongoing clinical practice experience, in the care of the elderly or disabled persons and who are not employees of MedImpact.

The P&T Committee shall include at least one: (a) licensed psychiatrist, or (b) licensed physician who is an expert, defined as a person who has training and/or ongoing clinical practice experience, in the treatment of substance abuse disorders.

At the discretion of the Chairperson, the P&T Committee may include additional non-voting members who may be employees of MedImpact or participating representatives of clients of MedImpact.

The P&T Committee may not include any member who is an employee of any product manufacturer or a representative of any product manufacturer that makes pharmaceutical products or supplies.

Process:

The P&T Committee must make a reasonable effort to review a new FDA approved drug product (or new FDA approved indication) within 90 days and will make a decision on each new FDA approved drug product (or new FDA approved indication) within 120 days of its release onto the market, or a justification will be provided if this timeframe is not met. A cutoff date of 30 days prior to the scheduled quarterly P&T Committee meeting date will be established to allow for preparation and dissemination of specific related drug information to P&T Committee members for review and discussion at the meeting. For special circumstances such as high-impact medications, the Chairperson may decide to call an ad hoc meeting.

7. Reviews and approves drug products for inclusion on MedImpact MAC list(s).
8. Advises MedImpact on suitable informational programs (e.g., for provider networks, clients benefit plan enrollees, and pharmacy chains).
9. Makes recommendations for the implementation of effective drug utilization control procedures.

Composition:

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New drugs or newly approved uses for drugs within six Medicare Part D protected clinical classes (immunosuppressant, antidepressant, antipsychotic, anticonvulsant, antiretroviral, antineoplastic) must be reviewed within 90 days. If any of these drugs come to market within 30 days prior to the scheduled quarterly meeting of the P&T Committee, a verbal presentation of the drug will be provided together with any available, pertinent documentation for discussion and decision by the P&T Committee. To the extent needed, document presentation will be made at the next regular meeting.

Drug(s) may be added to the formulary and assigned utilization management rules on an interim basis by the P&T Committee Chairperson prior to approval by the P&T Committee. If the drug(s) is (are) added as an interim product, the drug(s) will be brought to the next scheduled P&T Committee for final decision. The P&T Committee shall retain final authority on drug additions to the MedImpact formulary (ies).

Drugs to be considered by the P&T Committee at the next meeting shall be determined and announced by the Chairperson or CoChairperson. Additional recommendations for drugs to be considered by the P&T Committee may be made by other P&T Committee members or petitioned by client providers or representatives to the Chairperson. New drug products will not be reviewed solely based on requests by the pharmaceutical industry. Recommendations regarding the Therapeutic Designation status and the development or change of any Prescribing Guidelines may be voted during that session. Drugs coming to market as “line extensions” of existing agents currently available on MedImpact formularies may be added to the corresponding formulary by the Formulary Administration and Strategy (FAS) Department without the need for specific P&T Committee review or approval, unless such review of approval is recommended by the Director of FAS or the Director of Drug Information. The P&T Committee will also review new technology and new application of existing technology of pharmaceutical devices applicable to outpatient pharmaceutical utilization.

The P&T Committee meets quarterly, with one additional meeting annually for Part D pre-plan year formulary strategies, unless otherwise determined by the Chairperson. Additional meetings may be scheduled at the discretion of the Chairperson.

All decisions of the P&T Committee shall be binding when five or more members are present. a. A quorum shall be defined as attendance of at least five members of the current voting membership of the P&T Committee. P&T Committee decisions are binding if a majority ($\geq 51\%$) of all voting members present at the meeting approves the matter under consideration. In the event there is a tie among votes cast on a particular matter under consideration, the P&T Committee Chairperson shall make the decision

dissemination of specific related drug information to P&T Committee members for review and discussion at the meeting. For special circumstances such as high-impact medications, the Chairperson may decide to call an ad hoc meeting.

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An agenda and supplementary materials, including minutes of the previous meeting, is prepared and submitted to the P&T Committee members within a sufficient time before the meeting to ensure proper review of the material.

Presentations by non-Committee members (e.g., Advisory Board members and clients) is allowed, upon permission granted by the P&T Committee Chairperson. Product sponsor representatives may not present any materials or make any presentations to the P&T Committee.

At least annually, the P&T Committee reviews its procedures and criteria for drug selection, review, and non-formulary requests, including exception criteria for transitional beneficiaries. Modifications and additions to the P&T Committee's procedures and criteria for drug selection and review are reflected in the P&T Committee's Annual Work Plan.

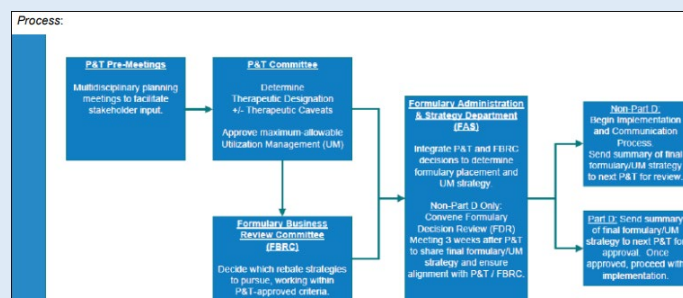
Formulary Business Review Committee (FBRC) purpose, composition, and process

Purpose:

The P&T Committee meets once a month to identify, evaluate and initiate implementation of clinically appropriate rebate strategies for MedImpact standard and custom formularies in a timely manner that allows MedImpact to deliver value to clients, be market competitive in underwriting, and be prepared for pending market or legislative changes.

Composition:

The FBRC is comprised of at least eight, but not more than twelve voting members, all of whom shall be MedImpact employees whose training and expertise materially contributes to the goals of the FBRC. The FBRC includes at least two representatives from each of the following departments: (a) Finance, (b) Client Services, (c) Operations or Regulatory, (d) Clinical. At the discretion of the Chairperson, the FBRC may include additional non-voting members who may be employees of MedImpact or participating representatives of vendors of MedImpact. The Principal, Formulary and Rebate Optimization acts as Chairperson.



under consideration, the P&T Committee Chairperson shall make the decision

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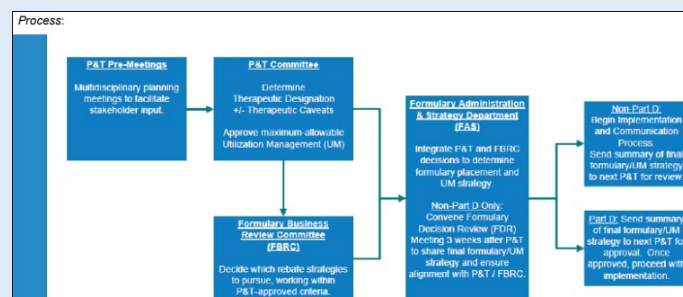
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The FBRC meets monthly, with one additional meeting annually for Part D pre-plan year formulary strategies, unless otherwise determined by the Chairperson. Additional meetings may be scheduled at the discretion of the Chairperson.

All decisions of the FBRC are binding when four or more members are present. A quorum is defined as attendance of at least four members of the current voting members of the FBRC, one of which must be present from each of the voting quadrants. FBRC decisions are binding if a majority ($\geq 51\%$) of all voting members present at the meeting approves the matter under consideration. In the event there is a tie among the votes cast on a particular matter under consideration, the FBRC Chairperson shall make the decision.

An agenda and supplementary material, including minutes of the previous meeting, are prepared and submitted to the FBRC members within a sufficient time before the meeting to ensure proper review of the material.

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Formulary decisions are clinically appropriate based on MedImpact's P&T Committee evaluation and financially cost-effective. In instances where decisions made at FBRC require additional clinical review by MedImpact's P&T Committee, the strategy will be implemented upon MedImpact P&T Committee approval. At least annually, the FBRC reviews its procedures and criteria for drug selection.

The FBRC liaisons with other MedImpact committees concerned with drug use, selection, efficacy, and safety.

Drugs to be considered by the FBRC at the next meeting are determined and announced by the Chairperson or Co-Chairperson. Additional recommendations for drugs to be considered by the FBRC may be made by other FBRC members or petitioned by internal client representatives to the Chairperson. Recommendations regarding formulary status and the development or change of any utilization management guideline may be voted during that session as long the request is vetted through with P&T Committee. Drugs coming to the market as "line extensions" of existing agents currently available on MedImpact formularies are reviewed at the Clinical/Formulary Strategy Weekly Drug Update meeting and may be added to the corresponding formulary without the need for specific FBRC review or approval, unless such review is recommended by the Principal, Formulary and Rebate Optimization

Final recommendations approved at the FBRC are sent to MedImpact Formulary Administration and Strategy (FAS)

The FBRC meets monthly, with one additional meeting annually for Part D pre-plan year formulary strategies, unless otherwise determined by the Chairperson. Additional meetings may be scheduled at the discretion of the Chairperson.

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Final recommendations approved at the FBRC are sent to MedImpact Formulary Administration and Strategy (FAS) Department to operationalize the formulary placement on

Department to operationalize the formulary placement on MedImpact standard formularies and subsequently to all the appropriate MedImpact delegating clients after each meeting and to P&T Committee for review, guidance, and clinical recommendations. The FBRC abides by all recommended Therapeutic Designations and Prescribing Guidelines of the P&T Committee.

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Step 5 – Describe the operation of the NQTL process in practice

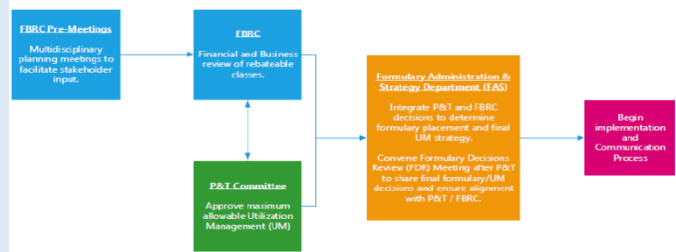
Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the **NQTL** for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing NQTL for medical surgical benefits.

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Pharmacy POS:</u> These procedures are related to the Kaiser Permanente Georgia open commercial formulary which includes step therapy and prior authorization. The Pharmacy and Therapeutics committee aligns with the plan's drug coverage formulary and tier design when placing drugs on each established formulary tier.</p> <p>The drug tier placement process is intended to enhance the quality of patient care by ensuring that available drugs meet established quality standards by providing information for safe and effective use and by limiting the availability of drugs that are unsafe, less effective, and ineffective or have high potential for toxicity or abuse. The process used is the same for both medical/surgical medications and mental health/substance use disorder medications. All medications, regardless of class of drug, indication, or specialty of the prescriber, are reviewed by the Pharmacy and Therapeutics Committee using the same factors and evidentiary standards to determine prescription medication drug coverage and formulary tier placement. MH/SUD meds are treated equitably at every step of the process, from submission for review, to determination of status, to application of the formulary during adjudication of prescription claim. Application of the above listed factors, evidentiary standards, and procedures are applied similarly to both med/surg and MH/SUD medications, allowing for parity across both areas.</p>	<p><u>Pharmacy POS:</u> These procedures are related to the Kaiser Permanente Georgia open commercial formulary which includes step therapy and prior authorization. The Pharmacy and Therapeutics committee aligns with the plan's drug coverage formulary and tier design when placing drugs on each established formulary tier.</p> <p>The drug tier placement process is intended to enhance the quality of patient care by ensuring that available drugs meet established quality standards by providing information for safe and effective use and by limiting the availability of drugs that are unsafe, less effective, and ineffective or have high potential for toxicity or abuse. The process used is the same for both medical/surgical medications and mental health/substance use disorder medications. All medications, regardless of class of drug, indication, or specialty of the prescriber, are reviewed by the Pharmacy and Therapeutics Committee using the same factors and evidentiary standards to determine prescription medication drug coverage and formulary tier placement. MH/SUD meds are treated equitably at every step of the process, from submission for review, to determination of status, to application of the formulary during adjudication of prescription claim. Application of the above listed factors, evidentiary standards, and procedures are applied similarly to both med/surg and MH/SUD medications, allowing for parity across both areas.</p>

Pharmacy PPO:

MedImpact Standard Non-Quantitative Treatment Limitation (NQTL) Analysis



Formulary Administration and Strategy (FAS) Department purpose, composition, and process:

Purpose:

Synthesizes clinical and financial considerations via integration of P&T recommendations and Trade strategies to determine final formulary placements and implementation of UM strategies.

Process:

The P&T Committee determines the Therapeutic Designation and Therapeutic Caveats (see section IV.E.), as well as the maximum-allowable utilization management criteria for each drug. The FBRC establishes rebate strategies consistent with P&T approved standards. FAS then integrates P&T criteria and FBRC strategy to make final formulary tiering and UM determinations.

Non-Part D Formulary recommendations are reviewed for quality-assurance at the Formulary Decision Review (FDR) meeting 3 weeks after P&T, after which the recommendations are considered final. They are then routed for implementation and, in parallel, sent to P&T for review.

Ongoing formulary maintenance is governed by a weekly and quarterly process.

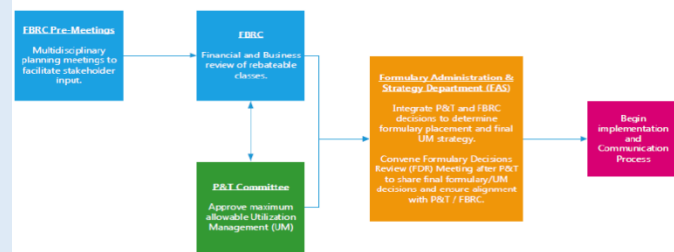
The weekly formulary maintenance process involves a review of new products as they become available through national drug databases. These new drug updates include first time drug entities, line extensions, and new generics. The weekly update includes the following steps:

- New products undergo review by Drug Information (DI) team for clinical effectiveness, safety, and cost.
- The FAS determines formulary placement and implementation of UM strategies proposed by the DI team.

Pharmacy PPO:

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

MedImpact Standard Non-Quantitative Treatment Limitation (NQTL) Analysis



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Synthesizes clinical and financial considerations via integration of P&T recommendations and Trade strategies to determine final formulary placements and implementation of UM strategies.

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The P&T Committee determines the Therapeutic Designation and Therapeutic Caveats (see section IV.E.), as well as the maximum-allowable utilization management criteria for each drug. The FBRC establishes rebate strategies consistent with P&T approved standards. FAS then integrates P&T criteria and FBRC strategy to make final formulary tiering and UM determinations.

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Ongoing formulary maintenance is governed by a weekly and quarterly process.

The weekly formulary maintenance process involves a review of new products as they become available through national drug databases. These new drug updates include first time drug entities, line extensions, and new generics. The weekly update includes the following steps:

- New products undergo review by Drug Information (DI) team for clinical effectiveness, safety, and cost.
- The FAS determines formulary placement and implementation of UM strategies proposed by the DI team.

- Federal legend drugs (prescription only) are manually added to the appropriate tier.
- MedImpact provides communication which highlight line-extensions with applied UM as well as products that will have an interim Prior Authorization applied (interim until approved during quarterly P&T Committee meeting)
- MedImpact distributes written drug reviews for clinically relevant products, including but not limited to:
 - First Time Rx's
 - Line-extensions
 - Non-Self Injectables
- MedImpact distributes communications for high-impact products and implements immediate Prior Authorization criteria when applicable

The quarterly formulary maintenance process includes finalizing formulary revisions after the quarterly P&T Committee and Formulary Decision Review meetings. The latter occurs following the quarterly P&T meeting and involves reviewing the UM approved during the P&T meeting and formulary status changes for all lines of business, as well as updating formularies with changes whether clinically and economically appropriate. The quarterly process also involves the development and distribution of client notification documents and negative change reports in supporting MedImpact's formulary decisions. Formulary changes are in place by the start of the next quarter.

Negative formulary changes only occur twice annually. Advance notice is provided to plans and plans are also provided with a report of affected beneficiaries, who are, in turn, provided with advance notice of a negative change to their benefits. The se beneficiaries will receive a 90 day grace period from the effective date of the formulary change to address the need for medication modification.

Operational Maintenance

Formulary maintenance strategies are built around an on-going review of drug therapeutic effectiveness, prescribing guidelines, clinical information, and cost-benefit analysis, which are executed on a weekly and quarterly basis.

Weekly Process

The weekly formulary maintenance process involves a review of new products as they become available through national drug databases. These new drug updates include first time drug entities, line extensions, and new generics. The weekly update includes the following steps:

- DI and MIDS collaborate to determine specialty designations.
- New products undergo review by Drug Information (DI) team for clinical effectiveness, safety, and cost.

- Federal legend drugs (prescription only) are manually added to the appropriate tier.
- MedImpact provides communication which highlight line-extensions with applied UM as well as products that will have an interim Prior Authorization applied (interim until approved during quarterly P&T Committee meeting)
- MedImpact distributes written drug reviews for clinically relevant products, including but not limited to:
 - First Time Rx's
 - Line-extensions
 - Non-Self Injectables
- MedImpact distributes communications for high-impact products and implements immediate Prior Authorization criteria when applicable

The quarterly formulary maintenance process includes finalizing formulary revisions after the quarterly P&T Committee and Formulary Decision Review meetings. The latter occurs following the quarterly P&T meeting and involves reviewing the UM approved during the P&T meeting and formulary status changes for all lines of business, as well as updating formularies with changes whether clinically and economically appropriate. The quarterly process also involves the development and distribution of client notification documents and negative change reports in supporting MedImpact's formulary decisions. Formulary changes are in place by the start of the next quarter.

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Operational Maintenance

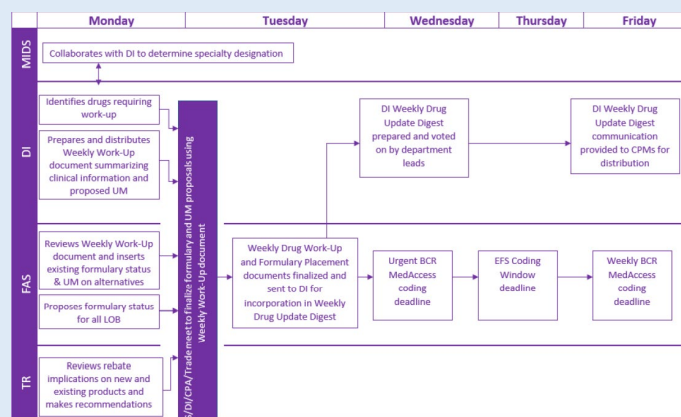
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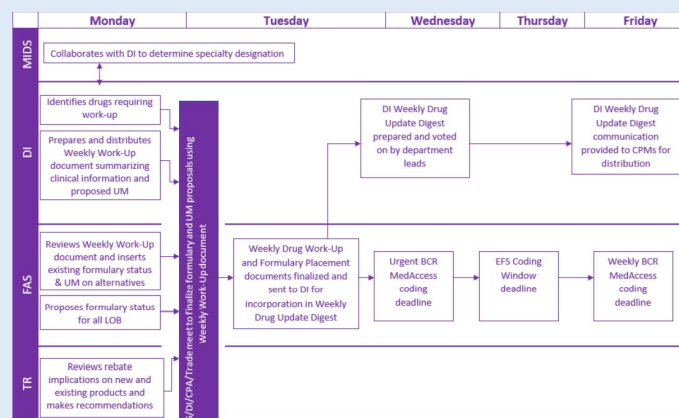
- FAS determines formulary placement.
- Formulary decisions for the week are reviewed and evaluated by the DI, FAS, and Trade teams. Department leadership for each team formally votes to approve the proposed placement
- Federal legend drugs (prescription only) are manually added to the appropriate tier.
- FAS provides communication which highlight placement for first time drug entities, line-extensions, and new Generics applied with the week. FAS will also submit coding directions for formulary placement.
- DI distributes written drug reviews for clinically relevant products and high-impact products, including but not limited to: first time drug entities, line-extensions and non-self injectable drugs.



Quarterly Process

The quarterly formulary maintenance process includes finalizing formulary revisions after the quarterly P&T and Formulary Decision Review (FDR) meetings. The P&T Committee determines Therapeutic Designations and Therapeutic Caveats. FDR reviews formulary status changes for all lines of business with client teams for finalization. The

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quarterly process concludes with the development and distribution of client notification documents and negative change reports detailing formulary decisions and rationale by FAS. Formulary changes are in place by the start of the next quarter.

- DI Team holds preparatory meetings (Clinical Strategy) informing internal teams of medications to be reviewed at the P&T Committee. The P&T Committee meets to finalize clinical criteria, Therapeutic Designations and Therapeutic Caveats.
- The Formulary Business Review Committee (FBRC) reviews trade and financial strategies to determine if P&T actions are needed, and whether operational or regulatory barriers exist. The FBRC accepts the clinical evaluation by the P&T Committee and implements rebate strategies in line with P&T standards.
- FAS cross-references the existing formulary with the proposed P&T and Trade recommended actions on the Formulary Action Grid. FAS integrates the P&T standards, FBRC strategy, and business strategy to implement final formulary placement.
- Formulary Decision Review Meeting is held after the P&T Committee to review formulary revisions after which the recommendations are considered final.
- Formulary changes are communicated to the client and client teams via the Formulary Action Grid. Formulary extract and print documents are produced upon completion of coding and print documents are distributed prior to the start of the new quarter (i.e., date of effective change).

Formulary Exceptions

Formulary Exception requests are considered through the Prior Authorization process. Please see the Prior Authorization NQTL analysis for details.

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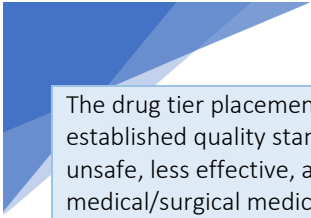
Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Pharmacy POS:

These procedures are related to the Kaiser Permanente Georgia open commercial formulary which includes prior authorization.



The drug tier placement process is intended to enhance the quality of patient care by ensuring that available drugs meet established quality standards by providing information for safe and effective use and by limiting the availability of drugs that are unsafe, less effective, and ineffective or have high potential for toxicity or abuse. The process used is the same for both medical/surgical medications and mental health/substance use disorder medications. All medications, regardless of class of drug, indication, or specialty of the prescriber, are reviewed by the Pharmacy and Therapeutics Committee using the same factors and evidentiary standards to determine prescription medication drug coverage and formulary tier placement. MH/SUD meds are treated equitably at every step of the process, from submission for review, to determination of status, to application of the formulary during adjudication of prescription claim. Application of the above listed factors, evidentiary standards, and procedures are applied similarly to both med/surg and MH/SUD medications, allowing for parity across both areas.

Pharmacy PPO:

All factors, sources, and evidentiary standards used for formulary tiering, as written, are applied consistently to all M/S and MH/SUD drugs, regardless of the conditions for which they are prescribed. All processes for applying formulary tiering, in operation, are also the same for all drugs, regardless of the conditions for which they are prescribed.

Operations measure data show that designations for non-preferred and specialty status are applied comparably and no more stringently to MH/SUD drugs relative to M/S drugs. (Identification of ACA and generic drugs is non-discretionary, so these data are merely provided for completeness.) Comparability is demonstrated by the tiering distribution data, which show that a greater proportion of brand MH/SUD drugs are covered in the preferred tier relative to the proportion of brand M/S drugs that are covered in the preferred tier, and that only a very small number of MH/SUD drugs are covered in the specialty tier. The data also demonstrate that a lower proportion of MH/SUD drugs are non-formulary relative to M/S drugs, as shown in Tier 4.

Thus, MedImpact concludes that the processes, strategies, evidentiary standards, and other factors that are used for Formulary Tiering are applied to MH/SUD drugs in a manner that is comparable to and no more stringent than the application to M/S drugs, as written and in operation.

Kaiser Permanente Insurance Company (KPIC) Georgia Region

Non-Quantitative Treatment Limits (NQTL)



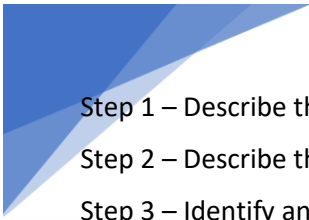
NQTL: Out of Network Standards and Standards for Providing Access to Out-of-Network Provider

Last Reviewed: November 14, 2023



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Benefits		Classifications					
Is NQTL applied to Medical/Surgical benefits?	Is NQTL applied to Mental Health/Substance Use Disorder benefits?	Is NQTL applied to In Network Inpatient classification?	Is NQTL applied to Out of Network Inpatient classification?	Is NQTL applied to In Network Outpatient classification?	Is NQTL applied to Out of Network Outpatient classification?	Is NQTL applied to Emergency classification?	Is NQTL applied to Prescription classification?
Y	Y	N	Y	N	Y	N	N

Benefit Classification 1: Inpatient – In Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than+ the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion
N/A

Benefit Classification 2: Inpatient – Out-of-Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>PPO/POS</u></p> <ul style="list-style-type: none"> • Primary Care • Specialty Care • Telemedicine and Telehealth Visits <ul style="list-style-type: none"> ○ Primary Care ○ Specialty Care • Injection Visits (other than Immunization) including Allergy Injection <ul style="list-style-type: none"> ○ Primary Care ○ Specialty Care • Allergy Testing (performed in Office Setting or Outpatient Hospital Setting) • Allergy Serum • Laboratory Services • Radiology Services other than High Tech Radiology Services • High Tech Radiology Services (e.g. MRI's, CTs, PET, Myelogram and Nuclear Medicine scans) • Chemotherapy, Radiation and Infusion Therapy • Chiropractic Care (spinal manipulation only) • Outpatient Surgery (includes Facility and Professional Charges) • Hospital Outpatient (includes Facility and Professional Charges) • Inpatient Services • Ambulance Services • CLINICAL TRIALS (M/S) • Durable Medical Equipment (DME) • Hearing Services • Home Health Care • Hospice Care • Infertility Services • Preventative Services • Prosthetic Devices and Orthotics • Rehabilitation Services and Habilitative services • Skilled Nursing Facility • Transplants • Urgent Care • Maternity inpatient hospital Services 	<p><u>PPO/POS</u></p> <ul style="list-style-type: none"> • Integrated Behavioral Health Consultation • Telemedicine and Telehealth Visits <ul style="list-style-type: none"> ○ Primary Care ○ Specialty Care • Autism Spectrum Disorder Services <ul style="list-style-type: none"> ○ Applied Behavior Analysis Program (Limited to Children through age 20) ○ Speech Therapy (Limited to Children through age 20) ○ Physical and Occupational Therapy (Limited to Children through age 20) • Clinical Trials (MH/SUD) • Mental Health and Chemical Dependency Services <ul style="list-style-type: none"> ○ Outpatient <ul style="list-style-type: none"> ▪ Individual visits ▪ Group visits ▪ Medication visit ▪ Partial Hospitalization ▪ Intensive Outpatient Therapy Programs ▪ Neurophysiological and psychological testing ▪ Electroconvulsive treatment: ○ Inpatient <ul style="list-style-type: none"> ▪ Hospital (includes Facility and Professional Charges)

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
<p>Kaiser Permanente Insurance Company (KPIC) offers the Dual Choice Plan in Georgia. This plan is composed of a In-Network PPO plan and Out-of-Network PPO plan. The Preferred Provider Organization (PPO) In-Network plan is comprised of Kaiser Providers and Contracted Providers and offers the Private Health Care System (PHCS) network. The Out-of-Network PPO allows members to access any licensed health care provider in the United States. The type of plan or network that the member elects for their medical care has different member cost-share. Kaiser Permanente administers both PPO plans. "Our goal at Kaiser Permanente Insurance Company (KPIC) is to offer affordable care to all Member through the provider networks".</p> <p>The Certificate of Insurance (COI) states: The Services are provided by a Plan Provider- PHCS provider network (unless they are qualified Urgent Services may be provided by PHCS Provider or Non-Plan Provider subject to an approved pre-certification as described in the “pre-certification” section, above) in accordance with the terms and conditions of this COI including but not limited to the requirements, if any, for pre-certification.</p> <p><u>Out-of-Network Providers</u></p> <p>If a Covered Person receives care from an Out-of-Network Provider as defined in the GENERAL DEFINITIONS section, benefits under the Group Policy are payable at the Out-of-Network Provider level.</p> <ul style="list-style-type: none">• Your out-of-pocket expenses for services received from Out-of-Network Providers may be higher than similar services provided by In-Network Providers.• You are responsible for assuring Your Out-of-Network Provider has obtained necessary Precertification.• You may be required to pay the full amount for the care You receive and submit a claim form for reimbursement.• You are also responsible for paying amounts that are greater than the Maximum Allowable Charge, except when specified in the No Surprise Billing Protections provision below. <p>KPIC is not responsible for Your decision to receive treatment, services or supplies from In-Network or Out-of-Network Providers. Additionally, KPIC is neither responsible for the qualifications of providers nor the treatments, services or</p>	<p>Kaiser Permanente Insurance Company (KPIC) offers the Dual Choice Plan in Georgia. This plan is composed of a In-Network PPO plan and Out-of-Network PPO plan. The Preferred Provider Organization (PPO) In-Network plan is comprised of Kaiser Providers and Contracted Providers and offers the Private Health Care System (PHCS) network. The Out-of-Network PPO allows members to access any licensed health care provider in the United States. The type of plan or network that the member elects for their medical care has different member cost-share. Kaiser Permanente administers both PPO plans. "Our goal at Kaiser Permanente Insurance Company (KPIC) is to offer affordable care to all Member through the provider networks".</p> <p>The Certificate of Insurance (COI) states: The Services are provided by a Plan Provider- PHCS provider network (unless they are qualified Urgent Services may be provided by PHCS Provider or Non-Plan Provider subject to an approved pre-certification as described in the “pre-certification” section, above) in accordance with the terms and conditions of this COI including but not limited to the requirements, if any, for pre-certification.</p> <p><u>Out-of-Network Providers</u></p> <p>If a Covered Person receives care from an Out-of-Network Provider as defined in the GENERAL DEFINITIONS section, benefits under the Group Policy are payable at the Out-of-Network Provider level.</p> <ul style="list-style-type: none">• Your out-of-pocket expenses for services received from Out-of-Network Providers may be higher than similar services provided by In-Network Providers.• You are responsible for assuring Your Out-of-Network Provider has obtained necessary Precertification.• You may be required to pay the full amount for the care You receive and submit a claim form for reimbursement.• You are also responsible for paying amounts that are greater than the Maximum Allowable Charge, except when specified in the No Surprise Billing Protections provision below. <p>KPIC is not responsible for Your decision to receive treatment, services or supplies from In-Network or Out-of-Network Providers. Additionally, KPIC is neither responsible for the qualifications of providers nor the treatments, services or</p>

Medical/Surgical

supplies under this coverage. You are responsible for assuring Your Network Provider and Out-of-Network Provider has obtained necessary Precertification.

Provider Nomination

KPIC also established a Provider Nomination process for non-participating providers. This nomination process includes contracting and credentialing. KPIC members can call Member Services Call Center (MSCC) to nominate a provider.

The MSCC Department will use the Online Provider Nomination tool to nominate individual practitioners, provider groups, acute care facilities and ancillary facilities for participation in our networks. This tool can also be used to check the status of your nominations and to create reports documenting the referrals submitted during specific time frames.

KPIC Implemented Process:

When an Insured is unable to obtain covered services from a participating provider or contracted provider due to the Maximum Distance, Wait Time Limits, or Geographical Maximum Distance (miles) per Provider Type, as outlined below, the covered services will be processed at the member's participating/ in network benefit. The Insured will be held harmless from any balance billing from the non-participating/ out of network provider. This policy sets the FLOOR for member experience. This process includes Claims Processing Rules Desk Level Procedures (DLP) that outlines the steps that will be taken by the internal and external Third-Party Administrators (TPAs).

This process applies to all KPIC Insureds and their eligible dependents who are enrolled in a KPIC Fully Insured Point of Service (POS), Exclusive Provider Organization (EPO) or Preferred Provider Organization (PPO) plan design.

Medical Review Program means the organization or program that: 1) evaluates proposed treatment or services; and 2) when appropriate, determines that KPIC will deny coverage on the grounds that the care is not Medically Necessary or is not Medically Necessary Treatment of a Mental Health or Substance Use Disorder. Precertification means the required assessment of the necessity, efficiency and or appropriateness of specified health care services or treatment made by the Medical Review Program. Request for Precertification must be made by the Covered Person or the Covered Person's attending Physician prior to the commencement of any service or treatment. If Precertification is required, it must be obtained to avoid a reduction in benefits in a form of a penalty. The Medical Review Program would only apply if precertification is required.

Qualifications/Training:

DPertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained

Mental Health/Substance Use Disorder

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Qualifications/Training:

DPertaining to MH/SUD and M/S the UM team is comprised of licensed physicians and licensed clinical staff who are trained

Medical/Surgical

Mental Health/Substance Use Disorder

and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing concurrent review requests are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

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Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical

Mental Health/Substance Use Disorder

KPIC is using the factors and sources below.

Factors

- Geographic location
- Multi-specialty co-location

Sources

- Claims data
- Expert medical review (if applicable)

KPIC is using the factors and sources below.

Factors

- Geographic location
- Multi-specialty co-location

Sources

- Claims data
- Expert medical review (if applicable)

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical

Mental Health/Substance Use Disorder

Kaiser Permanente Insurance Company (KPIC) offers members two Dual Choice Plans in the State of Georgia. The first plan is an in-network plan with Kaiser Providers and offers a partnered network with Private Health Care System (PHCS). The second plan is a PPO out of area plan whereby the member can receive medical care with any licensed provider in the Unites States.

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Medical/Surgical

The definition of out-of-network is comprised by both the geographic region of the plan and KPIC process outlined in the KPIC Process section in step 2 above for network strategy for provider and service sufficiency.

For medical necessity review (if precertification is required) KPIC utilizes nationally recognized treatment guidelines used to define clinically appropriate standards of care such as American Society of Addiction Medicine (ASAM) criteria/guidelines are utilized for Substance Use Disorder services, Milliman Care Guidelines (MCG™) are utilized for Medical/Surgical as well as Mental Health services and the World Professional Association for Transgender Health (WPATH) criteria/guidelines are utilized for Mental Health gender nonconformity care. The evidenced based criteria to make medical necessity determinations are reviewed, approved, and adopted annually at the Utilization Management / Quality Management (UM/QM) Committee, with involvement of the appropriate and credentialed practitioners. These processes are reflective in the Prior Authorization NQTL. This process helps to ensure access to the appropriate and effective level of care.

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Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical

KPIC does not deviate from standards or treatments.

Benefits and exclusions are noted and addressed in the Certificate of Insurance (COI) provided to the member and included in submission of Regulatory filings. Clinical reviews and consultation processes are in place with licensed clinical healthcare professionals that determine medical necessity for the purpose of approving or denying a pre-certification.

The KPIC Operations process is focused on member experience. Should KPIC receive a complaint from a member, KPIC will apply the following process in plan year 2022:

When an Insured is unable to obtain covered services from a participating provider or contracted provider due to the Maximum Distance, Wait Time Limits, or Geographical

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Medical/Surgical

Maximum Distance (miles) per Provider Type, as outlined below, the covered services will be processed at the member's participating/ in network benefit. The Insured will be held harmless from any balance billing from the non-participating/ out of network provider. This policy sets the FLOOR for member experience. Where applicable based on region, KPIC will also continue to comply with any additional or more stringent state mandates that vary from what has been outlined below. This process includes Claims Processing Rules Desk Level Procedures (DLP) that outlines the steps that will be taken by the internal and external Third-Party Administrators (TPAs).

This process applies to all KPIC Insureds and their eligible dependents who are enrolled in a KPIC Fully Insured Point of Service (POS), Exclusive Provider Organization (EPO) or Preferred Provider Organization (PPO) plan design.

Precertification Process

Precertification through the Medical Review Program This section describes (if applicable):

1. The Medical Review Program and Precertification procedures for Medical Benefits other than outpatient prescription drugs;
2. How failure to obtain Precertification affects coverage;
3. Precertification administrative procedures;
4. Which clinical procedures require Precertification; and
5. How to appeal an adverse determination by the Medical Review Program.

Precertification must be obtained for all Hospital stays and certain other services and procedures. Request for Precertification must be made by the Covered Person, the Covered Person's attending Physician, or the Covered Person's authorized representative prior to the commencement of any service or treatment. If Your services are provided by a Kaiser Permanente Provider, the Kaiser Permanente Provider will arrange for any necessary Precertification on Your behalf. If Precertification is required, it must be obtained to avoid a reduction in benefits. It is important to work with your provider to be certain services are Precertified when required or you will pay for the cost of the service.

Precertification will not result in payment of benefits that would not otherwise be covered under the Group Policy if You are no longer covered under the plan at the time the services are received, benefits under the plan have been exhausted, or in cases of fraud by You or the provider.

Medical Necessity Precertification requests are reviewed by the KPIC Utilization Management (UM) team, Permanente Advantage (PA).

Mental Health/Substance Use Disorder

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Medical Necessity Precertification requests are reviewed by the KPIC Utilization Management (UM) team, Permanente Advantage (PA).

Medical/Surgical

Mental Health/Substance Use Disorder

Medical Review Program means the organization or program that: 1) evaluates proposed treatment or services; and 2) when appropriate, determines that KPIC will deny coverage on the grounds that the care is not Medically Necessary or is not Medically Necessary Treatment of a Mental Health or Substance Use Disorder. Precertification means the required assessment of the necessity, efficiency and or appropriateness of specified health care services or treatment made by the Medical Review Program. Request for Precertification must be made by the Covered Person or the Covered Person's attending Physician prior to the commencement of any service or treatment. If Precertification is required, it must be obtained to avoid a reduction in benefits in a form of a penalty.

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Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical

Mental Health/Substance Use Disorder

Benefits and exclusions are noted and addressed in the Certificate of Insurance (COI) provided to the member and included in submission of Regulatory filings. Clinical reviews and consultation processes are in place with licensed clinical healthcare professionals that determine medical necessity for the purpose of approving or denying a pre-certification.

The KPIC Operations process is focused on member experience. Should KPIC receive a complaint from a member, KPIC will apply the following process in plan year 2022:

When an Insured is unable to obtain covered services from a participating provider or contracted provider due to the Maximum Distance, Wait Time Limits, or Geographical Maximum Distance (miles) per Provider Type, as outlined below, the covered services will be processed at the member's participating/ in network benefit. The Insured will be held harmless from any balance billing from the non-participating/ out of network provider. This policy sets the FLOOR for member experience. Where applicable based on region, KPIC will also continue to comply with any additional or more stringent state mandates that vary from what has been outlined below. This process includes Claims Processing Rules Desk Level Procedures (DLP) that outlines the steps that will be taken by the internal and external Third-Party Administrators (TPAs).

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When an Insured is unable to obtain covered services from a participating provider or contracted provider due to the Maximum Distance, Wait Time Limits, or Geographical Maximum Distance (miles) per Provider Type, as outlined below, the covered services will be processed at the member's participating/ in network benefit. The Insured will be held harmless from any balance billing from the non-participating/ out of network provider. This policy sets the FLOOR for member experience. Where applicable based on region, KPIC will also continue to comply with any additional or more stringent state mandates that vary from what has been outlined below. This process includes Claims Processing Rules Desk Level Procedures (DLP) that outlines the steps that will be taken by the internal and external Third-Party Administrators (TPAs).

Medical/Surgical

This process applies to all KPIC Insureds and their eligible dependents who are enrolled in a KPIC Fully Insured Point of Service (POS) or Preferred Provider Organization (PPO) plan design.

Mental Health/Substance Use Disorder

This process applies to all KPIC Insureds and their eligible dependents who are enrolled in a KPIC Fully Insured Point of Service (POS) or Preferred Provider Organization (PPO) plan design.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

KPIC benefits for MH/SUD are comparable to Med/Surg and applied no more stringently than the processes, strategies, evidentiary standards, and factors noted in the COI provided to all members for the awareness of their benefits.

Benefit Classification 3: Outpatient – In Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical

N/A

Mental Health/Substance Use Disorder

N/A

Step 1 – Describe the NQTL's requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical

N/A

Mental Health/Substance Use Disorder

N/A

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

N/A

N/A

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

N/A

N/A

Step 4 – Processes and strategies used to design NQTL as written

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

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

N/A

N/A

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

N/A

N/A

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

N/A

Benefit Classification 4: Outpatient – Out-of-Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
<u>PPO/POS</u> <ul style="list-style-type: none">• Primary Care• Specialty Care• Telemedicine and Telehealth Visits<ul style="list-style-type: none">○ Primary Care○ Specialty Care• Injection Visits (other than Immunization) including Allergy Injection<ul style="list-style-type: none">○ Primary Care○ Specialty Care• Allergy Testing (performed in Office Setting or Outpatient Hospital Setting)• Allergy Serum• Laboratory Services• Radiology Services other than High Tech Radiology Services• High Tech Radiology Services (e.g. MRI's, CTs, PET, Myelogram and Nuclear Medicine scans)• Chemotherapy, Radiation and Infusion Therapy• Chiropractic Care (spinal manipulation only)• Outpatient Surgery (includes Facility and Professional Charges)• Hospital Outpatient (includes Facility and Professional Charges)• Inpatient Services• Ambulance Services• CLINICAL TRIALS (M/S)• Durable Medical Equipment (DME)• Hearing Services• Home Health Care• Hospice Care	<u>PPO/POS</u> <ul style="list-style-type: none">• Integrated Behavioral Health Consultation• Telemedicine and Telehealth Visits<ul style="list-style-type: none">○ Primary Care○ Specialty Care• Autism Spectrum Disorder Services<ul style="list-style-type: none">○ Applied Behavior Analysis Program (Limited to Children through age 20)○ Speech Therapy (Limited to Children through age 20)○ Physical and Occupational Therapy (Limited to Children through age 20)• Clinical Trials (MH/SUD)• Mental Health and Chemical Dependency Services<ul style="list-style-type: none">○ Outpatient<ul style="list-style-type: none">▪ Individual visits▪ Group visits▪ Medication visit▪ Partial Hospitalization▪ Intensive Outpatient Therapy Programs▪ Neurophysiological and psychological testing▪ Electroconvulsive treatment:○ Inpatient<ul style="list-style-type: none">▪ Hospital (includes Facility and Professional Charges)

Medical/Surgical

Mental Health/Substance Use Disorder

- Infertility Services
- Preventative Services
- Prosthetic Devices and Orthotics
- Rehabilitation Services and Habilitative services
- Skilled Nursing Facility
- Transplants
- Urgent Care
- Maternity inpatient hospital Services

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical

Mental Health/Substance Use Disorder

The Certificate of Insurance (COI) states: The Services are provided by a Plan Provider- PHCS provider network (unless they are qualified Urgent Services may be provided by PHCS Provider or Non-Plan Provider subject to an approved pre-certification as described in the “pre-certification” section, above) in accordance with the terms and conditions of this COI including but not limited to the requirements, if any, for pre-certification.

In the event a member does not have appropriate network adequacy within the State and/or Jurisdiction Regulatory requirements, KPIC is proactive in identifying impacted members, notifying the members and provides network access to a non-contracted provider by nominating (contracting) a provide or negotiating a Letter of Agreement (LOA) for the member to have adequate access to medical care.

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Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical

Mental Health/Substance Use Disorder

KPIC is using the factors and sources below.

Factors

- Geographic location
- Multi-specialty co-location

Sources

KPIC is using the factors and sources below.

Factors

- Geographic location
- Multi-specialty co-location

Sources

Medical/Surgical

- Claims data
- Expert medical review (if applicable)

Mental Health/Substance Use Disorder

- Claims data
- Expert medical review (if applicable)

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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Medical/Surgical	Mental Health/Substance Use Disorder
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Medical/Surgical

Mental Health/Substance Use Disorder

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Precertification will not result in payment of benefits that would not otherwise be covered under the Group Policy if You are no longer covered under the plan at the time the services are received, benefits under the plan have been exhausted, or in cases of fraud by You or the provider.

Medical Necessity Precertification requests are reviewed by the KPIC Utilization Management (UM) team, Permanente Advantage (PA).

Medical Review Program means the organization or program that: 1) evaluates proposed treatment or services; and 2) when appropriate, determines that KPIC will deny coverage on the grounds that the care is not Medically Necessary or is not Medically Necessary Treatment of a Mental Health or Substance Use Disorder. Precertification means the required assessment of the necessity, efficiency and or appropriateness of specified health care services or treatment made by the Medical Review Program. Request for Precertification must be made by the Covered Person or the Covered Person's attending Physician prior to the commencement of any service or treatment. If Precertification is required, it must be obtained to avoid a reduction in benefits in a form of a penalty.

5. How to appeal an adverse determination by the Medical Review Program.

Precertification must be obtained for all Hospital stays and certain other services and procedures. Request for Precertification must be made by the Covered Person, the Covered Person's attending Physician, or the Covered Person's authorized representative prior to the commencement of any service or treatment. If Your services are provided by a Kaiser Permanente Provider, the Kaiser Permanente Provider will arrange for any necessary Precertification on Your behalf. If Precertification is required, it must be obtained to avoid a reduction in benefits. It is important to work with your provider to be certain services are Precertified when required or you will pay for the cost of the service.

Precertification will not result in payment of benefits that would not otherwise be covered under the Group Policy if You are no longer covered under the plan at the time the services are received, benefits under the plan have been exhausted, or in cases of fraud by You or the provider.

Medical Necessity Precertification requests are reviewed by the KPIC Utilization Management (UM) team, Permanente Advantage (PA).

Medical Review Program means the organization or program that: 1) evaluates proposed treatment or services; and 2) when appropriate, determines that KPIC will deny coverage on the grounds that the care is not Medically Necessary or is not Medically Necessary Treatment of a Mental Health or Substance Use Disorder. Precertification means the required assessment of the necessity, efficiency and or appropriateness of specified health care services or treatment made by the Medical Review Program. Request for Precertification must be made by the Covered Person or the Covered Person's attending Physician prior to the commencement of any service or treatment. If Precertification is required, it must be obtained to avoid a reduction in benefits in a form of a penalty.

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical

Benefits and exclusions are noted and addressed in the Certificate of Insurance (COI) provided to the member and included in submission of Regulatory filings. Clinical reviews and consultation processes are in place with licensed clinical healthcare professionals that determine medical necessity for the purpose of approving or denying a pre-certification.

The KPIC Operations process is focused on member experience. Should KPIC receive a complaint from a member, KPIC will apply the following process in plan year 2022:

When an Insured is unable to obtain covered services from a participating provider or contracted provider due to the Maximum Distance, Wait Time Limits, or Geographical Maximum Distance (miles) per Provider Type, as outlined below, the covered services will be processed at the member's participating/ in network benefit. The Insured will be held harmless from any balance billing from the non-participating/ out of network provider. This policy sets the FLOOR for member experience. Where applicable based on region, KPIC will also continue to comply with any additional or more stringent state mandates that vary from what has been outlined below. This process includes Claims Processing Rules Desk Level Procedures (DLP) that outlines the steps that will be taken by the internal and external Third-Party Administrators (TPAs).

This process applies to all KPIC Insureds and their eligible dependents who are enrolled in a KPIC Fully Insured Point of Service (POS) or Preferred Provider Organization (PPO) plan design.

Mental Health/Substance Use Disorder

Benefits and exclusions are noted and addressed in the Certificate of Insurance (COI) provided to the member and included in submission of Regulatory filings. Clinical reviews and consultation processes are in place with licensed clinical healthcare professionals that determine medical necessity for the purpose of approving or denying a pre-certification.

The KPIC Operations process is focused on member experience. Should KPIC receive a complaint from a member, KPIC will apply the following process in plan year 2022:

When an Insured is unable to obtain covered services from a participating provider or contracted provider due to the Maximum Distance, Wait Time Limits, or Geographical Maximum Distance (miles) per Provider Type, as outlined below, the covered services will be processed at the member's participating/ in network benefit. The Insured will be held harmless from any balance billing from the non-participating/ out of network provider. This policy sets the FLOOR for member experience. Where applicable based on region, KPIC will also continue to comply with any additional or more stringent state mandates that vary from what has been outlined below. This process includes Claims Processing Rules Desk Level Procedures (DLP) that outlines the steps that will be taken by the internal and external Third-Party Administrators (TPAs).

This process applies to all KPIC Insureds and their eligible dependents who are enrolled in a KPIC Fully Insured Point of Service (POS) or Preferred Provider Organization (PPO) plan design.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

KPIC benefits for MH/SUD are comparable to Med/Surg and applied no more stringently than the processes, strategies, evidentiary standards, and factors noted in the COI provided to all members for the awareness of their benefits.

Benefit Classification 5: Emergency Services

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
<u>PPO/ POS</u> <ul style="list-style-type: none"> Emergency Services (covered in the in-network benefit) Ambulance Services (covered in the in-network benefit) <ul style="list-style-type: none"> Ambulance (per trip) Non-Emergency Ambulance (per trip) 	<u>PPO/ POS</u> <ul style="list-style-type: none"> Emergency Services (covered in the in-network benefit) Ambulance Services (covered in the in-network benefit) <ul style="list-style-type: none"> Ambulance (per trip) Non-Emergency Ambulance (per trip)

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
<p>ER Services are covered under the POS Tier 1 plan which is always in network for our members cost share. KPIC plans have various member cost share and out of pocket expenses.</p> <p>The KPIC Certificate of Insurance (COI) states the following:</p> <p>Emergency Services Precertification is not required for Emergency Services however, it is very important that you, your provider, or someone else acting on your behalf, call us to notify us that you need Post-Stabilization Care. Post-Stabilization Care is Medically Necessary Services related to your Emergency Medical Condition that you receive after your treating physician determines that your Emergency Medical Condition is Stabilized. Please call Customer Services at 1-855-364-3185, 711(TTY).</p>	<p>ER Services are covered under the POS Tier 1 plan which is always in network for our members cost share. KPIC plans have various member cost share and out of pocket expenses.</p> <p>The KPIC Certificate of Insurance (COI) states the following:</p> <p>Emergency Services Precertification is not required for Emergency Services however, it is very important that you, your provider, or someone else acting on your behalf, call us to notify us that you need Post-Stabilization Care. Post-Stabilization Care is Medically Necessary Services related to your Emergency Medical Condition that you receive after your treating physician determines that your Emergency Medical Condition is Stabilized. Please call Customer Services at 1-855-364-3185, 711(TTY).</p>

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
Not Applicable since Emergency Services and are covered out of network for both Med/Surg and MH/SUD.	Not Applicable since Emergency Services and are covered out of network for both Med/Surg and MH/SUD.

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor

identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

The KPIC Certificate of Insurance (COI) does not distinguish emergency services for Med/Surg or MH/SUD. All emergency services are covered at the same level.

Benefit Classification 6: Pharmacy Services

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
Please refer to response in Step 1.	Please refer to response in Step 1.

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
Plans may elect to cover prescription drugs at out of network pharmacies through a direct member reimbursement. Applicable out of network cost share would apply and deductible may or may not be applied. This process is the same regardless of whether the medication is for medical/surgical or mental health/substance use disorder.	Plans may elect to cover prescription drugs at out of network pharmacies through a direct member reimbursement. Applicable out of network cost share would apply and deductible may or may not be applied. This process is the same regardless of whether the medication is for medical/surgical or mental health/substance use disorder.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
Please refer to response in Step 1.	Please refer to response in Step 1.

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
Please refer to response in Step 1. N/A- KPIC does not distinguish benefits for Med/Surg and MH/SUD. KPIC benefits for Med/Surg are comparable and applied no more stringently.	Please refer to response in Step 1. N/A- KPIC does not distinguish benefits for Med/Surg and MH/SUD. KPIC benefits for Med/Surg are comparable and applied no more stringently.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
Please refer to response in Step 1.	Please refer to response in Step 1.

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
Please refer to response in Step 1.	Please refer to response in Step 1.

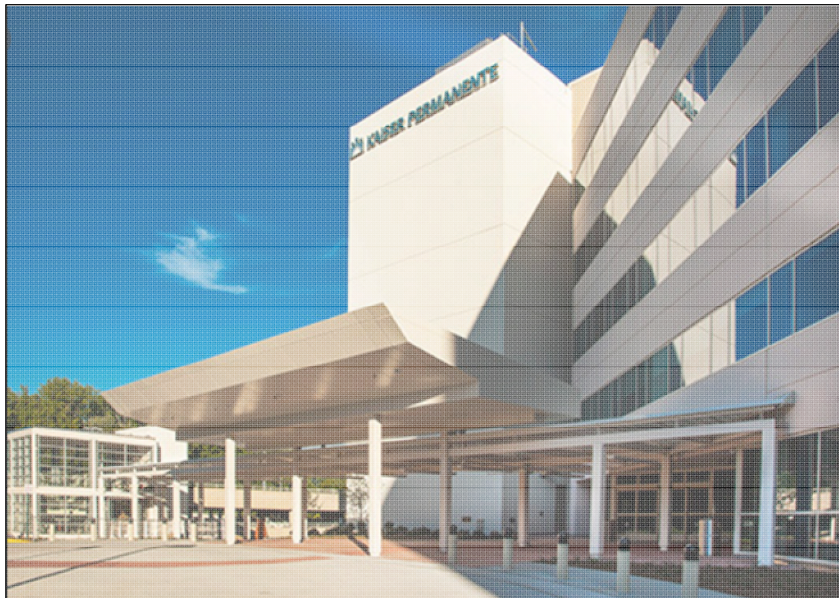
Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion
Please refer to response in Step 1.

Kaiser Permanente Insurance Company (KPIC) Georgia

Non-Quantitative Treatment Limits (NQTL)



NQTL: Retrospective Review

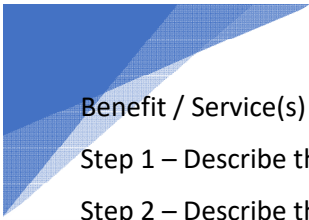
Point-of-Service (POS) and Preferred Provider Organization (PPO)
Plans

Last Reviewed: December 20, 2023



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Benefits		Classifications					
Is NQTL applied to Medical/Surgical benefits?	Is NQTL applied to Mental Health/Substance Use Disorder benefits?	Is NQTL applied to In Network Inpatient classification?	Is NQTL applied to Out of Network Inpatient classification?	Is NQTL applied to In Network Outpatient classification?	Is NQTL applied to Out of Network Outpatient classification?	Is NQTL applied to Emergency classification?	Is NQTL applied to Prescription classification?
Yes	Yes	Yes	Yes	Yes	Yes	No	No

Benefit Classification 1: Inpatient – In Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage POS:</u> N/A	<u>Permanente Advantage POS:</u> N/A
<u>Permanente Advantage PPO:</u> <ul style="list-style-type: none"> Inpatient Medical / Surgical Hospital Care Inpatient Medically Necessary Bariatric Surgery (Morbid Obesity Services) Inpatient Infertility Services Inpatient Rehabilitation and Habilitation Services Skilled Nursing Facility Inpatient Transplant Services 	<u>Permanente Advantage PPO:</u> <ul style="list-style-type: none"> Inpatient Behavioral Health (BH)/Mental Health (MH) Hospital Care Inpatient Substance Use Disorder (SUD) Services

Step 1 – Describe the NQTL's requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage PPO</u> <u>Post-service Claims</u> mean a Claim involving the payment or reimbursement of costs for Covered Services that has already been received. <u>Post-service Claims Procedures:</u> Within 12 months after the date the Covered Person received the services or as soon as reasonably possible, the Covered Person may file a claim (request for payment/reimbursement). The following information is needed to process the claim: (a) Member/ Patient Name and Medical/Health Record Number, (b) the date the	<u>Permanente Advantage PPO</u> <u>Post-service Claims</u> mean a Claim involving the payment or reimbursement of costs for Covered Services that has already been received. <u>Post-service Claims Procedures:</u> Within 12 months after the date the Covered Person received the services or as soon as reasonably possible, the Covered Person may file a claim (request for payment/reimbursement). The following information is needed to process the claim: (a) Member/ Patient Name and Medical/Health Record Number, (b) the date the

Medical/Surgical

Covered Person received the services, (c) where the Covered Person received the services, (d) who provided the services, (e) why the Covered Person thinks KPIC should pay for the services, (f) a copy of the bill, (g) the medical record(s) for the services, and (h) the receipt if the Covered Person has paid for the services.

If KPIC denies the Covered Person's Claim (if KPIC does not pay for all the Services requested), the Adverse Benefit Determination will tell the Covered Person why KPIC denied their claim and include information regarding the mandatory appeal rights, including external review, that may be available to them.

Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person's health care needs; and (3) manages Your plan of care.

Permanente Advantage (PA) utilizes the same Retrospective (Post-Service) Medical Necessity Review procedures for MH/SUD and M/S. However, the manner which the request is received could differ. PA receives a Retrospective (Post-Service) Medical Necessity Review request directly from the Member/Member's Representative or Provider for both M/S as well as MH/SUD. A claim that requires a Retrospective (Post-Service) Medical Necessity Review is routed to PA via a secured message from KPIC's Claims Department for both M/S as well as MH/SUD. Each case is reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. PA applies relevant Utilization Management (UM) criteria to make medical necessity decisions and the relevant UM criteria is applied to MH/SUD and M/S in the exact same manner. The Retrospective NQTL does not apply to the Emergency Services benefit because all emergency services are automatically covered for all plans. PA has adopted and utilizes nationally developed evidence-based clinical criteria/guidelines approved by the Utilization and Quality Management Committee. PA utilizes American Society of Addiction Medicine (ASAM) for SUD, Milliman Care Guidelines (MCG™) for Med/Surg as well as MH, and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. Medical Necessity decisions are based on sound clinical evidence to make utilization decisions and specifies procedures for appropriately applying the criteria.

- For an approved retrospective (post-service) Medical Necessity review PA receives directly from the Member / Member's Representative or Provider, a written notification is provided to both the Member / Member's Representative and Provider/Facility.
- For a denied retrospective (post-service) Medical Necessity review PA receives directly from the Member / Member's Representative or Provider, both verbal and written

Mental Health/Substance Use Disorder

Covered Person received the services, (c) where the Covered Person received the services, (d) who provided the services, (e) why the Covered Person thinks KPIC should pay for the services, (f) a copy of the bill, (g) the medical record(s) for the services, and (h) the receipt if the Covered Person has paid for the services.

If KPIC denies the Covered Person's Claim (if KPIC does not pay for all the Services requested), the Adverse Benefit Determination will tell the Covered Person why KPIC denied their claim and include information regarding the mandatory appeal rights, including external review, that may be available to them.

Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person's health care needs; and (3) manages Your plan of care.

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- For an approved retrospective (post-service) Medical Necessity review PA receives directly from the Member / Member's Representative or Provider, a written notification is provided to both the Member / Member's Representative and Provider/Facility.
- For a denied retrospective (post-service) Medical Necessity review PA receives directly from the Member / Member's Representative or Provider, both verbal and written

Medical/Surgical

notification are provided to the Member / Member's Representative and Provider/Facility. The denial letter will include information on how to file for an appeal. Medical Necessity cases are reviewed and processed within the regulatory turnaround times.

- For an approved or denied Retrospective (Post-Service) Medical Necessity review claim the Explanation of Benefits (EOB) and Explanation of Payment (EOP) is generated and sent to the member and provider.

Qualifications/Training:

Pertaining to MH/SUD and M/S Retrospective (Post-Service) Medical Necessity Reviews the Utilization Management (UM) team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing medical necessity reviews are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. If any of the attributes indicate that the UM criteria are not appropriate, the case is referred to the UM Physician Reviewer for discussion, and final decision. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

The scope of the UM Program includes oversight, review, approval, and adoption annually, of the evidenced based criteria to make medical necessity determinations, with involvement of the appropriate and credentialed practitioners. Currently, Permanente Advantage does not modify or revise any nationally developed and recognized treatment guidelines approved and adopted. We apply medical necessity criteria to subclassification and/or sub-classification of benefits that require medical necessity review.

Mental Health/Substance Use Disorder

notification are provided to the Member / Member's Representative and Provider/Facility. The denial letter will include information on how to file for an appeal. Medical Necessity cases are reviewed and processed within the regulatory turnaround times.

- For an approved or denied Retrospective (Post-Service) Medical Necessity review claim the Explanation of Benefits (EOB) and Explanation of Payment (EOP) is generated and sent to the member and provider.

Qualifications/Training:

Pertaining to MH/SUD and M/S Retrospective (Post-Service) Medical Necessity Reviews the Utilization Management (UM) team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing medical necessity reviews are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. If any of the attributes indicate that the UM criteria are not appropriate, the case is referred to the UM Physician Reviewer for discussion, and final decision. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

The scope of the UM Program includes oversight, review, approval, and adoption annually, of the evidenced based criteria to make medical necessity determinations, with involvement of the appropriate and credentialed practitioners. Currently, Permanente Advantage does not modify or revise any nationally developed and recognized treatment guidelines approved and adopted. We apply medical necessity criteria to subclassification and/or sub-classification of benefits that require medical necessity review.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical

Permanente Advantage PPO

Factors

Variation of length of stay
Variability and/or lack of adherence to criteria
Provider discretion and variation in determining medical necessity

Mental Health/Substance Use Disorder

Permanente Advantage PPO

Factors

Variation of length of stay
Variability and/or lack of adherence to criteria
Provider discretion and variation in determining medical necessity

Medical/Surgical	Mental Health/Substance Use Disorder
Appropriate level of care Severity or chronicity of medical surgical conditions	Appropriate level of care Severity or chronicity of MH/SUD conditions
Sources Utilization data Internal UM quality audits National Accreditation standards Electronic medical record Internal and external medical necessity requirements Certification of Insurance	Sources Utilization data Internal UM quality audits National Accreditation standards Electronic medical record Internal and external medical necessity requirements Certification of Insurance

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage PPO</u></p> <p>The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as Milliman Care Guidelines (MCG™) are utilized for M/S services. This standard applies to the following factors:</p> <ol style="list-style-type: none"> Variation in length of stay: <ol style="list-style-type: none"> MCG guideline goal length of stay is condition or diagnosis-specific length of stay, assuming optimal recovery and decision making. MCG statistical benchmarks and data apply data science to clinical improvement efforts. They are available for utilization and management in inpatient, post-acute, and ambulatory settings of care. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity: 	<p><u>Permanente Advantage PPO</u></p> <p>The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as American Society of Addiction Medicine (ASAM) criteria/guidelines are utilized for SUD services, Milliman Care Guidelines (MCG™) are utilized for MH services and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. This standard applies to the following factors:</p> <ol style="list-style-type: none"> Variation in length of stay: <ol style="list-style-type: none"> ASAM criteria concepts has moved from a fixed length of service to a variable length of service. The length of stay must be individualized, based on severity of illness and level of functioning, as well as response to treatment, progress, and outcomes.

Medical/Surgical

- a. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards.
3. Severity or chronicity of the M/S conditions:
 - a. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.
4. Appropriate level of care:
 - a. MCG care guidelines offer evidence-based criteria, goals, and optimal care pathways to move the patient through the continuum of care. Clinical indications for admission or procedure, continued stay, extended stay, goal length of stay, readmission risk, and discharge planning. Transitions of care guidelines address transitions between care settings.
5. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, severity or chronicity of the M/S conditions, and the appropriate level of care.

Mental Health/Substance Use Disorder

- b. MCG guideline goal length of stay is condition or diagnosis-specific length of stay, assuming optimal recovery and decision making. MCG statistical benchmarks and data apply data science to clinical improvement efforts. They are available for utilization and management in inpatient, post-acute, and ambulatory settings of care.
2. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity:
 - a. ASAM criteria developed to replace the 40-50 criteria sets of criteria used, proactively offer clinically sound alternatives to proprietary and variable criteria used by payers who funded or managed care. Coalition of National Clinical Criteria continues to work towards a national set of criteria (ASAM) accepted by providers, payers, managed care, and policy makers to reduce variability and/or adherence to standards of care.
 - b. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards.
 - c. WPATH standards of care are international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health, including gender dysphoria.
3. Severity or chronicity of the MH/BH/SUD conditions:
 - a. ASAM addresses co-occurring and complexity capability, recognizing that co-occurring mental health is an expectation, not an exception. This has been incorporated into the ASAM patient placement criteria utilized. Matrix is available for matching severity and level of function with type and intensity of service.
 - b. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.
 - c. WPATH standards of care incorporate the evaluation of coexisting mental health concerns as one of the steps in the assessment and referral process: assess, diagnose, and discuss treatment options for coexisting mental health concerns.
4. Appropriate level of care:
 - a. ASAM describes treatment as a continuum of care marked by 4 broad levels of care and an early intervention level. Diagnostic admission criteria for levels of care ensures appropriate level of care at admission. Levels of care 0.5 (early intervention) through 4 (medically managed intensive inpatient services). Movement through any level of service(s)

Medical/Surgical

Mental Health/Substance Use Disorder

the patient's progress in all six dimensions is assessed at regular intervals.

- b. MCG care guidelines offer evidence-based criteria, goals, and optimal care pathways to move the patient through the continuum of care. Clinical indications for admission or procedure, continued stay, extended stay, goal length of stay, readmission risk, and discharge planning. Transitions of care guidelines address transitions between care settings. MCG behavioral health level of care comparison charts address 5 levels of care; inpatient, residential, partial hospital, intensive outpatient, and outpatient care.
5. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, severity or chronicity of the MH/SUD conditions, and the appropriate level of care.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO

1. Review of Kaiser Permanente Insurance Company Certificate of Insurance procedures for Post-Service Claims indicates one procedure applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, concluding comparable.
2. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente

Permanente Advantage PPO

1. Review of Kaiser Permanente Insurance Company Certificate of Insurance procedures for Post-Service Claims indicates one procedure applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, concluding comparable.
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Medical/Surgical

Mental Health/Substance Use Disorder

Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.

- Internal UM audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #4, #5

Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.

- Internal UM audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #4, #5

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO

- Permanente Advantage utilizes the same Retrospective (Post-Service) Medical Necessity review procedures for MH, SUD and M/S reviews. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved retrospective (post-service) Medical Necessity reviews PA receives directly from the Member / Member's Representative or Provider/Facility, written notification is provided to both the Member / Member's Representative and Provider/Facility. For denied retrospective (post-service) Medical Necessity reviews PA receives directly from the Member / Member's Representative or Provider, both verbal and written notification are provided to the Member / Member's Representative and Provider/Facility. The denial letter will include information on how to file for an appeal. For approved and denied retrospective (post-service) medical necessity review claims the Explanation of Benefits (EOB) and Explanation of Payment (EOP) are generated and sent to the member and provider. Medical Necessity requests are reviewed and processed within the regulatory turnaround times.
- Internal UM audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.

Permanente Advantage PPO

- Permanente Advantage utilizes the same Retrospective (Post-Service) Medical Necessity review procedures for MH, SUD and M/S reviews. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved retrospective (post-service) Medical Necessity reviews PA receives directly from the Member / Member's Representative or Provider/Facility, written notification is provided to both the Member / Member's Representative and Provider/Facility. For denied retrospective (post-service) Medical Necessity reviews PA receives directly from the Member / Member's Representative or Provider, both verbal and written notification are provided to the Member / Member's Representative and Provider/Facility. The denial letter will include information on how to file for an appeal. For approved and denied retrospective (post-service) medical necessity review claims the Explanation of Benefits (EOB) and Explanation of Payment (EOP) are generated and sent to the member and provider. Medical Necessity requests are reviewed and processed within the regulatory turnaround times.
- Internal UM audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.

Medical/Surgical

3. Internal UM audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.
4. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6
5. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.
6. Analysis of utilization data identified (15) retrospective review cases for In Network Inpatient M/S services, in which (15) were approved.

Mental Health/Substance Use Disorder

3. Internal UM audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.
4. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6
5. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.
6. Analysis of utilization data identified (4) retrospective review cases for In Network Inpatient MH/SUD services which (4) were denied as they required a lower level of care.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Permanente Advantage PPO

Permanente Advantage utilizes the same Retrospective (Post-Service) Medical Necessity Review procedures for In Network Inpatient services for both MH/SUD and M/S. No Medical Necessity review of emergency services is required. Review of Kaiser Permanente Insurance Company (KPIC) Certificate of Insurance definition of Post-Service Claims indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S. In comparing the utilization data there were a low volume of Retrospective Medical Necessity reviews for both M/S and MH/SUD In Network Inpatient services with (4) denials for MH/SUD services, which we deem comparable. The URAC audit of Permanente Advantage's Utilization Management (UM) policies, procedures, and clinical chart review of denial and appeal charts, concluded Permanente Advantage met the URAC accreditation standards and were consistent and comparable as written and in operation for MH/SUD and M/S. Internal UM audits and inter-rater reliability confirmed the competency of selection and utilization of the Medical Necessity criteria for all services requiring medical necessity review, as written and in operation, the caveat being that ASAM criteria is utilized for SUD, MCG is utilized for MH and M/S and WPATH is used for MH TGD people. Permanente Advantage concludes that as written and in operation, the UM policies, process, factors, and evidentiary standards used to develop and apply Retrospective (Post-Service) Medical Necessity Review NQTL for all MH/SUD In Network Inpatient services is comparable and no more stringent than M/S for the KPIC plans, and therefore are compliant with the final regulation of the Mental Health Parity and Addiction Equity Act.

Benefit Classification 2: Inpatient – Out-of-Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage POS:</u></p> <ul style="list-style-type: none"> • Inpatient Medical / Surgical Hospital Care • Skilled Nursing Facility <p><u>Permanente Advantage PPO:</u></p> <ul style="list-style-type: none"> • Inpatient Medical / Surgical Hospital Care • Inpatient Medically Necessary Bariatric Surgery (Morbid Obesity Services) • Inpatient Infertility Services • Inpatient Rehabilitation and Habilitation Services • Skilled Nursing Facility • Inpatient Transplant Services 	<p><u>Permanente Advantage POS:</u></p> <ul style="list-style-type: none"> • Inpatient Behavioral Health (BH)/Mental Health (MH) Hospital Care • Inpatient Substance Use Disorder (SUD) Services <p><u>Permanente Advantage PPO:</u></p> <ul style="list-style-type: none"> • Inpatient Behavioral Health (BH)/Mental Health (MH) Hospital Care • Inpatient Substance Use Disorder (SUD) Services

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage PPO & POS</u></p> <p><u>Post-service Claims</u> mean a Claim involving the payment or reimbursement of costs for Covered Services that has already been received.</p> <p><u>Post-service Claims Procedures:</u> Within 12 months after the date the Covered Person received the services or as soon as reasonably possible, the Covered Person may file a claim (request for payment/reimbursement). The following information is needed to process the claim: (a) Member/ Patient Name and Medical/Health Record Number, (b) the date the Covered Person received the services, (c) where the Covered Person received the services, (d) who provided the services, (e) why the Covered Person thinks KPIC should pay for the services, (f) a copy of the bill, (g) the medical record(s) for the services, and (h) the receipt if the Covered Person has paid for the services.</p> <p>If KPIC denies the Covered Person’s Claim (if KPIC does not pay for all the Services requested), the Adverse Benefit Determination will tell the Covered Person why KPIC denied their claim and include information regarding the mandatory appeal rights, including external review, that may be available to them.</p> <p><u>Medical Review Program</u> means the organization or program that: (1) evaluates proposed treatments and/or services to</p>	<p><u>Permanente Advantage PPO & POS</u></p> <p><u>Post-service Claims</u> mean a Claim involving the payment or reimbursement of costs for Covered Services that has already been received.</p> <p><u>Post-service Claims Procedures:</u> Within 12 months after the date the Covered Person received the services or as soon as reasonably possible, the Covered Person may file a claim (request for payment/reimbursement). The following information is needed to process the claim: (a) Member/ Patient Name and Medical/Health Record Number, (b) the date the Covered Person received the services, (c) where the Covered Person received the services, (d) who provided the services, (e) why the Covered Person thinks KPIC should pay for the services, (f) a copy of the bill, (g) the medical record(s) for the services, and (h) the receipt if the Covered Person has paid for the services.</p> <p>If KPIC denies the Covered Person’s Claim (if KPIC does not pay for all the Services requested), the Adverse Benefit Determination will tell the Covered Person why KPIC denied their claim and include information regarding the mandatory appeal rights, including external review, that may be available to them.</p> <p><u>Medical Review Program</u> means the organization or program that: (1) evaluates proposed treatments and/or services to</p>

Medical/Surgical

determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person's health care needs; and (3) manages Your plan of care.

Permanente Advantage (PA) utilizes the same Retrospective (Post-Service) Medical Necessity Review procedures for MH/SUD and M/S. However, the manner which the request is received could differ. PA receives a Retrospective (Post-Service) Medical Necessity Review request directly from the Member/Member's Representative or Provider for both M/S as well as MH/SUD. A claim that requires a Retrospective (Post-Service) Medical Necessity Review is routed to PA via a secured message from KPIC's Claims Department for both M/S as well as MH/SUD. Each case is reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. PA applies relevant Utilization Management (UM) criteria to make medical necessity decisions and the relevant UM criteria is applied to MH/SUD and M/S in the exact same manner. The Retrospective NQTL does not apply to the Emergency Services benefit because all emergency services are automatically covered for all plans. PA has adopted and utilizes nationally developed evidence-based clinical criteria/guidelines approved by the Utilization and Quality Management Committee. PA utilizes American Society of Addiction Medicine (ASAM) for SUD, Milliman Care Guidelines (MCG™) for Med/Surg as well as MH, and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. Medical Necessity decisions are based on sound clinical evidence to make utilization decisions and specifies procedures for appropriately applying the criteria.

- For an approved retrospective (post-service) Medical Necessity review PA receives directly from the Member / Member's Representative or Provider, a written notification is provided to both the Member / Member's Representative and Provider/Facility.
- For a denied retrospective (post-service) Medical Necessity review PA receives directly from the Member / Member's Representative or Provider, both verbal and written notification are provided to the Member / Member's Representative and Provider/Facility. The denial letter will include information on how to file for an appeal. Medical Necessity cases are reviewed and processed within the regulatory turnaround times.
- For an approved or denied Retrospective (Post-Service) Medical Necessity review claim the Explanation of Benefits (EOB) and Explanation of Payment (EOP) is generated and sent to the member and provider.

Qualifications/Training:

Pertaining to MH/SUD and M/S Retrospective (Post-Service) Medical Necessity Reviews the Utilization Management (UM) team is comprised of licensed physicians and licensed clinical

Mental Health/Substance Use Disorder

determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person's health care needs; and (3) manages Your plan of care.

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- For an approved retrospective (post-service) Medical Necessity review PA receives directly from the Member / Member's Representative or Provider, a written notification is provided to both the Member / Member's Representative and Provider/Facility.
- For a denied retrospective (post-service) Medical Necessity review PA receives directly from the Member / Member's Representative or Provider, both verbal and written notification are provided to the Member / Member's Representative and Provider/Facility. The denial letter will include information on how to file for an appeal. Medical Necessity cases are reviewed and processed within the regulatory turnaround times.
- For an approved or denied Retrospective (Post-Service) Medical Necessity review claim the Explanation of Benefits (EOB) and Explanation of Payment (EOP) is generated and sent to the member and provider.

Qualifications/Training:

Pertaining to MH/SUD and M/S Retrospective (Post-Service) Medical Necessity Reviews the Utilization Management (UM) team is comprised of licensed physicians and licensed clinical

Medical/Surgical

staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing medical necessity reviews are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. If any of the attributes indicate that the UM criteria are not appropriate, the case is referred to the UM Physician Reviewer for discussion, and final decision. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

The scope of the UM Program includes oversight, review, approval, and adoption annually, of the evidenced based criteria to make medical necessity determinations, with involvement of the appropriate and credentialed practitioners. Currently, Permanente Advantage does not modify or revise any nationally developed and recognized treatment guidelines approved and adopted. We apply medical necessity criteria to subclassification and/or sub-classification of benefits that require medical necessity review.

Mental Health/Substance Use Disorder

staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing medical necessity reviews are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. If any of the attributes indicate that the UM criteria are not appropriate, the case is referred to the UM Physician Reviewer for discussion, and final decision. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

The scope of the UM Program includes oversight, review, approval, and adoption annually, of the evidenced based criteria to make medical necessity determinations, with involvement of the appropriate and credentialed practitioners. Currently, Permanente Advantage does not modify or revise any nationally developed and recognized treatment guidelines approved and adopted. We apply medical necessity criteria to subclassification and/or sub-classification of benefits that require medical necessity review.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical

Permanente Advantage PPO & POS

Factors

Variation of length of stay
Variability and/or lack of adherence to criteria
Provider discretion and variation in determining medical necessity
Appropriate level of care
Severity or chronicity of medical surgical conditions

Sources

Utilization data
Internal UM quality audits
National Accreditation standards
Electronic medical record
Internal and external medical necessity requirements
Certification of Insurance

Mental Health/Substance Use Disorder

Permanente Advantage PPO & POS

Factors

Variation of length of stay
Variability and/or lack of adherence to criteria
Provider discretion and variation in determining medical necessity
Appropriate level of care
Severity or chronicity of MH/SUD conditions

Sources

Utilization data
Internal UM quality audits
National Accreditation standards
Electronic medical record
Internal and external medical necessity requirements
Certification of Insurance

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage PPO & POS</u></p> <p>The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as Milliman Care Guidelines (MCG™) are utilized for M/S services. This standard applies to the following factors:</p> <ol style="list-style-type: none">1. Variation in length of stay:<ol style="list-style-type: none">a. MCG guideline goal length of stay is condition or diagnosis-specific length of stay, assuming optimal recovery and decision making. MCG statistical benchmarks and data apply data science to clinical improvement efforts. They are available for utilization and management in inpatient, post-acute, and ambulatory settings of care.2. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity:<ol style="list-style-type: none">a. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards.3. Severity or chronicity of the M/S conditions:<ol style="list-style-type: none">a. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.4. Appropriate level of care:<ol style="list-style-type: none">a. MCG care guidelines offer evidence-based criteria, goals, and optimal care pathways to move the patient through the continuum of care. Clinical indications for admission or procedure, continued stay, extended stay, goal length of stay, readmission risk, and discharge	<p><u>Permanente Advantage PPO & POS</u></p> <p>The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as American Society of Addiction Medicine (ASAM) criteria/guidelines are utilized for SUD services, Milliman Care Guidelines (MCG™) are utilized for MH services and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. This standard applies to the following factors:</p> <ol style="list-style-type: none">1. Variation in length of stay:<ol style="list-style-type: none">a. ASAM criteria concepts has moved from a fixed length of service to a variable length of service. The length of stay must be individualized, based on severity of illness and level of functioning, as well as response to treatment, progress, and outcomes.b. MCG guideline goal length of stay is condition or diagnosis-specific length of stay, assuming optimal recovery and decision making. MCG statistical benchmarks and data apply data science to clinical improvement efforts. They are available for utilization and management in inpatient, post-acute, and ambulatory settings of care.2. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity:<ol style="list-style-type: none">a. ASAM criteria developed to replace the 40-50 criteria sets of criteria used, proactively offer clinically sound alternatives to proprietary and variable criteria used by payers who funded or managed care. Coalition of National Clinical Criteria continues to work towards a national set of criteria (ASAM) accepted by providers,

Medical/Surgical

planning. Transitions of care guidelines address transitions between care settings.

5. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, severity or chronicity of the M/S conditions, and the appropriate level of care.

Mental Health/Substance Use Disorder

- b. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards.
 - c. WPATH standards of care are international, multidisciplinary, professional association whose mission is to promote evidence-based care, education, research, advocacy, public policy, and respect in transgender health, including gender dysphoria.
3. Severity or chronicity of the MH/BH/SUD conditions:
 - a. ASAM addresses co-occurring and complexity capability, recognizing that co-occurring mental health is an expectation, not an exception. This has been incorporated into the ASAM patient placement criteria utilized. Matrix is available for matching severity and level of function with type and intensity of service.
 - b. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.
 - c. WPATH standards of care incorporate the evaluation of coexisting mental health concerns as one of the steps in the assessment and referral process: assess, diagnose, and discuss treatment options for coexisting mental health concerns.
4. Appropriate level of care:
 - a. ASAM describes treatment as a continuum of care marked by 4 broad levels of care and an early intervention level. Diagnostic admission criteria for levels of care ensures appropriate level of care at admission. Levels of care 0.5 (early intervention) through 4 (medically managed intensive inpatient services). Movement through any level of service(s) the patient's progress in all six dimensions is assessed at regular intervals.
 - b. MCG care guidelines offer evidence-based criteria, goals, and optimal care pathways to move the patient through the continuum of care. Clinical indications for admission or procedure, continued stay, extended stay, goal length of stay, readmission risk, and discharge planning. Transitions of care guidelines address transitions between care settings. MCG behavioral health level of care comparison charts address 5 levels of care; inpatient, residential, partial hospital, intensive outpatient, and outpatient care.
5. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The

Medical/Surgical

Mental Health/Substance Use Disorder

certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards, severity or chronicity of the MH/SUD conditions, and the appropriate level of care.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO & POS

1. Review of Kaiser Permanente Insurance Company Certificate of Insurance procedures for Post-Service Claims indicates one procedure applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, concluding comparable.
2. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.
3. Internal UM audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #4, #5

Permanente Advantage PPO & POS

1. Review of Kaiser Permanente Insurance Company Certificate of Insurance procedures for Post-Service Claims indicates one procedure applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, concluding comparable.
2. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.
3. Internal UM audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #4, #5

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage PPO & POS</u></p> <ol style="list-style-type: none"> 1. Permanente Advantage utilizes the same Retrospective (Post-Service) Medical Necessity review procedures for MH, SUD and M/S reviews. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved retrospective (post-service) Medical Necessity reviews PA receives directly from the Member / Member's Representative or Provider/Facility, written notification is provided to both the Member / Member's Representative and Provider/Facility. For denied retrospective (post-service) Medical Necessity reviews PA receives directly from the Member / Member's Representative or Provider, both verbal and written notification are provided to the Member / Member's Representative and Provider/Facility. The denial letter will include information on how to file for an appeal. For approved and denied retrospective (post-service) medical necessity review claims the Explanation of Benefits (EOB) and Explanation of Payment (EOP) are generated and sent to the member and provider. Medical Necessity requests are reviewed and processed within the regulatory turnaround times. 2. Internal UM audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%. 3. Internal UM audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%. 4. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6 5. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024. 6. Analysis of utilization data identified (1) retrospective review cases for Out of Network Inpatient M/S services wherein it was denied. 	<p><u>Permanente Advantage PPO & POS</u></p> <ol style="list-style-type: none"> 1. Permanente Advantage utilizes the same Retrospective (Post-Service) Medical Necessity review procedures for MH, SUD and M/S reviews. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved retrospective (post-service) Medical Necessity reviews PA receives directly from the Member / Member's Representative or Provider/Facility, written notification is provided to both the Member / Member's Representative and Provider/Facility. For denied retrospective (post-service) Medical Necessity reviews PA receives directly from the Member / Member's Representative or Provider, both verbal and written notification are provided to the Member / Member's Representative and Provider/Facility. The denial letter will include information on how to file for an appeal. For approved and denied retrospective (post-service) medical necessity review claims the Explanation of Benefits (EOB) and Explanation of Payment (EOP) are generated and sent to the member and provider. Medical Necessity requests are reviewed and processed within the regulatory turnaround times. 2. Internal UM audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%. 3. Internal UM audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%. 4. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6 5. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024. 6. Analysis of utilization data identified (5) retrospective review cases for Out of Network Inpatient MH/SUD services, wherein (3) were approved and (2) denied.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Permanente Advantage PPO & POS

Permanente Advantage utilizes the same Retrospective (Post-Service) Medical Necessity Review procedures for Out-of-Network Inpatient services for both MH/SUD and M/S. No Medical Necessity review of emergency services is required. Review of Kaiser Permanente Insurance Company (KPIC) Certificate of Insurance definition of Post-Service Claims indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S. In reviewing the utilization data there were a low volume (6 total) of Retrospective Medical Necessity reviews for M/S and MH/SUD Out-of-Network Inpatient services wherein (3) were approved and (3) were denied. Therefore, we are comparable and no more stringent on MH/SUD than M/S services. The URAC audit of Utilization Management (UM) policies, procedures, and clinical chart review of denial and appeal charts, concluded Permanente Advantage met the URAC accreditation standards and were consistent and comparable as written and in operation for MH/SUD and M/S. Internal UM audits and inter-rater reliability confirmed the competency of selection and utilization of the Medical Necessity criteria for all services requiring medical necessity review, as written and in operation, the caveat being that ASAM criteria is utilized for SUD, MCG is utilized for MH and M/S and WPATH is used for MH TGD people. Permanente Advantage concludes that as written and in operation, the UM policies, process, factors, and evidentiary standards used to develop and apply Retrospective (Post-Service) Medical Necessity Review NQTL for all MH/SUD Out-of-Network Inpatient services is comparable and no more stringent than M/S for the KPIC plans, and therefore are compliant with the final regulation of the Mental Health Parity and Addiction Equity Act.

Benefit Classification 3: Outpatient – In Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage POS:</u> N/A	<u>Permanente Advantage POS:</u> N/A
<u>Permanente Advantage PPO:</u> <ul style="list-style-type: none">Genetic Laboratory ServicesHigh Tech Radiology Services (e.g., MRI's, CTs, PET, Myelogram and Nuclear Medicine scans)Chemotherapy, Radiation, and Infusion TherapyOutpatient Surgery (includes Facility and Professional Charges)Hospital Outpatient (includes Facility and Professional Charges)Medically Necessary Non-Emergency AmbulanceClinical TrialsMedically Necessary Dental ServicesMedically Necessary Durable Medical Equipment (DME)	<u>Permanente Advantage PPO:</u> <ul style="list-style-type: none">Autism Spectrum Disorder Services<ul style="list-style-type: none">Applied Behavior Analysis Program (Limited to Children through age 20)Speech Therapy (Limited to Children through age 20)Physical and Occupational Therapy (Limited to Children through age 20):Clinical Trials

Medical/Surgical	Mental Health/Substance Use Disorder
<ul style="list-style-type: none"> • Medically Necessary Pediatric Hearing Aid(s) and services for children through age 18 • Home Health Care • Hospice Care • Outpatient Infertility Services • Outpatient Bariatric Surgery (Morbid Obesity Services) • Office / Outpatient Administered Drugs Supplies Supplements • Prosthetic Devices (External) and Orthotics (P&O) • Prosthetic (Internally Implanted) • Reconstructive Surgery • Rehabilitation Services and Habilitative Services <ul style="list-style-type: none"> ○ Speech Therapy ○ Physical and Occupational Therapy ○ Pulmonary Therapy (in-home only) ○ Cognitive Therapy for Traumatic Brain Injury ○ Multi-disciplinary Rehabilitation • Outpatient Transplant Services 	

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage PPO</u></p> <p><u>Post-service Claims</u> mean a Claim involving the payment or reimbursement of costs for Covered Services that has already been received.</p> <p><u>Post-service Claims Procedures:</u> Within 12 months after the date the Covered Person received the services or as soon as reasonably possible, the Covered Person may file a claim (request for payment/reimbursement). The following information is needed to process the claim: (a) Member/ Patient Name and Medical/Health Record Number, (b) the date the Covered Person received the services, (c) where the Covered Person received the services, (d) who provided the services, (e) why the Covered Person thinks KPIC should pay for the services, (f) a copy of the bill, (g) the medical record(s) for the services, and (h) the receipt if the Covered Person has paid for the services.</p> <p>If KPIC denies the Covered Person’s Claim (if KPIC does not pay for all the Services requested), the Adverse Benefit Determination will tell the Covered Person why KPIC denied their claim and include information regarding the mandatory appeal rights, including external review, that may be available to them.</p>	<p><u>Permanente Advantage PPO</u></p> <p><u>Post-service Claims</u> mean a Claim involving the payment or reimbursement of costs for Covered Services that has already been received.</p> <p><u>Post-service Claims Procedures:</u> Within 12 months after the date the Covered Person received the services or as soon as reasonably possible, the Covered Person may file a claim (request for payment/reimbursement). The following information is needed to process the claim: (a) Member/ Patient Name and Medical/Health Record Number, (b) the date the Covered Person received the services, (c) where the Covered Person received the services, (d) who provided the services, (e) why the Covered Person thinks KPIC should pay for the services, (f) a copy of the bill, (g) the medical record(s) for the services, and (h) the receipt if the Covered Person has paid for the services.</p> <p>If KPIC denies the Covered Person’s Claim (if KPIC does not pay for all the Services requested), the Adverse Benefit Determination will tell the Covered Person why KPIC denied their claim and include information regarding the mandatory appeal rights, including external review, that may be available to them.</p>

Medical/Surgical

Mental Health/Substance Use Disorder

Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person's health care needs; and (3) manages Your plan of care.

Permanente Advantage (PA) utilizes the same Retrospective (Post-Service) Medical Necessity Review procedures for MH/SUD and M/S. However, the manner which the request is received could differ. PA receives a Retrospective (Post-Service) Medical Necessity Review request directly from the Member/Member's Representative or Provider for both M/S as well as MH/SUD. A claim that requires a Retrospective (Post-Service) Medical Necessity Review is routed to PA via a secured message from KPIC's Claims Department for both M/S as well as MH/SUD. Each case is reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. PA applies relevant Utilization Management (UM) criteria to make medical necessity decisions and the relevant UM criteria is applied to MH/SUD and M/S in the exact same manner. The Retrospective NQTL does not apply to the Emergency Services benefit because all emergency services are automatically covered for all plans. PA has adopted and utilizes nationally developed evidence-based clinical criteria/guidelines approved by the Utilization and Quality Management Committee. PA utilizes American Society of Addiction Medicine (ASAM) for SUD, Milliman Care Guidelines (MCG™) for Med/Surg as well as MH, and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. Medical Necessity decisions are based on sound clinical evidence to make utilization decisions and specifies procedures for appropriately applying the criteria.

- For an approved retrospective (post-service) Medical Necessity review PA receives directly from the Member / Member's Representative or Provider, a written notification is provided to both the Member / Member's Representative and Provider/Facility.
- For a denied retrospective (post-service) Medical Necessity review PA receives directly from the Member / Member's Representative or Provider, both verbal and written notification are provided to the Member / Member's Representative and Provider/Facility. The denial letter will include information on how to file for an appeal. Medical Necessity cases are reviewed and processed within the regulatory turnaround times.
- For an approved or denied Retrospective (Post-Service) Medical Necessity review claim the Explanation of Benefits (EOB) and Explanation of Payment (EOP) is generated and sent to the member and provider.

Qualifications/Training:

Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person's health care needs; and (3) manages Your plan of care.

Permanente Advantage (PA) utilizes the same Retrospective (Post-Service) Medical Necessity Review procedures for MH/SUD and M/S. However, the manner which the request is received could differ. PA receives a Retrospective (Post-Service) Medical Necessity Review request directly from the Member/Member's Representative or Provider for both M/S as well as MH/SUD. A claim that requires a Retrospective (Post-Service) Medical Necessity Review is routed to PA via a secured message from KPIC's Claims Department for both M/S as well as MH/SUD. Each case is reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. PA applies relevant Utilization Management (UM) criteria to make medical necessity decisions and the relevant UM criteria is applied to MH/SUD and M/S in the exact same manner. The Retrospective NQTL does not apply to the Emergency Services benefit because all emergency services are automatically covered for all plans. PA has adopted and utilizes nationally developed evidence-based clinical criteria/guidelines approved by the Utilization and Quality Management Committee. PA utilizes American Society of Addiction Medicine (ASAM) for SUD, Milliman Care Guidelines (MCG™) for Med/Surg as well as MH, and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. Medical Necessity decisions are based on sound clinical evidence to make utilization decisions and specifies procedures for appropriately applying the criteria.

- For an approved retrospective (post-service) Medical Necessity review PA receives directly from the Member / Member's Representative or Provider, a written notification is provided to both the Member / Member's Representative and Provider/Facility.
- For a denied retrospective (post-service) Medical Necessity review PA receives directly from the Member / Member's Representative or Provider, both verbal and written notification are provided to the Member / Member's Representative and Provider/Facility. The denial letter will include information on how to file for an appeal. Medical Necessity cases are reviewed and processed within the regulatory turnaround times.
- For an approved or denied Retrospective (Post-Service) Medical Necessity review claim the Explanation of Benefits (EOB) and Explanation of Payment (EOP) is generated and sent to the member and provider.

Qualifications/Training:

Medical/Surgical

Pertaining to MH/SUD and M/S Retrospective (Post-Service) Medical Necessity Reviews the Utilization Management (UM) team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing medical necessity reviews are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. If any of the attributes indicate that the UM criteria are not appropriate, the case is referred to the UM Physician Reviewer for discussion, and final decision. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

The scope of the UM Program includes oversight, review, approval, and adoption annually, of the evidenced based criteria to make medical necessity determinations, with involvement of the appropriate and credentialed practitioners. Currently, Permanente Advantage does not modify or revise any nationally developed and recognized treatment guidelines approved and adopted. We apply medical necessity criteria to subclassification and/or sub-classification of benefits that require medical necessity review.

Mental Health/Substance Use Disorder

Pertaining to MH/SUD and M/S Retrospective (Post-Service) Medical Necessity Reviews the Utilization Management (UM) team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing medical necessity reviews are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. If any of the attributes indicate that the UM criteria are not appropriate, the case is referred to the UM Physician Reviewer for discussion, and final decision. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

The scope of the UM Program includes oversight, review, approval, and adoption annually, of the evidenced based criteria to make medical necessity determinations, with involvement of the appropriate and credentialed practitioners. Currently, Permanente Advantage does not modify or revise any nationally developed and recognized treatment guidelines approved and adopted. We apply medical necessity criteria to subclassification and/or sub-classification of benefits that require medical necessity review.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical

Permanente Advantage PPO

Factors

Variability and/or lack of adherence to criteria
Provider discretion and variation in determining medical necessity
Severity or chronicity of medical surgical conditions

Sources

Utilization data
Internal UM quality audits
National Accreditation standards
Electronic medical record
Internal and external medical necessity requirements
Certification of Insurance

Mental Health/Substance Use Disorder

Permanente Advantage PPO

Factors

Variability and/or lack of adherence to criteria
Provider discretion and variation in determining medical necessity
Severity or chronicity of MH/SUD conditions

Sources

Utilization data
Internal UM quality audits
National Accreditation standards
Electronic medical record
Internal and external medical necessity requirements
Certification of Insurance

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage PPO</u></p> <p>The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as Milliman Care Guidelines (MCG™) are utilized for M/S services. This standard applies to the following factors:</p> <ol style="list-style-type: none">1. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity:<ol style="list-style-type: none">a. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards.2. Severity or chronicity of the M/S conditions:<ol style="list-style-type: none">a. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.3. Health plan accreditation standards for quality assurance. URAC’s HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards and severity or and chronicity of the M/S conditions.	<p><u>Permanente Advantage PPO</u></p> <p>The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as American Society of Addiction Medicine (ASAM) criteria/guidelines are utilized for SUD services, Milliman Care Guidelines (MCG™) are utilized for MH services and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. This standard applies to the following factors:</p> <ol style="list-style-type: none">1. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity:<ol style="list-style-type: none">a. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards.2. Severity or chronicity of the MH/BH/SUD conditions:<ol style="list-style-type: none">a. ASAM addresses co-occurring and complexity capability, recognizing that co-occurring mental health is an expectation, not an exception. This has been incorporated into the ASAM patient placement criteria utilized. Matrix is available for matching severity and level of function with type and intensity of service.b. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.

Medical/Surgical

Mental Health/Substance Use Disorder

- c. WPATH standards of care support assess, diagnose, and discuss treatment options for coexisting mental health concerns.
3. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards and severity or chronicity of the MH/SUD conditions.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO

1. Review of Kaiser Permanente Insurance Company Certificate of Insurance procedures for Post-Service Claims indicates one procedure applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, concluding comparable.
2. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.
3. Internal UM audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #4, #5

Permanente Advantage PPO

1. Review of Kaiser Permanente Insurance Company Certificate of Insurance procedures for Post-Service Claims indicates one procedure applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, concluding comparable.
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Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage PPO</u> <ol style="list-style-type: none">1. Permanente Advantage utilizes the same Retrospective (Post-Service) Medical Necessity review procedures for MH, SUD and M/S reviews. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved retrospective (post-service) Medical Necessity reviews PA receives directly from the Member / Member's Representative or Provider/Facility, written notification is provided to both the Member / Member's Representative and Provider/Facility. For denied retrospective (post-service) Medical Necessity reviews PA receives directly from the Member / Member's Representative or Provider, both verbal and written notification are provided to the Member / Member's Representative and Provider/Facility. The denial letter will include information on how to file for an appeal. For approved and denied retrospective (post-service) medical necessity review claims the Explanation of Benefits (EOB) and Explanation of Payment (EOP) are generated and sent to the member and provider. Medical Necessity requests are reviewed and processed within the regulatory turnaround times.2. Internal UM audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.3. Internal UM audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.4. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #65. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.	<u>Permanente Advantage PPO</u> <ol style="list-style-type: none">1. Permanente Advantage utilizes the same Retrospective (Post-Service) Medical Necessity review procedures for MH, SUD and M/S reviews. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved retrospective (post-service) Medical Necessity reviews PA receives directly from the Member / Member's Representative or Provider/Facility, written notification is provided to both the Member / Member's Representative and Provider/Facility. For denied retrospective (post-service) Medical Necessity reviews PA receives directly from the Member / Member's Representative or Provider, both verbal and written notification are provided to the Member / Member's Representative and Provider/Facility. The denial letter will include information on how to file for an appeal. For approved and denied retrospective (post-service) medical necessity review claims the Explanation of Benefits (EOB) and Explanation of Payment (EOP) are generated and sent to the member and provider. Medical Necessity requests are reviewed and processed within the regulatory turnaround times.2. Internal UM audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.3. Internal UM audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.4. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #65. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.

Medical/Surgical

Mental Health/Substance Use Disorder

6. Analysis of utilization data identified (115) retrospective review cases for In Network Outpatient M/S services, where (110) were approved and (5) were denied.

6. Analysis of utilization data identified (6) retrospective review cases for In Network Outpatient MH/SUD services wherein all were approved.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Permanente Advantage PPO

Permanente Advantage utilizes the same Retrospective (Post-Service) Medical Necessity Review procedures for In Network Outpatient services for both MH/SUD and M/S. Review of Kaiser Permanente Insurance Company (KPIC) Certificate of Insurance definition of Post-Service Claims indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S. In comparing the utilization data there were only (6) Retrospective Medical Necessity reviews for MH/SUD In Network Outpatient services, compared to (115) for M/S services. This is because the precertification requirements are less restrictive for MH/SUD Outpatient services. Therefore, we are comparable and no more stringent on MH/SUD than M/S services. The URAC audit of Utilization Management (UM) policies, procedures, and clinical chart review of denial and appeal charts concluded Permanente Advantage met the URAC accreditation standards and were consistent and comparable as written and in operation for MH/SUD and M/S. Internal UM audits and inter-rater reliability confirmed the competency of selection and utilization of the Medical Necessity criteria for all services requiring medical necessity review, as written and in operation. Permanente Advantage concludes that as written and in operation, the UM policies, process, factors, and evidentiary standards used to develop and apply Retrospective (Post-Service) Medical Necessity Review NQTL for all In Network MH/SUD Outpatient services is comparable and no more stringent than M/S for the KPIC plans, and therefore are compliant with the final regulation of the Mental Health Parity and Addiction Equity Act.

Benefit Classification 4: Outpatient – Out-of-Network

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage POS:

- Genetic Laboratory Services
- High Tech Radiology Services (e.g., MRI's, CTs, PET, Myelogram and Nuclear Medicine scans)
- Chemotherapy, Radiation, and Infusion Therapy
- Outpatient Surgery (includes Facility and Professional Charges)
- Hospital Outpatient (includes Facility and Professional Charges)
- Clinical Trials
- Medically Necessary Durable Medical Equipment (DME)

Permanente Advantage POS:

- Autism Spectrum Disorder Services
 - Applied Behavior Analysis Program (Limited to Children through age 20)
 - Speech Therapy (Limited to Children through age 20)
 - Physical and Occupational Therapy (Limited to Children through age 20)
- Clinical Trials

Medical/Surgical

- Medically Necessary Pediatric Hearing Aid(s) and services for children through age 18
- Home Health Care
- Hospice Care
- Office / Outpatient Administered Drugs Supplies Supplements
- Prosthetic Devices (External) and Orthotics (P&O)
- Prosthetic (Internally Implanted)
- Rehabilitation Services
 - Speech Therapy
 - Physical and Occupational Therapy

Permanente Advantage PPO:

- Genetic Laboratory Services
- High Tech Radiology Services (e.g., MRI's, CTs, PET, Myelogram and Nuclear Medicine scans):
- Chemotherapy, Radiation, and Infusion Therapy
- Outpatient Surgery (includes Facility and Professional Charges)
- Hospital Outpatient (includes Facility and Professional Charges)
- Medically Necessary Non-Emergency Ambulance
- Clinical Trials
- Medically Necessary Dental Services
- Medically Necessary Durable Medical Equipment (DME)
- Medically Necessary Pediatric Hearing Aid(s) and services for children through age 18
- Home Health Care
- Hospice Care
- Outpatient Infertility Services
- Outpatient Bariatric Surgery (Morbid Obesity Services)
- Office / Outpatient Administered Drugs Supplies Supplements
- Prosthetic Devices (External) and Orthotics (P&O)
- Prosthetic (Internally Implanted)
- Reconstructive Surgery
- Rehabilitation Services and Habilitative Services
 - Speech Therapy
 - Physical and Occupational Therapy
 - Pulmonary Therapy (in-home only)
 - Cognitive Therapy for Traumatic Brain Injury
 - Multi-disciplinary Rehabilitation
- Outpatient Transplant Services

Mental Health/Substance Use Disorder

Permanente Advantage PPO:

- Autism Spectrum Disorder Services
 - Applied Behavior Analysis Program (Limited to Children through age 20)
 - Speech Therapy (Limited to Children through age 20)
 - Physical and Occupational Therapy (Limited to Children through age 20)
- Clinical Trials

Step 1 – Describe the NQTL's requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>Permanente Advantage PPO & POS</u> <u>Post-service Claims</u> mean a Claim involving the payment or reimbursement of costs for Covered Services that has already been received. <u>Post-service Claims Procedures:</u> Within 12 months after the date the Covered Person received the services or as soon as reasonably possible, the Covered Person may file a claim (request for payment/reimbursement). The following information is needed to process the claim: (a) Member/ Patient Name and Medical/Health Record Number, (b) the date the Covered Person received the services, (c) where the Covered Person received the services, (d) who provided the services, (e) why the Covered Person thinks KPIC should pay for the services, (f) a copy of the bill, (g) the medical record(s) for the services, and (h) the receipt if the Covered Person has paid for the services. If KPIC denies the Covered Person’s Claim (if KPIC does not pay for all the Services requested), the Adverse Benefit Determination will tell the Covered Person why KPIC denied their claim and include information regarding the mandatory appeal rights, including external review, that may be available to them. <u>Medical Review Program</u> means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person’s health care needs; and (3) manages Your plan of care.</p> <p>Permanente Advantage (PA) utilizes the same Retrospective (Post-Service) Medical Necessity Review procedures for MH/SUD and M/S. However, the manner which the request is received could differ. PA receives a Retrospective (Post-Service) Medical Necessity Review request directly from the Member/Member’s Representative or Provider for both M/S as well as MH/SUD. A claim that requires a Retrospective (Post-Service) Medical Necessity Review is routed to PA via a secured message from KPIC’s Claims Department for both M/S as well as MH/SUD. Each case is reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. PA applies relevant Utilization Management (UM) criteria to make medical necessity decisions and the relevant UM criteria is applied to MH/SUD and M/S in the exact same manner. The Retrospective NQTL does not apply to the Emergency Services benefit because all emergency services are automatically covered for all plans. PA has adopted and utilizes nationally developed evidence-based clinical criteria/guidelines approved by the Utilization and Quality Management Committee. PA utilizes American Society of Addiction Medicine (ASAM) for SUD, Milliman Care Guidelines (MCG™) for Med/Surg as well as MH, and the World Professional Association for Transgender Health (WPATH)</p>	<p><u>Permanente Advantage PPO & POS</u> <u>Post-service Claims</u> mean a Claim involving the payment or reimbursement of costs for Covered Services that has already been received. <u>Post-service Claims Procedures:</u> Within 12 months after the date the Covered Person received the services or as soon as reasonably possible, the Covered Person may file a claim (request for payment/reimbursement). The following information is needed to process the claim: (a) Member/ Patient Name and Medical/Health Record Number, (b) the date the Covered Person received the services, (c) where the Covered Person received the services, (d) who provided the services, (e) why the Covered Person thinks KPIC should pay for the services, (f) a copy of the bill, (g) the medical record(s) for the services, and (h) the receipt if the Covered Person has paid for the services. If KPIC denies the Covered Person’s Claim (if KPIC does not pay for all the Services requested), the Adverse Benefit Determination will tell the Covered Person why KPIC denied their claim and include information regarding the mandatory appeal rights, including external review, that may be available to them. <u>Medical Review Program</u> means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person’s health care needs; and (3) manages Your plan of care.</p> <p>Permanente Advantage (PA) utilizes the same Retrospective (Post-Service) Medical Necessity Review procedures for MH/SUD and M/S. However, the manner which the request is received could differ. PA receives a Retrospective (Post-Service) Medical Necessity Review request directly from the Member/Member’s Representative or Provider for both M/S as well as MH/SUD. A claim that requires a Retrospective (Post-Service) Medical Necessity Review is routed to PA via a secured message from KPIC’s Claims Department for both M/S as well as MH/SUD. Each case is reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. PA applies relevant Utilization Management (UM) criteria to make medical necessity decisions and the relevant UM criteria is applied to MH/SUD and M/S in the exact same manner. The Retrospective NQTL does not apply to the Emergency Services benefit because all emergency services are automatically covered for all plans. PA has adopted and utilizes nationally developed evidence-based clinical criteria/guidelines approved by the Utilization and Quality Management Committee. PA utilizes American Society of Addiction Medicine (ASAM) for SUD, Milliman Care Guidelines (MCG™) for Med/Surg as well as MH, and the World Professional Association for Transgender Health (WPATH)</p>

Medical/Surgical

Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. Medical Necessity decisions are based on sound clinical evidence to make utilization decisions and specifies procedures for appropriately applying the criteria.

- For an approved retrospective (post-service) Medical Necessity review PA receives directly from the Member / Member's Representative or Provider, a written notification is provided to both the Member / Member's Representative and Provider/Facility.
- For a denied retrospective (post-service) Medical Necessity review PA receives directly from the Member / Member's Representative or Provider, both verbal and written notification are provided to the Member / Member's Representative and Provider/Facility. The denial letter will include information on how to file for an appeal. Medical Necessity cases are reviewed and processed within the regulatory turnaround times.
- For an approved or denied Retrospective (Post-Service) Medical Necessity review claim the Explanation of Benefits (EOB) and Explanation of Payment (EOP) is generated and sent to the member and provider.

Qualifications/Training:

Pertaining to MH/SUD and M/S Retrospective (Post-Service) Medical Necessity Reviews the Utilization Management (UM) team is comprised of licensed physicians and licensed clinical staff who are trained and qualified to assess clinical information used to make medical necessity review decisions. The licensed clinical staff members responsible for processing medical necessity reviews are trained on the workflow and utilize their clinical education to complete and utilize the appropriate clinical criteria for each medical necessity review. If any of the attributes indicate that the UM criteria are not appropriate, the case is referred to the UM Physician Reviewer for discussion, and final decision. The licensed physician is ultimately responsible for issuing denials using their clinical knowledge, UM workflow and appropriate clinical criteria during the medical necessity review process.

The scope of the UM Program includes oversight, review, approval, and adoption annually, of the evidenced based criteria to make medical necessity determinations, with involvement of the appropriate and credentialed practitioners. Currently, Permanente Advantage does not modify or revise any nationally developed and recognized treatment guidelines approved and adopted. We apply medical necessity criteria to subclassification and/or sub-classification of benefits that require medical necessity review.

Mental Health/Substance Use Disorder

Standards of Care for Mental Health (MH) transgender and gender diverse (TGD) people. Medical Necessity decisions are based on sound clinical evidence to make utilization decisions and specifies procedures for appropriately applying the criteria.

- For an approved retrospective (post-service) Medical Necessity review PA receives directly from the Member / Member's Representative or Provider, a written notification is provided to both the Member / Member's Representative and Provider/Facility.
- For a denied retrospective (post-service) Medical Necessity review PA receives directly from the Member / Member's Representative or Provider, both verbal and written notification are provided to the Member / Member's Representative and Provider/Facility. The denial letter will include information on how to file for an appeal. Medical Necessity cases are reviewed and processed within the regulatory turnaround times.
- For an approved or denied Retrospective (Post-Service) Medical Necessity review claim the Explanation of Benefits (EOB) and Explanation of Payment (EOP) is generated and sent to the member and provider.

Qualifications/Training:

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The scope of the UM Program includes oversight, review, approval, and adoption annually, of the evidenced based criteria to make medical necessity determinations, with involvement of the appropriate and credentialed practitioners. Currently, Permanente Advantage does not modify or revise any nationally developed and recognized treatment guidelines approved and adopted. We apply medical necessity criteria to subclassification and/or sub-classification of benefits that require medical necessity review.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage PPO & POS</u> Factors Variability and/or lack of adherence to criteria Provider discretion and variation in determining medical necessity Severity or chronicity of medical surgical conditions Sources Utilization data Internal UM quality audits National Accreditation standards Electronic medical record Internal and external medical necessity requirements Certification of Insurance	<u>Permanente Advantage PPO & POS</u> Factors Variability and/or lack of adherence to criteria Provider discretion and variation in determining medical necessity Severity or chronicity of MH/SUD conditions Sources Utilization data Internal UM quality audits National Accreditation standards Electronic medical record Internal and external medical necessity requirements Certification of Insurance

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical	Mental Health/Substance Use Disorder
<u>Permanente Advantage PPO & POS</u> The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as Milliman Care Guidelines (MCG™) are utilized for M/S services. This standard applies to the following factors:	<u>Permanente Advantage PPO & POS</u> The assurance of consistency in applying criteria has been designed with the goal to determine which resources are necessary and appropriate for an individual member, and to provide those services in an appropriate setting and in a timely manner, while also monitoring and responding to over and under-utilization of services to support quality and patient safety by ensuring appropriate use of these services. Nationally recognized treatment guidelines used to define clinically appropriate standards of care such as American Society of Addiction Medicine (ASAM) criteria/guidelines are utilized for SUD services, Milliman Care Guidelines (MCG™) are utilized for MH services and the World Professional Association for Transgender Health (WPATH) Standards of Care for Mental

Medical/Surgical

1. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity:
 - a. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards.
2. Severity or chronicity of the M/S conditions:
 - a. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.
3. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards and severity or and chronicity of the M/S conditions.

Mental Health/Substance Use Disorder

- Health (MH) transgender and gender diverse (TGD) people. This standard applies to the following factors:
1. Variability and/or lack of adherence to quality standards and provider discretion and variation in determining medical necessity:
 - a. MCG clinical editors analyze and classify peer-reviewed papers and research studies each year to develop care guidelines in strict accordance with principles of evidence-based medicine, reducing variability and adherence in guidelines and standards.
 2. Severity or chronicity of the MH/BH/SUD conditions:
 - a. ASAM addresses co-occurring and complexity capability, recognizing that co-occurring mental health is an expectation, not an exception. This has been incorporated into the ASAM patient placement criteria utilized. Matrix is available for matching severity and level of function with type and intensity of service.
 - b. MCG provides multiple condition management guidelines that addresses co-occurring diagnosis and optimal recovery course to proactively manage the recovery of patients with multiple active conditions.
 - c. WPATH standards of care support assess, diagnose, and discuss treatment options for coexisting mental health concerns.
 3. Health plan accreditation standards for quality assurance. URAC's HUM Certification demonstrates proven commitment to high performance by embedding quality management principles into your daily operations. The certification process verifies you have reviewed and confirmed your operational soundness, developed policies and procedures, set priorities, and identified organizational improvements. This standard applies to the following factors: Variability and/or lack of adherence to quality standards and severity or chronicity of the MH/SUD conditions.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO & POS

1. Review of Kaiser Permanente Insurance Company Certificate of Insurance procedures for Post-Service Claims indicates one procedure applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, concluding comparable.
2. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.
3. Internal UM audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #4, #5

Permanente Advantage PPO & POS

1. Review of Kaiser Permanente Insurance Company Certificate of Insurance procedures for Post-Service Claims indicates one procedure applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S, concluding comparable.
2. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC desktop and virtual review of UM policies, found Permanente Advantage to be compliant with UM policies as written. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in HUM, effective 09/01/2021-09/01/2024.
3. Internal UM audit for comparability and stringency of written policies and procedures for medical necessity review (Utilization review criteria, Utilization and Quality Management Program descriptions, Utilization and Quality Management Committee minutes, Inter-Rater reliability) identified consistent and comparable written documentation for MH/SUD and M/S. The clinical criteria utilized may differ, but they go through the same approval process at the Utilization Management Committee. Exhibits #1, #4, #5

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical

Mental Health/Substance Use Disorder

Permanente Advantage PPO & POS

1. Permanente Advantage utilizes the same Retrospective (Post-Service) Medical Necessity review procedures for MH, SUD and M/S reviews. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved retrospective (post-service) Medical Necessity reviews PA receives directly from the Member / Member's Representative or Provider/Facility, written notification is provided to both the Member / Member's Representative and Provider/Facility. For denied retrospective (post-service) Medical Necessity reviews PA receives directly from the Member / Member's Representative or Provider, both verbal and written notification are provided to the Member / Member's Representative and Provider/Facility. The denial letter will

Permanente Advantage PPO & POS

1. Permanente Advantage utilizes the same Retrospective (Post-Service) Medical Necessity review procedures for MH, SUD and M/S reviews. Requests are reviewed for medical necessity by the appropriate specialty clinical nurses and physicians. For approved retrospective (post-service) Medical Necessity reviews PA receives directly from the Member / Member's Representative or Provider/Facility, written notification is provided to both the Member / Member's Representative and Provider/Facility. For denied retrospective (post-service) Medical Necessity reviews PA receives directly from the Member / Member's Representative or Provider, both verbal and written notification are provided to the Member / Member's Representative and Provider/Facility. The denial letter will

include information on how to file for an appeal. For approved and denied retrospective (post-service) medical necessity review claims the Explanation of Benefits (EOB) and Explanation of Payment (EOP) are generated and sent to the member and provider. Medical Necessity requests are reviewed and processed within the regulatory turnaround times.

2. Internal UM audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.
3. Internal UM audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.
4. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6
5. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.
6. Analysis of utilization data identified (12) retrospective review cases for Out of Network Outpatient M/S services in which all were approved.

include information on how to file for an appeal. For approved and denied retrospective (post-service) medical necessity review claims the Explanation of Benefits (EOB) and Explanation of Payment (EOP) are generated and sent to the member and provider. Medical Necessity requests are reviewed and processed within the regulatory turnaround times.

2. Internal UM audit of inpatient and outpatient referrals for Medical Necessity review, that decision notifications were completed timely, resulted in 92% for MH/SUD and 91% for M/S, which exceeded our benchmark of 90%.
3. Internal UM audit of inpatient and outpatient referrals for Medical Necessity review, that criteria were correctly selected, resulted in 100 % of the time for MH/SUD as well as for M/S, which exceeded our benchmark of 90%.
4. Inter-rater reliability scores for nurses and physicians performing MH/SUD reviews were 97% versus 99% for M/S, which exceeded our threshold of 90%. Exhibit #6
5. Permanente Advantage underwent URAC Accreditation review for Health Utilization Management (HUM) on 07/29/2021. URAC virtual review of UM chart, found Permanente Advantage to be compliant and comparable with UM policies as in operation. Permanente Advantage utilizes the same UM policies for MH/SUD and Med/Surg. Permanente Advantage was awarded full accreditation in UM, effective 09/01/2021-09/01/2024.
6. Analysis of utilization data identified (4) retrospective review case for Out of Network Outpatient MH/SUD services in which all were approved.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Permanente Advantage PPO & POS

Permanente Advantage utilizes the same Retrospective (Post-Service) Medical Necessity Review procedures for Out-of-Network Outpatient services for both MH/SUD and M/S. Review of Kaiser Permanente Insurance Company (KPIC) Certificate of Insurance definition of Post-Service Claims indicates one definition applicable to MH/SUD and M/S, with no differences documented between MH/SUD and M/S. In comparing the utilization data there were only (4) Retrospective Medical Necessity reviews for MH/SUD Out-of-Network services, which is because the precertification requirements are less restrictive for MH/SUD Outpatient services. Therefore, we are comparable and no more stringent on MH/SUD than M/S services. The URAC audit of Utilization Management (UM) policies, procedures, and clinical chart review of denial and appeal charts concluded Permanente Advantage met the URAC accreditation standards and were consistent and comparable as written and in operation for MH/SUD and M/S. Internal UM audits and inter-rater reliability confirmed the competency of selection and utilization of the Medical Necessity criteria for all services requiring medical necessity review, as written and in operation. Permanente Advantage concludes that as written and in operation, the UM policies, process, factors, and evidentiary standards used to develop and apply Retrospective (Post-Service) Medical Necessity Review NQTL for all Out-of-Network MH/SUD Outpatient services is comparable and no more stringent than M/S for the KPIC plans, and therefore are compliant with the final regulation of the Mental Health Parity and Addiction Equity Act.

Benefit Classification 5: Emergency Services

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – Retrospective Medical Necessity Review is not required for Emergency Services	N/A – Retrospective Medical Necessity Review is not required for Emergency Services

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – Retrospective Medical Necessity Review is not required for Emergency Services	N/A – Retrospective Medical Necessity Review is not required for Emergency Services

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A – Retrospective Medical Necessity Review is not required for Emergency Services	N/A – Retrospective Medical Necessity Review is not required for Emergency Services

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical

Mental Health/Substance Use Disorder

N/A – Retrospective Medical Necessity Review is not required for Emergency Services

N/A – Retrospective Medical Necessity Review is not required for Emergency Services

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical

Mental Health/Substance Use Disorder

N/A – Retrospective Medical Necessity Review is not required for Emergency Services

N/A – Retrospective Medical Necessity Review is not required for Emergency Services

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical

Mental Health/Substance Use Disorder

N/A – Retrospective Medical Necessity Review is not required for Emergency Services

N/A – Retrospective Medical Necessity Review is not required for Emergency Services

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

N/A – Retrospective Medical Necessity Review is not required for Emergency Services

Benefit Classification 6: Pharmacy Services

Benefit / Service(s) to which the NQTL applies

Please list the benefits/services that the NQTL applies to in this classification. When referring to the Classification of Benefits document, please note that not all the benefits/services listed may be subject to the NQTL under analysis.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A - Kaiser Permanente and/or MedImpact do not make medication treatment authorization determinations subsequent to the delivery of treatment. All authorization requests are determined prior to the delivery or dispensing of the drug or other treatment.	N/A - Kaiser Permanente and/or MedImpact do not make medication treatment authorization determinations subsequent to the delivery of treatment. All authorization requests are determined prior to the delivery or dispensing of the drug or other treatment.

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits. Identify the factors and provide a definition. Include the sources for ascertaining each of the factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A	N/A

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Medical/Surgical

Mental Health/Substance Use Disorder

N/A

N/A

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical

Mental Health/Substance Use Disorder

N/A

N/A

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical

Mental Health/Substance Use Disorder

N/A

N/A

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

N/A

Kaiser Permanente Insurance Company (KPIC)

Non-Quantitative Treatment Limits (NQTL)



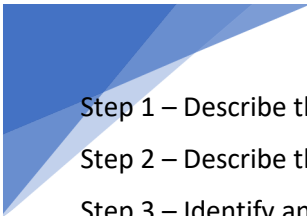
NQTL: Usual, Customary, and Reasonable (UCR)/(PPO/POS)

Last Reviewed: November 21, 2023



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Benefits		Classifications					
Is NQTL applied to Medical/Surgical benefits?	Is NQTL applied to Mental Health/Substance Use Disorder benefits?	Is NQTL applied to In Network Inpatient classification?	Is NQTL applied to Out of Network Inpatient classification?	Is NQTL applied to In Network Outpatient classification?	Is NQTL applied to Out of Network Outpatient classification?	Is NQTL applied to Emergency classification?	Is NQTL applied to Prescription classification?
Yes	Yes	No	Yes	No	Yes	No	No

Benefit Classification 1: Inpatient – In Network

Prompt – Benefit / Service(s) to which the NQTL applies

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- Kaiser Permanente Insurance Company (KPIC) does not apply UCR to Inpatient- In Network Services because we use Kaiser direct contracts, or the Private Health Care Systems (PHCS) contracted network.	N/A- Kaiser Permanente Insurance Company (KPIC) does not apply UCR to Inpatient- In Network Services because we use Kaiser direct contracts, or the Private Health Care Systems (PHCS) contracted network.

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- please refer to response in Benefit Classification 1.	N/A- please refer to response in Benefit Classification 1.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors are used to determine the applicability of the **NQTL** for MH/SUD benefits and for medical/surgical benefits. Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of retrospective review for the identified MH/SUD benefits as were used for medical/surgical benefits, including the sources for ascertaining each of these factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors. Examples of factors for determining that retrospective review is appropriate include (these examples are merely illustrative and not exhaustive):

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

• Examples of sources for data to identify factors:

- ☐ Internal claims analyses
- ☐ Internal quality standard studies
- ☐ Expert medical review

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- please refer to response in Benefit Classification 1.	N/A- please refer to response in Benefit Classification 1.
<p style="text-align: center;">Factors Examples:</p> <div style="display: flex; justify-content: space-between;"> <div> Market price Geographic location Disability accommodations Community reputation </div> <div> Value-added services Languages spoken Multi-specialty co-location Additional training/skills </div> </div>	
N/A- please refer to response in Benefit Classification 1.	N/A- please refer to response in Benefit Classification 1.
<p style="text-align: center;">Sources Examples of sources for data to identify factors:</p> <div style="text-align: center;"> Internal claims analyses Internal quality standard studies Expert medical review </div>	
N/A- please refer to response in Benefit Classification 1.	N/A- please refer to response in Benefit Classification 1.

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Examples of evidentiary standards, their sources, and other evidence considered include:

- ☐ Patient experience surveys
- ☐ Provider professional profiles
- ☐ Provider rating services
- ☐ Word of mouth/reputation

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- please refer to response in Benefit Classification 1.	N/A- please refer to response in Benefit Classification 1.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical

Mental Health/Substance Use Disorder

N/A- please refer to response in Benefit Classification 1.

N/A- please refer to response in Benefit Classification 1.

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical

Mental Health/Substance Use Disorder

N/A- please refer to response in Benefit Classification 1.

N/A- please refer to response in Benefit Classification 1.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

N/A- please refer to response in Benefit Classification 1.

Benefit Classification 2: Inpatient – Out-of-Network

Prompt – Benefit / Service(s) to which the NQTL applies

Medical/Surgical

Mental Health/Substance Use Disorder

PPO

- Physician and other Professional Charges

PPO

- Physician and other Professional Charges

Step 1 – Describe the NQTL's requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical

Mental Health/Substance Use Disorder

Usual, Customary, and Reasonable (UCR) refers to a methodology used by a health plan to determine the reasonable value of services in order to compensate a provider where there is no agreement as to price between the plan and the provider.

Kaiser Permanente Insurance Companies' (KPIC) use of UCR is relatively limited given that KPIC plans in Georgia (GA) use the Private Healthcare System (PHCS) provider network contract for access of medical care.

In addition, with limited exceptions discussed below, the Federal No Surprises Act now requires that many payors adjudicate surprise claims based on the "Qualifying Payment Amount (QPA)," which generally represents the payor's median contract rate for the service in the relevant geography. In some jurisdictions, this has further limited the potential need for plans to employ a UCR method to adjudicate claims. In other jurisdictions, existing state law requires payment of "surprise" claims based on specific methodologies, such as HB 888 in Georgia. A number of these state methodologies will continue to apply following enactment of the No Surprises Act.

We note that a UCR method is only applied where there is no agreement as to pricing, and when no other law or regulation requires payment in a particular manner such as HB 888 in Georgia or Federal mandate HR 133 for Inpatient Professional claims only. In many circumstances, KPIC has mechanisms in place to arrive at an agreement as to price. In general, KPIC employs a payment "hierarchy" that first pays under a direct contract or a PHCS contract if one is in place. If there is no contract, KPIC may then send the claim for fee negotiation and potential execution of a letter of agreement or may utilize a partner rental network to price the claim.

As discussed in more detail below, KPIC may use UCR for payment of non-contracted, post-stabilization claims. This method does not vary based on whether services are Med/Surg or MH/SUD.

What are the required qualifications/training for persons who create and implement the UCR process?

KPIC's UCR methodology was created and is maintained by Fair Health and Multiplan.

Usual, Customary, and Reasonable (UCR) refers to a methodology used by a health plan to determine the reasonable value of services in order to compensate a provider where there is no agreement as to price between the plan and the provider.

Kaiser Permanente Insurance Companies' (KPIC) use of UCR is relatively limited given that KPIC plans in Georgia (GA) use the Private Healthcare System (PHCS) provider network contract for access of medical care.

In addition, with limited exceptions discussed below, the Federal No Surprises Act now requires that many payors adjudicate surprise claims based on the "Qualifying Payment Amount (QPA)," which generally represents the payor's median contract rate for the service in the relevant geography. In some jurisdictions, this has further limited the potential need for plans to employ a UCR method to adjudicate claims. In other jurisdictions, existing state law requires payment of "surprise" claims based on specific methodologies, such as HB 888 in Georgia. A number of these state methodologies will continue to apply following enactment of the No Surprises Act.

We note that a UCR method is only applied where there is no agreement as to pricing, and when no other law or regulation requires payment in a particular manner such as HB 888 in Georgia or Federal mandate HR 133 for Inpatient Professional claims only. In many circumstances, KPIC has mechanisms in place to arrive at an agreement as to price. In general, KPIC employs a payment "hierarchy" that first pays under a direct contract or a PHCS contract if one is in place. If there is no contract, KPIC may then send the claim for fee negotiation and potential execution of a letter of agreement or may utilize a partner rental network to price the claim.

As discussed in more detail below, KPIC may use UCR for payment of non-contracted, post-stabilization claims. This method does not vary based on whether services are Med/Surg or MH/SUD.

What are the required qualifications/training for persons who create and implement the UCR process?

KPIC's UCR methodology was created and is maintained by Fair Health and Multiplan.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors are used to determine the applicability of the **NQTL** for MH/SUD benefits and for medical/surgical benefits. Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of retrospective review for the identified MH/SUD benefits as were used for medical/surgical benefits, including the sources for ascertaining each of these factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors. Examples of factors for determining that retrospective review is appropriate include (these examples are merely illustrative and not exhaustive):

- ☐ Excessive utilization
- ☐ Recent medical cost escalation
- ☐ Lack of adherence to quality standards
- ☐ High levels of variation in length of stay
- ☐ High variability in cost per episode of care
- ☐ Clinical efficacy of the proposed treatment or

service ☐ Provider discretion in determining diagnoses ☐ Claims associated with a high percentage of fraud ☐ Severity or chronicity of the MH/SUD condition • Examples of sources for data to identify factors: ☐ Internal claims analyses ☐ Internal quality standard studies ☐ Expert medical review

Medical/Surgical		Mental Health/Substance Use Disorder									
<p>(a) The Usual, Customary and Reasonable Charge (UCR):</p> <p>(i) the charge generally made by a Physician or other supplier of services, medicines, or supplies; or</p> <p>(ii) the general level of charge made by Physicians or other suppliers within an area in which the charge is incurred for a Covered Service comparable in severity and nature to the Injury of Sickness being treated. The general level of charges is determined in accordance with schedules on file with the authorized Claims Administrator. For charges not listed in the schedules. If the Maximum Allowable Charge is the UCR, the Covered Person will be responsible for payment to a Non-Participating Provider of any amount in excess of the UCR when the UCR is less than the actual billed charges.</p>		<p>(a) The Usual, Customary and Reasonable Charge (UCR):</p> <p>(i) the charge generally made by a Physician or other supplier of services, medicines, or supplies; or</p> <p>(ii) the general level of charge made by Physicians or other suppliers within an area in which the charge is incurred for a Covered Service comparable in severity and nature to the Injury of Sickness being treated. The general level of charges is determined in accordance with schedules on file with the authorized Claims Administrator. For charges not listed in the schedules. If the Maximum Allowable Charge is the UCR, the Covered Person will be responsible for payment to a Non-Participating Provider of any amount in excess of the UCR when the UCR is less than the actual billed charges.</p>									
<p style="text-align: center;">Factors Examples:</p> <table><tr><td>Market price</td><td>Value-added services</td></tr><tr><td>Geographic location</td><td>Languages spoken</td></tr><tr><td>Disability accommodations</td><td>Multi-specialty co-location</td></tr><tr><td>Community reputation</td><td>Additional training/skills</td></tr></table>				Market price	Value-added services	Geographic location	Languages spoken	Disability accommodations	Multi-specialty co-location	Community reputation	Additional training/skills
Market price	Value-added services										
Geographic location	Languages spoken										
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<p>Only Non-PAR professional services are priced with UCR. Factors include:</p> <p>1) Source UCR benchmark vendor (FairHealth/Multiplan)</p> <p>2) Vendor methodology in compiling the data</p> <p>3) KPIC selection of UCR percentile</p> <p>4) KPIC application of UCR standard</p>		<p>Only Non-PAR professional services are priced with UCR. Factors include:</p> <p>1) Source UCR benchmark vendor (FairHealth/Multiplan)</p> <p>2) Vendor methodology in compiling the data</p> <p>3) KPIC selection of UCR percentile</p> <p>4) KPIC application of UCR standard</p>									
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<p>1) KPIC's own internal procedure document," KPIC Pricing Hierarchy".</p> <p>2) Correspondence between Fair Health and KPIC, quotation from Fair Health: "Fair Health does not prescribe, recommend or suggest any particular value or standard, nor determine applicability of UCR. FAIR Health’s benchmarks are created by CPT, HCPC, DRG and ICD-10 procedure and revenue codes. To create benchmark values, FAIR Health applies the same methodology, geographical standards, and procedures to MH/SUD codes that we do to any other codes, including medical and surgical codes".</p> <p>In fact, in many cases, the same code is used for a service, whether it is associated with a Med/Surg or MH/SUD diagnosis, in which case we will provide one set of benchmark values for that code. In the relatively rare cases where a service code is specific to MH/SUD, the methodologies used are the same and are applied no more stringently than for Med/Surg codes."</p>		<p>1) KPIC's own internal procedure document," KPIC Pricing Hierarchy".</p> <p>2) Correspondence between Fair Health and KPIC, quotation from Fair Health: "Fair Health does not prescribe, recommend or suggest any particular value or standard, nor determine applicability of UCR. FAIR Health’s benchmarks are created by CPT, HCPC, DRG and ICD-10 procedure and revenue codes. To create benchmark values, FAIR Health applies the same methodology, geographical standards, and procedures to MH/SUD codes that we do to any other codes, including medical and surgical codes".</p> <p>In fact, in many cases, the same code is used for a service, whether it is associated with a Med/Surg or MH/SUD diagnosis, in which case we will provide one set of benchmark values for that code. In the relatively rare cases where a service code is specific to MH/SUD, the methodologies used are the same and are applied no more stringently than for Med/Surg codes."</p>									

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Examples of evidentiary standards, their sources, and other evidence considered include:

- ☐ Patient experience surveys
- ☐ Provider professional profiles
- ☐ Provider rating services
- ☐ Word of mouth/reputation

Medical/Surgical	Mental Health/Substance Use Disorder
The basis of the evidentiary standard are: 1) Confirmation from Fair Health that all methodologies used in compiling benchmark data are equivalent between MH/SUD and Med/Surg. 2) KPIC's documented procedure for determination of UCR; a single procedure exists for out-of-network payments that applies to both MH/SUD and Med/Surg with no distinction between the two. KPIC's selection of a benchmark vendor, selection of benchmark percentile, and methodology for applying the benchmark for UCR purposes are equivalent for MH/SUD and Med/Surg. Analysis indicates that there is no difference.	The basis of the evidentiary standard are: 1) Confirmation from Fair Health that all methodologies used in compiling benchmark data are equivalent between MH/SUD and Med/Surg. 2) KPIC's documented procedure for determination of UCR; a single procedure exists for out-of-network payments that applies to both MH/SUD and Med/Surg with no distinction between the two. KPIC's selection of a benchmark vendor, selection of benchmark percentile, and methodology for applying the benchmark for UCR purposes are equivalent for MH/SUD and Med/Surg. Analysis indicates that there is no difference.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
Analysis indicates that as described in writing by Fair Health, no distinction exists in the Fair Health methodology for compiling	Analysis indicates that as described in writing by Fair Health, no distinction exists in the Fair Health methodology for compiling

MH/SUD benchmark or Med/Surg benchmarks. In addition, analysis of KPIC's written documentation of the UCR practice of using Fair Health 80th Percentile for out of network providers indicates that there is no distinction between MH/SUD and Med/Surg. All factors are one and the same for MH/SUD and Med/Surg. Analysis indicates that there is no difference.

MH/SUD benchmark or Med/Surg benchmarks. In addition, analysis of KPIC's written documentation of the UCR practice of using Fair Health 80th Percentile for out of network providers indicates that there is no distinction between MH/SUD and Med/Surg. All factors are one and the same for MH/SUD and Med/Surg. Analysis indicates that there is no difference.

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
Analysis confirmed that in operational practice, the four factors for UCR (selection of a benchmark vendor, vendor methodology in compiling benchmarks, KPIC's selection of 80 th percentile, and KPIC's application of the benchmark) are applied uniformly between MH/SUD and Med/Surg. Analysis indicates that there is no difference.	Analysis confirmed that in operational practice, the four factors for UCR (selection of a benchmark vendor, vendor methodology in compiling benchmarks, KPIC's selection of 80 th percentile, and KPIC's application of the benchmark) are applied uniformly between MH/SUD and Med/Surg. Analysis indicates that there is no difference.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Because KPIC's UCR methodology for MH/SUD benefits and Med/Surg benefits are one and the same (both set at the 80th percentile of billed charges for the service/geography in question, based on benchmarks from Fair Health), and because Fair Health applies the exact same methodology to MH/SUD and Med/Surg services when compiling its benchmarks, no additional analysis is needed to confirm compliance.

Benefit Classification 3: Outpatient – In Network

Prompt – Benefit / Service(s) to which the NQTL applies

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- Kaiser Permanente Insurance Company (KPIC) does not apply UCR to Outpatient In-Network Services because we use Kaiser direct contracts, or the Private Health Care Systems (PHCS) contracted network.	N/A- Kaiser Permanente Insurance Company (KPIC) does not apply UCR to Outpatient In-Network Services because we use Kaiser direct contracts, or the Private Health Care Systems (PHCS) contracted network.

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- please refer to response in Benefit Classification 3.	N/A- please refer to response in Benefit Classification 3.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors are used to determine the applicability of the **NQTL** for MH/SUD benefits and for medical/surgical benefits. Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of retrospective review for the identified MH/SUD benefits as were used for medical/surgical benefits, including the sources for ascertaining each of these factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors. Examples of factors for determining that retrospective review is appropriate include (these examples are merely illustrative and not exhaustive):
☐ Excessive utilization ☐ Recent medical cost escalation ☐ Lack of adherence to quality standards ☐ High levels of variation in length of stay ☐ High variability in cost per episode of care ☐ Clinical efficacy of the proposed treatment or service ☐ Provider discretion in determining diagnoses ☐ Claims associated with a high percentage of fraud ☐ Severity or chronicity of the MH/SUD condition • Examples of sources for data to identify factors: ☐ Internal claims analyses ☐ Internal quality standard studies ☐ Expert medical review

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- please refer to response in Benefit Classification 3.	N/A- please refer to response in Benefit Classification 3.
Factors Examples:	
Market price Geographic location Disability accommodations Community reputation	Value-added services Languages spoken Multi-specialty co-location Additional training/skills
N/A- please refer to response in Benefit Classification 3.	N/A- please refer to response in Benefit Classification 3.
Sources Examples of sources for data to identify factors: Internal claims analyses Internal quality standard studies Expert medical review	
N/A- please refer to response in Benefit Classification 3.	N/A- please refer to response in Benefit Classification 3.

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Examples of evidentiary standards, their sources, and other evidence considered include:

- ☐ Patient experience surveys
- ☐ Provider professional profiles
- ☐ Provider rating services
- ☐ Word of mouth/reputation

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- please refer to response in Benefit Classification 3.	N/A- please refer to response in Benefit Classification 3.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- please refer to response in Benefit Classification 3.	N/A- please refer to response in Benefit Classification 3.

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- please refer to response in Benefit Classification 3.	N/A- please refer to response in Benefit Classification 3.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

N/A- please refer to response in Benefit Classification 3.

Benefit Classification 4: Outpatient – Out-of-Network

Prompt – Benefit / Service(s) to which the NQTL applies

Medical/Surgical	Mental Health/Substance Use Disorder
<p><u>PPO</u></p> <p>Outpatient Services</p> <ul style="list-style-type: none"> • Primary Care • Specialty Care • Telemedicine and Telehealth Visits • Primary Care • Specialty Care • Allergy Testing (performed in Office Setting or Outpatient Hospital Setting): • Allergy Serum • Laboratory Services • Radiology Services other than High Tech Radiology Services • High Tech Radiology Services (e.g., MRI's, CTs, PET, Myelogram and Nuclear Medicine scans) • Chemotherapy, Radiation, and Infusion Therapy • Chiropractic Care (spinal manipulation only) • Physician and other Professional Charges • CLINICAL TRIALS (M/S) <p>DENTAL SERVICES</p> <ul style="list-style-type: none"> • Accidental injury teeth • Treatment of TMJ and CMJ: • DURABLE MEDICAL EQUIPMENT (DME) • Ultraviolet Light Therapy System (Light box) for Psoriasis and Atopic Dermatitis <p>HEARING SERVICES</p> <ul style="list-style-type: none"> • Hearing exams and tests • Pediatric Hearing Aid(s) and services for children through age 18: • Infertility Services - Limited to Diagnosis • PREVENTIVE VISITS AND SERVICES Preventative Care • Primary Care Visit • Specialty Care Visit • Well Child Exams (through age 5) • Well Child Exams (age 6 through 21) • Screening • Health Promotion • Disease Prevention • Other Covered Preventive Care • Routine Adult Physical Exams • Primary Care Visit • Preventive Care DME • Blood Pressure Monitors for Hypertension 	<p><u>PPO</u></p> <p>Integrated Behavioral Health Consultation</p> <p>AUTISM SPECTRUM DISORDER SERVICES:</p> <p>Applied Behavior Analysis Program (Limited to Children through age 20):</p> <p>Speech Therapy (Limited to Children through age 20):</p> <p>Physical and Occupational Therapy (Limited to Children through age 20):</p> <p>CLINICAL TRIALS (MH/SUD)</p> <p>MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES</p> <ul style="list-style-type: none"> • Individual visits • Group visits • Medication visit • Partial Hospitalization • Intense Outpatient Therapy Programs • Neurophysiological and psychological testing • Electroconvulsive treatment <p><u>POS</u></p> <ul style="list-style-type: none"> • AUTISM SPECTRUM DISORDER SERVICES • Applied Behavior Analysis • Physical therapy visits • Occupational therapy visits • Speech therapy visits • MENTAL HEALTH SERVICES • Outpatient individual therapy • Outpatient group therapy • Outpatient Mental Health visits for the purpose of monitoring drug therapy • Physician/Professional charges • Outpatient Chemical Dependency Treatment • Outpatient individual therapy (performed in a physician's office) • Outpatient group therapy • Physician/Professional charges

- Preventive Care Labs and Screening
- Prostate specific antigen (PSA) test
- Tobacco Cessation Drugs for Pregnant Women
- Iron Deficiency Anemia Screening for Pregnant Woman
- **Prosthetic Devices and Orthotics**
- Prosthetic Devices (External) and Orthotics (P&O)
- Internally Implanted Prosthetics
- **Reconstructive Surgery**

Rehabilitative and Habilitative Services

- Habilitative Services
- Speech Therapy
- Physical and Occupational Therapy
- Pulmonary Therapy
- Cardiac Rehabilitation
- Cognitive Therapy for Traumatic Brain Injury
- Multi-disciplinary Rehabilitation
- **URGENT CARE**
- **VISION SERVICES**
- Routine Eye Exam
- Pediatric Routine Eye Exam (Children through age 18)
- **Other Covered Services**
- **OPTIONAL BENEFITS**
- Chiropractic Care Manipulative Treatment
- Hearing Aids Adults (19 and over)

Infertility Services

- Treatment
- Outpatient Prescription Drugs for Infertility
- **Morbid Obesity Services**
- Treatment

Vision (Optical) Hardware

- Pediatric Optical Hardware (Children through age 18):
- Pediatric Eyeware (Children through age 18)
- Adults (19 and older):

POS

Office Services

- Primary Care visits
- Specialty Care visits
- Laboratory Services
- X-Ray and other routine radiology Services
- High Tech Radiology Services (including CT, PET, MRI, Myelogram and Nuclear Medicine scans):
- Physician/Professional charges
- Allergy treatment serum
- Allergy injections visits
- **Preventive Visits and Services**
- Well-childcare visits (up to age 6)
- Annual Physical exams for children age 6 and above and adults
- Annual well-woman exams
- Preventive care screening services and procedures (Including pap smears, mammograms, and prostate specific antigen (PSA) tests)
- **Maternity Care**

- Routine prenatal visits and delivery (obstetrician, nurse midwife, OB nurse practitioner) and first postpartum visit
- All other visits during pregnancy, (including genetics counselors and perinatologists)
- Physician/Professional charges

OUTPATIENT SERVICES

- Laboratory Services (When performed in an outpatient facility setting)
- X-ray and other routine radiology Services (When performed in an outpatient facility setting)
- High tech radiology Services (including CT, PET, MRI, myelograms, and nuclear medicine scans)
- Chemotherapy and other visits to infusion centers
- Radiation therapy
- **Rehabilitative Services: Physical, Occupational, Speech Therapy, Multidisciplinary Rehabilitation Care, and Cardiac Rehabilitation**
- Physical therapy visits
- Occupational therapy visits
- Speech therapy visits
- Multidisciplinary Rehabilitation
- Cardiac Rehabilitation
- **After hours urgent care services**
- Physician/Professional charges

Drugs and Supplies

- Contraceptive drugs and intrauterine devices, oral transdermal and vaginal ring
- Administered drugs for treatment of infertility
- **Durable Medical Equipment (DME)**
- Covered equipment or devices
- **Pediatric Hearing Aids for Children to age 19**
- A hearing aid for each ear once every 48 months including fitting and follow-up care up to \$3,000 per aid per ear.
Once Medically Necessary replacement ad per ear every 48 months up to \$3,000 per aid per ear.
- **PROSTHETIC AND ORTHOTICS**
- Covered devices
- **Infertility Services**
- Diagnosis Services
- Treatment Services (including related imaging, lab tests, procedures, and professional Services)
- **In Vitro Fertilization Services**
- \$25,000 Lifetime Maximum combined with Infertility Treatment combined across all provider levels
- **Vision Services**
- Treatment for eye disease and accidental injury of the eye
- Optical Exam for corrective lenses for adults 19 and Older (Does not include fitting for cosmetic lenses)
- **Chiropractic Services**
- **Acupuncture Services**
- Adult Hearing Aids – age 19 and Older
- A hearing aid for each ear once every 24 months
- Limited to one aid per ear every 24 months

- **Dental Services**
- Dental Services and appliances for accidental bodily injury to teeth
- Non-surgical dental treatment, including splints and appliances, for Temporomandibular Joint Dysfunction
- **Adult Hearing Aids – age 19 and Older**
- A hearing aid for each ear once every 24 months
Limited to one aid per ear every 24 months

Step 1 – Describe the NQTL’s requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
<p>Usual, Customary, and Reasonable (UCR) refers to a methodology used by a health plan to determine the reasonable value of services to compensate a provider where there is no agreement as to price between the plan and the provider.</p> <p>Kaiser Permanente Insurance Companies’ (KPIC) use of UCR is relatively limited given that KPIC plans in Georgia (GA) use the Private Healthcare System (PHCS) provider network contract for access of medical care.</p> <p>In addition, with limited exceptions discussed below, the Federal No Surprises Act now requires that many payors adjudicate “surprise” claims based on the “Qualifying Payment Amount (QPA),” which generally represents the payor’s median contract rate for the service in the relevant geography. In some jurisdictions, this has further limited the potential need for plans to employ a UCR method to adjudicate “surprise” claims. In other jurisdictions, existing state law requires payment of “surprise” claims based on specific methodologies, such as HB 888 in Georgia. A number of these state methodologies will continue to apply following enactment of the No Surprises Act.</p> <p>We note that a UCR method is only applied where there is no agreement as to pricing, and when no other law or regulation requires payment in a particular manner such as HB 888 in Georgia or Federal mandate HR 133 for Professional outpatient claims only. In many circumstances, KPIC has mechanisms in place to arrive at an agreement as to price. In general, KPIC employs a payment “hierarchy” that first pays under a direct contract or a PHCS contract if one is in place. If there is no contract, KPIC may then send the claim for fee negotiation and</p>	<p>Usual, Customary, and Reasonable (UCR) refers to a methodology used by a health plan to determine the reasonable value of services to compensate a provider where there is no agreement as to price between the plan and the provider.</p> <p>Kaiser Permanente Insurance Companies’ (KPIC) use of UCR is relatively limited given that KPIC plans in Georgia (GA) use the Private Healthcare System (PHCS) provider network contract for access of medical care.</p> <p>In addition, with limited exceptions discussed below, the Federal No Surprises Act now requires that many payors adjudicate “surprise” claims based on the “Qualifying Payment Amount (QPA),” which generally represents the payor’s median contract rate for the service in the relevant geography. In some jurisdictions, this has further limited the potential need for plans to employ a UCR method to adjudicate “surprise” claims. In other jurisdictions, existing state law requires payment of “surprise” claims based on specific methodologies, such as HB 888 in Georgia. A number of these state methodologies will continue to apply following enactment of the No Surprises Act.</p> <p>We note that a UCR method is only applied where there is no agreement as to pricing, and when no other law or regulation requires payment in a particular manner such as HB 888 in Georgia or Federal mandate HR 133 for Professional outpatient claims only. In many circumstances, KPIC has mechanisms in place to arrive at an agreement as to price. In general, KPIC employs a payment “hierarchy” that first pays under a direct contract or a PHCS contract if one is in place. If there is no contract, KPIC may then send the claim for fee negotiation and</p>

potential execution of a Letter of Agreement (LOA) or may utilize a partner rental network to price the claim.

As discussed in more detail below, KPIC may use UCR for payment of non-contracted, and post-stabilization claims. This method does not vary based on whether services are Med/Surg or MH/SUD.

What are the required qualifications/training for persons who create and implement the UCR process?

KPIC's UCR methodology was created and is maintained by Fair Health and Multiplan.

potential execution of a Letter of Agreement (LOA) or may utilize a partner rental network to price the claim.

As discussed in more detail below, KPIC may use UCR for payment of non-contracted, and post-stabilization claims. This method does not vary based on whether services are Med/Surg or MH/SUD.

What are the required qualifications/training for persons who create and implement the UCR process?

KPIC's UCR methodology was created and is maintained by Fair Health and Multiplan.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors are used to determine the applicability of the **NQTL** for MH/SUD benefits and for medical/surgical benefits. Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of retrospective review for the identified MH/SUD benefits as were used for medical/surgical benefits, including the sources for ascertaining each of these factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors. Examples of factors for determining that retrospective review is appropriate include (these examples are merely illustrative and not exhaustive):

☐ Excessive utilization ☐ Recent medical cost escalation ☐ Lack of adherence to quality standards ☐ High levels of variation in length of stay ☐ High variability in cost per episode of care ☐ Clinical efficacy of the proposed treatment or service ☐ Provider discretion in determining diagnoses ☐ Claims associated with a high percentage of fraud ☐ Severity or chronicity of the MH/SUD condition • Examples of sources for data to identify factors: ☐ Internal claims analyses ☐ Internal quality standard studies ☐ Expert medical review

Medical/Surgical	Mental Health/Substance Use Disorder
<p>(a) The Usual, Customary and Reasonable Charge (UCR):</p> <p>(i) the charge generally made by a Physician or other supplier of services, medicines, or supplies; or</p> <p>(ii) the general level of charge made by Physicians or other suppliers within an area in which the charge is incurred for a Covered Service comparable in severity and nature to the Injury of Sickness being treated. The general level of charges is determined in accordance with schedules on file with the authorized Claims Administrator. For charges not listed in the schedules. If the Maximum Allowable Charge is the UCR, the Covered Person will be responsible for payment to a Non-Participating Provider of any amount in excess of the UCR when the UCR is less than the actual billed charges.</p>	<p>(a) The Usual, Customary and Reasonable Charge (UCR):</p> <p>(i) the charge generally made by a Physician or other supplier of services, medicines, or supplies; or</p> <p>(ii) the general level of charge made by Physicians or other suppliers within an area in which the charge is incurred for a Covered Service comparable in severity and nature to the Injury of Sickness being treated. The general level of charges is determined in accordance with schedules on file with the authorized Claims Administrator. For charges not listed in the schedules. If the Maximum Allowable Charge is the UCR, the Covered Person will be responsible for payment to a Non-Participating Provider of any amount in excess of the UCR when the UCR is less than the actual billed charges.</p>
<p style="text-align: center;">Factors Examples:</p> <div style="display: flex; justify-content: space-between;"> <div> <p>Market price</p> <p>Geographic location</p> <p>Disability accommodations</p> <p>Community reputation</p> </div> <div> <p>Value-added services</p> <p>Languages spoken</p> <p>Multi-specialty co-location</p> <p>Additional training/skills</p> </div> </div>	
<p>Only Non-PAR professional services are priced with UCR. Factors include:</p> <p>1) Source UCR benchmark vendor (FairHealth/Multiplan)</p>	<p>Only Non-PAR professional services are priced with UCR. Factors include:</p> <p>1) Source UCR benchmark vendor (FairHealth/Multiplan)</p>

- 2) Vendor methodology in compiling the data.
- 3) KPIC selection of UCR percentile
- 4) KPIC application of UCR standard

- 2) Vendor methodology in compiling the data.
- 3) KPIC selection of UCR percentile
- 4) KPIC application of UCR standard

Sources

Examples of sources for data to identify factors:

Internal claims analyses
Internal quality standard studies
Expert medical review

- 1) KPIC's own internal procedure document, "KPIC Pricing Hierarchy".
- 2) Correspondence between Fair Health and KPIC, quotation from Fair Health: "Fair Health does not prescribe, recommend or suggest any particular value or standard, nor determine applicability of UCR. FAIR Health's benchmarks are created by CPT, HCPC, DRG and ICD-10 procedure and revenue codes. To create benchmark values, FAIR Health applies the same methodology, geographical standards, and procedures to MH/SUD codes that we do to any other codes, including medical and surgical codes".

In fact, in many cases, the same code is used for a service, whether it is associated with a Med/Surg or MH/SUD diagnosis, in which case we will provide one set of benchmark values for that code. In the relatively rare cases where a service code is specific to MH/SUD, the methodologies used are the same and are applied no more stringently than for Med/Surg codes."

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Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Examples of evidentiary standards, their sources, and other evidence considered include:

- ☐ Patient experience surveys
- ☐ Provider professional profiles
- ☐ Provider rating services
- ☐ Word of mouth/reputation

Medical/Surgical

Mental Health/Substance
Use Disorder

The basis of the evidentiary standard are:

- 1) Confirmation from Fair Health that all methodologies used in compiling benchmark data are equivalent between MH/SUD and Med/Surg.
- 2) KPIC's documented procedure for determination of UCR; a single procedure exists for out-of-network payments that applies to both MH/SUD and Med/Surg with no distinction between the two. KPIC's selection of a benchmark vendor, selection of benchmark percentile, and methodology for applying the benchmark for UCR purposes are equivalent for MH/SUD and Med/Surg. Analysis indicates that there is no difference.

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Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
Analysis indicates that as described in writing by Fair Health, no distinction exists in the Fair Health methodology for compiling MH/SUD benchmark or Med/Surg benchmarks. In addition, analysis of KPIC's written documentation of the UCR practice of using Fair Health 80 th Percentile for out of network providers indicates that there is no distinction between MH/SUD and Med/Surg. All factors are one and the same for MH/SUD and Med/Surg. Analysis indicates that there is no difference.	Analysis indicates that as described in writing by Fair Health, no distinction exists in the Fair Health methodology for compiling MH/SUD benchmark or Med/Surg benchmarks. In addition, analysis of KPIC's written documentation of the UCR practice of using Fair Health 80 th Percentile for out of network providers indicates that there is no distinction between MH/SUD and Med/Surg. All factors are one and the same for MH/SUD and Med/Surg. Analysis indicates that there is no difference.

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
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Analysis confirmed that in operational practice, the four factors for UCR (selection of a benchmark vendor, vendor methodology in compiling benchmarks, KPIC's selection of 80th percentile, and KPIC's application of the benchmark) are applied uniformly between MH/SUD and Med/Surg. Analysis indicates that there is no difference.

Analysis confirmed that in operational practice, the four factors for UCR (selection of a benchmark vendor, vendor methodology in compiling benchmarks, KPIC's selection of 80th percentile, and KPIC's application of the benchmark) are applied uniformly between MH/SUD and Med/Surg. Analysis indicates that there is no difference.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion

Because KPIC's UCR methodology for MH/SUD benefits and Med/Surg benefits are one and the same (both set at the 80th percentile of billed charges for the service/geography in question, based on benchmarks from Fair Health), and because Fair Health applies the exact same methodology to MH/SUD and Med/Surg services when compiling its benchmarks, no additional analysis is needed to confirm compliance.

Benefit Classification 5: Emergency Services

Prompt – Benefit / Service(s) to which the NQTL applies

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- KPIC does not apply UCR to Emergency Services.	N/A- KPIC does not apply UCR to Emergency Services.

Step 1 – Describe the NQTL's requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- KPIC does not apply UCR to Emergency Services.	N/A- KPIC does not apply UCR to Emergency Services.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors are used to determine the applicability of the **NQTL** for MH/SUD benefits and for medical/surgical benefits. Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of retrospective review for the identified MH/SUD benefits as were used for medical/surgical benefits, including the sources for ascertaining each of these factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors. Examples of factors for determining that retrospective review is appropriate include (these examples are merely illustrative and not exhaustive):
 ☐ Excessive utilization ☐ Recent medical cost escalation ☐ Lack of adherence to quality standards ☐ High levels of variation in length of stay ☐ High variability in cost per episode of care ☐ Clinical efficacy of the proposed treatment or

service ☐ Provider discretion in determining diagnoses ☐ Claims associated with a high percentage of fraud ☐ Severity or chronicity of the MH/SUD condition • Examples of sources for data to identify factors: ☐ Internal claims analyses ☐ Internal quality standard studies ☐ Expert medical review

Medical/Surgical	Mental Health/Substance Use Disorder								
N/A- please refer to response in Benefit Classification 5.	N/A- please refer to response in Benefit Classification 5.								
<p>Factors Examples:</p> <table> <tr> <td>Market price</td><td>Value-added services</td></tr> <tr> <td>Geographic location</td><td>Languages spoken</td></tr> <tr> <td>Disability accommodations</td><td>Multi-specialty co-location</td></tr> <tr> <td>Community reputation</td><td>Additional training/skills</td></tr> </table>		Market price	Value-added services	Geographic location	Languages spoken	Disability accommodations	Multi-specialty co-location	Community reputation	Additional training/skills
Market price	Value-added services								
Geographic location	Languages spoken								
Disability accommodations	Multi-specialty co-location								
Community reputation	Additional training/skills								

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Examples of evidentiary standards, their sources, and other evidence considered include:

- ☐ Patient experience surveys
- ☐ Provider professional profiles
- ☐ Provider rating services
- ☐ Word of mouth/reputation

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- please refer to response in Benefit Classification 5.	N/A- please refer to response in Benefit Classification 5.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- please refer to response in Benefit Classification 5.	N/A- please refer to response in Benefit Classification 5.

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- please refer to response in Benefit Classification 5.	N/A- please refer to response in Benefit Classification 5.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion
N/A- please refer to response in Benefit Classification 5.

Benefit Classification 6: Pharmacy Services

Prompt – Benefit / Service(s) to which the NQTL applies

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- KPIC does not apply UCR to Pharmacy Services.	N/A- KPIC does not apply UCR to Pharmacy Services.

Step 1 – Describe the NQTL's requirements and associated procedures

Describe the **NQTL** procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms, and requirements.

Are the required qualifications/training for persons performing NQTL review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.)

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- please refer to response in Benefit Classification 6.	N/A- please refer to response in Benefit Classification 6.

Step 2 – Describe the reason for applying the NQTL

Provide the comparative analysis demonstrating that comparable factors are used to determine the applicability of the **NQTL** for MH/SUD benefits and for medical/surgical benefits.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- please refer to response in Benefit Classification 6.	N/A- please refer to response in Benefit Classification 6.
Factors Examples: Market price□ Volume of service capacity Geographic location Disability accommodations Community reputation	
Value-added services Languages spoken Multi-specialty co-location Additional training/skills	
N/A- please refer to response in Benefit Classification 6.	N/A- please refer to response in Benefit Classification 6.
Sources Examples of sources for data to identify factors: Internal claims analyses Internal quality standard studies Expert medical review	
N/A- please refer to response in Benefit Classification 6.	N/A- please refer to response in Benefit Classification 6.

Step 3 – Identify and describe evidentiary standards and other evidence relied upon

Provide the comparative analysis demonstrating that the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish the **NQTL** for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard used to support the application of a factor identified in Step 2 and any other evidence or data relied upon to establish NQTL for medical/surgical benefits. Describe evidentiary standards that were considered but rejected.

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

Examples of evidentiary standards, their sources, and other evidence considered include:

- ☐ Patient experience surveys
- ☐ Provider professional profiles
- ☐ Provider rating services
- ☐ Word of mouth/reputation

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- please refer to response in Benefit Classification 6.	N/A- please refer to response in Benefit Classification 6.

Step 4 – Processes and strategies used to design NQTL as written

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

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

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- please refer to response in Benefit Classification 6.	N/A- please refer to response in Benefit Classification 6.

Step 5 – Describe the operation of the NQTL process in practice

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

Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.

Medical/Surgical	Mental Health/Substance Use Disorder
N/A- please refer to response in Benefit Classification 6.	N/A- please refer to response in Benefit Classification 6.

Step 6 – Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the **NQTL** on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose NQTL on medical/surgical benefits in each classification of benefits in which NQTL is imposed.

Summary Conclusion
N/A- please refer to response in Benefit Classification 6.