MHPAEA Summary Form

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

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

Kaiser Permanente Insurance Company has performed an analysis of mental health parity as required by Maryland law and has submitted the required report to the State of Maryland. Below is a summary of that report.

If you have any questions on this summary, please call 1-888-225-7202 (TTY 711).

If you have questions on your specific health plan, please call 1-888-225-7202 (TTY 711).

Overview:

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

1. Prior Authorization Review Process

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

Medical / Surgical

- Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; and (2) assures that the care received is appropriate and Medically Necessary to the Covered Person's health care needs. If the Medical Review Program determines that the care is not Medically Necessary, Pre-certification will be denied. Pre-certification/Pre-certified means the required assessment of the necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review Program. 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 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 Plan
- If Pre-certification is not obtained when required, or obtained but not followed, benefits payable for all Covered Charges incurred in connection with the treatment or service will be reduced by 30% (thirty percent). However, the reduction will be limited to $5,000 per Calendar Year. Any such reduction in benefits will not count toward satisfaction of any Deductible, Co-payment, Coinsurance or Out-of-Pocket Maximum applicable under the Group Policy.
- An Adverse Decision regarding an admission of a Covered Person may not be rendered during the first 24 hours after the admission when: 1) the admission is based on a determination that the Covered Person is in imminent danger to self or others; 2) the determination has been made by the Covered Person's Physician or psychologist in conjunction with a member of the medical staff of the facility who has privileges to make the admission; and 3) the hospital immediately notifies the Medical Review Program of the admission of the Covered Person, and the reason for the admission.
- An Adverse Decision regarding a Hospital admission of a Covered Person may not be rendered for up to 72 hours when: 1) the Hospital admission is determined to be Medically Necessary by the Covered Person's treating Physician; 2) the admission is an

involuntary admission (as defined in the Maryland Insurance Code); and 3) the hospital immediately notifies the Medical Review Program of the admission of the Covered Person, and the reason for the admission.

- Pregnancy Pre-certification: When a Covered Person is admitted to a Hospital for delivery of a child, the Covered Person is authorized to stay in the hospital for a minimum of: 1. Forty-eight (48) hours for an uncomplicated vaginal delivery; and 2. Ninety-six (96) hours for an uncomplicated Cesarean section delivery.

Mental Health / Behavioral Health / Substance Use Disorder:

- Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; and (2) assures that the care received is appropriate and Medically Necessary to the Covered Person's health care needs. If the Medical Review Program determines that the care is not Medically Necessary, Pre-certification will be denied. Pre-certification/Pre-certified means the required assessment of the necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review Program. 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 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 Plan
- If Pre-certification is not obtained when required, or obtained but not followed, benefits payable for all Covered Charges incurred in connection with the treatment or service will be reduced by 30% (thirty percent). However, the reduction will be limited to $5,000 per Calendar Year. Any such reduction in benefits will not count toward satisfaction of any Deductible, Co-payment, Coinsurance or Out-of-Pocket Maximum applicable under the Group Policy.
- An Adverse Decision regarding an admission of a Covered Person may not be rendered during the first 24 hours after the admission when: 1) the admission is based on a determination that the Covered Person is in imminent danger to self or others; 2) the determination has been made by the Covered Person's Physician or psychologist in conjunction with a member of the medical staff of the facility who has privileges to make the admission; and 3) the hospital immediately notifies the Medical Review Program of the admission of the Covered Person, and the reason for the admission.
- An Adverse Decision regarding a Hospital admission of a Covered Person may not be rendered for up to 72 hours when: 1) the Hospital admission is determined to be Medically Necessary by the Covered Person's treating Physician; 2) the admission is an

involuntary admission (as defined in the Maryland Insurance Code); and 3) the hospital immediately notifies the Medical Review Program of the admission of the Covered Person, and the reason for the admission.

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

- Length of stay
- Adherence to criteria
- Clinical effectiveness of the treatment or service
- Appropriate level of care
- Severity or chronicity of MH/BH/SUD or M/S condition(s)
- Consistency in prior authorization services
- Medically Necessary
- Quality and Regulatory Standards

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

- Sources, processes, strategies, and evidentiary standards utilized for Prior Authorization include:
    - Encoder Pro which is utilized for M/S as well as MH/BH/SUD in the In Network Inpatient, Out of Network Inpatient, In Network Outpatient - All Other and Out of Network Outpatient - All Other Benefit Classifications. Encoder Pro is an online coding and reference platform for CPT and HCPC codes; it ensures users have access to the latest codes in use. Permanente Advantage utilizes this tool on a quarterly basis to assess any new, amended, or discontinued CPT and HCPC codes, subsequently reviewing and updating the list of services requiring prior authorization.
    - Healthcare Market Prior Authorization Lists which are utilized for M/S as well as MH/BH/SUD in the In Network Inpatient, Out of Network Inpatient, In Network Outpatient - All Other and Out of Network Outpatient - All Other Benefit Classifications. Permanente Advantage conducts an annual analysis of its required services for prior authorization with those of other national healthcare markets (market analysis)
    - URAC Accreditation Standards for Health Utilization Management are utilized for M/S and MH/BH/SUD in the In Network Inpatient, Out of Network Inpatient, In Network Outpatient – All Other and Out of Network Outpatient – All Other Benefit Classifications. Permanente Advantage's URAC Accreditation occurs every 3 years. Permanente Advantage's current URAC

accreditation is through September 1, 2024. The UM Program requirements for URAC Accreditation include UM 1-1: Program Structure as well as UM 1-2: Utilization Review Monitoring.

- Maryland Insurance Administration laws and regulations are utilized for M/S and MH/BH/SUD in the In Network Inpatient, Out of Network Inpatient, In Network Outpatient – All Other and Out of Network Outpatient – All Other Benefit Classifications. Permanente Advantage ensures to follow the prior authorization laws and regulations set forth by the MIA which include: (1) Md. Code, Ins. § 15-10B – 6; (2) Md. Code, Ins. § 15-10A-02 (f)(1); (3) Md. Code Regs. 31.10.21.02-1:(B); Md. Code, Ins. § 15-10B-05 (a)(5) and Md. Code, Ins. § 15-10B-06 (a)(3) and (d)
- Private Review Agency Certification Requirements which are utilized for M/S and MH/BH/SUD in the In Network Inpatient, Out of Network Inpatient, In Network Outpatient – All Other and Out of Network Outpatient – All Other Benefit Classifications. Permanente Advantage completes certification to operate as a Private Review Agent every 2 years which also indicates that we are compliant with the regulations noted in Md. Code, Ins. § 15-10A and 15-10B, COMAR 31.10.18 and COMAR 31.10.21.
- Internal quality audits which are utilized for M/S and MH/BH/SUD in the In Network Inpatient, Out of Network Inpatient, In Network Outpatient – All Other and Out of Network Outpatient – All Other Benefit Classifications. The internal audits are conducted quarterly to ensure the prior authorization reviews (including the criteria we utilize are applied appropriately) as well as notifications are completed timely in addition the written notifications requirements.
- Utilization data which is evaluated for M/S and MH/BH/SUD in the In Network Inpatient, Out of Network Inpatient, In Network Outpatient – All Other and Out of Network Outpatient – All Other Benefit Classifications. The data is reviewed on a quarterly basis and analyzes volume as well as any trends that might be present.
- Inter-rater Reliability (IRR) review is utilized for M/S and MH/BH/SUD in the In Network Inpatient, Out of Network Inpatient, In Network Outpatient – All Other and Out of Network Outpatient – All Other Benefit Classifications. Each year an IRR review is completed to evaluate the accuracy, effectiveness and consistency amongst the clinical reviewers to ensure adherence to internal quality measures and procedures.
- Medical Necessity Review guidelines / criteria for the specific service, item or treatment which are utilized for M/S and MH/BH/SUD in the In Network Inpatient, Out of Network Inpatient, In Network Outpatient – All Other and Out of Network Outpatient – All Other Benefit Classifications. Each service, item or treatment that requires prior authorization will go through a clinical review process to determine if it is medically necessary. The guidelines / criteria that are utilized to determine if an item, services or treatment is medically necessary are noted below:
    - M/S Guidelines / Criteria utilized are (1) MCG Guidelines (for various M/S items, services and treatments), (2) Internal and Kaiser Regional Guidelines/Criteria for Transplants, Morbid Obesity and Bariatric Surgery which are developed and implemented by actively practicing physicians representing primary care and the major specialties

utilizing clinical experience, judgment, and evidence from published medical literature and are reviewed and approved annually by the UM committee, (3) National Comprehensive Cancer Network (NCCN) Guidelines (for cancer care and treatment), (4) CMS National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) (for M/S durable medical equipment).

- MH/BH/SUD Guidelines / Criteria utilized are (1) MCG Guidelines (for various M/S items, services and treatments), (2) American Society of Addiction Medicine (ASAM) Criteria (for SUD), (3) Internal and Kaiser Regional Guidelines/Criteria MH/BH Infusion of Brexanolone which is developed and implemented by actively practicing physicians representing primary care and the major specialties utilizing clinical experience, judgment, and evidence from published medical literature and are reviewed and approved annually by the UM committee, (4) World Professional Association of Transgender Health (WPATH) Standards of Care (for MH Transgender and Gender Diverse (TGD) services).

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

- The method for determining the application of prior authorization NQTL consistently involves referencing the most current list of services that require prior authorization. The prior authorization NQTL applies solely to the services listed within the list of services requiring prior authorization. The Utilization Management Program's scope encompasses the oversight and review of utilization data to ascertain which services necessitate prior authorization or can be removed from the list. Encoder Pro is utilized quarterly to assess any new, amended, or discontinued CPT and HCPC codes. Furthermore, National Healthcare Markets Prior Authorization Lists are reviewed to ensure comparable. The Clinical Leadership, with input from specialty physicians, decide on necessary updates each quarter.

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

- Permanente Advantage's market analysis for the KPIC Prior Authorization list confirmed comparable national healthcare markets also require prior authorization review for all M/S and MH/BH/SUD services in the In Network and Out of Network Inpatient Benefit Classifications as well as selected M/S and MH/BH/SUD services in the In Network and Out of Network Outpatient – All Other Benefit Classifications. KPIC, however, is found to be less restrictive by not requiring prior authorization reviews for any In or Out of Network Outpatient – Office, or the following In or Out of Network Outpatient – All Other services (1) M/S Rehabilitative Therapies

(2) M/S or MH/BH Autism Spectrum Disorder (ASD) Habilitative Therapies, (3) MH/BH ABA Therapy (4) MH/BH/SUD PHP or (5) MH/BH/SUD IOP.

- Permanente Advantage's review of the Prior Authorization list has led to the removal of a few M/S services and the addition of a few MH/BH/SUD codes. Regardless of whether a member is receiving services in network or out of network, the list of services requiring prior authorization remains the same.
- The review of the 2023 utilization data for services that require prior authorization was not feasible due to the absence of utilization data for MH/BH/SUD services. Additionally, in 2023 there were no In Network or Out of Network Inpatient cases within the utilization data to evaluate and compare the length of stay factor.
- The URAC audit of the Utilization Management Program along with policies, procedures, and clinical chart review of denial and appeal charts, determined that Permanente Advantage complies with the URAC Health Utilization Management (HUM) accreditation standards as written and in operation for MH/BH/SUD and M/S services.
- The annual IRR review confirmed the proper selection and application of the Medical Necessity criteria, despite the variation in criteria that is used, for M/S and MH/BH/SUD services that require prior authorization, 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 Prior Authorization NQTL for all In and Out of Network Inpatient and selected In and Out of Network Outpatient – All Other Benefit Classifications is comparable and no more stringent than M/S for the KPIC benefit plan, and therefore are compliant with the final regulation of the Mental Health Parity and Addiction Equity Act.

2. Prescription Drug Formulary Design

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

Prescription Drugs

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

1. Safety and Effectiveness
2. Availability of current formulary drugs to meet the therapeutic need
3. Reliability and quality control of the drug manufacturer
4. Current utilization of the drug by practitioners within the program
5. Comparative cost of alternative equivalent therapy
6. Other unique attributes which may warrant inclusion of the drug
7. State and local mandates for benefit coverage and Medicare regulations
8. Whether drug is a brand or generic drug
9. Inclusion in the health benefit package

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

1. Medical evidence (nationally published clinical guidelines, primary research and clinical research studies, manufacturer package insert); expert opinion (, Nationally published consensus statements); relevant findings of appropriate
2. Kaiser Formulary and preferred alternatives drug list, clinical guidelines, standard of care
3. FDA approval process, Medwatch
4. Kaiser Utilization Data with 4-month lookback period from claims and sold data
5. Available pharmacoeconomic studies
6. National published consensus statements
7. Code of Maryland Regulations (COMAR), Code of Federal Regulations (CFR), accreditation standards (NCQA), applicable statutes/regulations
8. MNOY multi-source indicator from Medi-Span, product package insert.
9. Plan documents

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

The NQTL is designed and applied comparably to MH/SUD and M/S medications as written. As described above, KPIC follows the same process and considers the same factors, evidentiary standards, and sources in making decisions regarding formulary development and placement for MH/SUD and M/S drugs. These factors, evidentiary standards, and sources are specific and provide clear parameters that the P&T Committee follows in making decisions regarding the application of the NQTL.

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

The NQTL is designed and applied comparably to MH/SUD and M/S medications in operation. The factors, evidentiary standards, and sources that KPIC uses are specific and provide clear parameters that the P&T Committee follows in making decisions regarding the application of the NQTL. As such, KPIC is comparable in operation.

To further support that the NQTL is comparable and no more stringently applied in operation, we have included a number of metrics regarding the inclusion of drugs on the formulary.

3. <u>Provider (Including Facility) Reimbursement</u>

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

Kaiser Permanente Insurance Company (KPIC) offers an Out of Area (OOA) Preferred Provider Organization (PPO) Plan in the State of Maryland. This plan allows members to make the best health choice by combining an in-network and an out-of-network provider option in one plan. In the out-of-network option, members can access any licensed health care provider in the United States. The NQTL applies to all medical/surgical and mental health and/or substance use disorder OOA PPO benefits.

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

KPIC applies proprietary provider reimbursement standards and MD COMAR 31.10.51 standards and federal regulatory agency standards to adherence.

MultiPlan (PHCS) 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.

State Regulated Methodology for Reimbursement Rates - Maryland Health General Code 19-710.1

Usual, Customary and Reasonable Charge (UCR)

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

KPIC applies proprietary provider reimbursement standards and MD COMAR 31.10.51 standards and federal regulatory agency standards to adherence.

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.

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

KPIC applies proprietary provider reimbursement standards and MD COMAR 31.10.51 standards and federal regulatory agency standards to adherence.

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 in the comparative analysis.

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

KPIC applies proprietary provider reimbursement standards and MD COMAR 31.10.51 standards and federal regulatory agency standards to adherence.

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.

4. <u>Strategies for Addressing Provider Shortages</u>

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

Applies to all In-Network benefits.

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

MultiPlan applies proprietary network adequacy standards and MD COMAR 31.1.44 standards and federal regulatory agency standards to ensure adequate access to Network Providers for members.

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

MultiPlan's proprietary Network Adequacy standards and MD COMAR 31.1.44 standards are based on measurements for urban, suburban, and rural markets to provide Clients' members reasonable access to a sufficient number of Network Providers. In addition, MultiPlan applies the Network Adequacy standards established by state regulatory agencies, including geographic distribution of providers, provider ratios, and appointment wait times.

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

MultiPlan's proprietary Network Adequacy standards and MD COMAR 31.1.44 standards are based on measurements for urban, suburban, and rural markets to provide Clients' members reasonable access to a sufficient number of Network Providers. In addition, MultiPlan applies the Network Adequacy standards established by state regulatory agencies, including geographic distribution of providers, provider ratios, and appointment wait times.

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

MultiPlan develops, monitors, and maintains proprietary Network Adequacy Standards, except where state or federal law requires a specific standard. Network Adequacy Standards for MH/SUD and medical/surgical providers are applied consistently to determine whether a market provides appropriate levels of access to Network Providers. MH/SUD specialist geographic adequacy requirements defined in MultiPlan's proprietary Network Adequacy Standards are the same criteria used for Medical/Surgical providers. MultiPlan requires a minimum of two

providers by specialty category within a defined distance in Urban, Suburban, and Rural markets, regardless of whether the provider is a MH/SUD or Medical/Surgical provider. However, state or federal laws may dictate different standards; in those instances, the application of standards equitably between MH/SUD providers and Medical/Surgical providers is not determined by MultiPlan. MultiPlan's Network Adequacy program is monitored annually, unless state or federal laws require a more frequent review. MultiPlan regularly reviews and analyzes information relating to Network Adequacy to determine if there are any markets that fail to comply with Network Adequacy standards. In such cases, corrective action is taken to correct the deficiency.

5. Provider Network Directories

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

- MultiPlan uses a single process to verify and update directory information for all participating providers and facilities in their network. The directory includes information about the providers' specialties and services, as reported by the providers and verified by MultiPlan's credentialing team for directly credentialed providers.
- To ensure accuracy, MultiPlan's Provider Directory Management team works year-round to confirm and update provider data. They use multiple methods to collect, verify, and correct provider data, including outbound telephone and email outreach, collecting rosters from large provider groups, and comparing rosters with local regulatory requirements. Providers that have not been verified in the prior 12 months are removed from the directories according to the No Surprises Act, and this process is completed on the first business day of each month.
- In addition to telephone outreach, MultiPlan conducts monthly email outreach for directory verification and provides a Provider Portal for network providers to verify and submit real-time updates to their directory information.
- MultiPlan's directory is available online in Spanish, and language assistance is provided through specific phone numbers. The directory also indicates the accessibility of a practitioner's office location and the languages spoken there. ADA barriers can be reported by contacting an email address or clicking on a link in Multiplan provider directories.
- The directory is searchable by name, license number, National Provider Identification Number, zip code/specialty, and facility name. Searches can be filtered by location perimeters, new patient status, gender, language, hospital affiliations, handicap accessibility, telemedicine services, office visit wait times, board certification, education, and degree.

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

- MultiPlan maintains accurate directories in accordance with the No Surprises Act and current state requirements.

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

1. MultiPlan collects demographic information as required by state and/or federal law as outlined in the MultiPlan’ State Specific Directory Policy, which sets minimum requirements for publishing demographic data in print and electronic directories.

2. MultiPlan verifies and updates directory information on the frequency outlined in the policy and more frequently as may be required by applicable law, including but not limited to, at a minimum, annually reviewing and updating all provider directory information for providers located in Maryland, Providers that do not respond to verification attempts, must be suppressed from the directory according to this policy.
3. All online and print directories are updated within no more than one hour following a change to provider information, exceeding weekly and quarterly updates required by law.
4. MultiPlan's Outbound Call Center performs outreach to ensure accuracy of demographic data.
5. MultiPlan utilizes a Roster Procurement process to gather data for groups.
6. MultiPlan leverages claim data matching name/address as a verification for directory information.
7. MultiPlan conducts audits as required by applicable state law, including but not limited to bi-annual audits of providers
8. MultiPlan's Service Operations regularly updates and verifies provider information when interacting with providers.
9. MultiPlan maintains a Directory Suppression process for non-verified provider locations.
10. MultiPlan periodically conducts outreach and research for the purposes of unsuppressing provider locations, if applicable.
11. MultiPlan has an online form, an e-mail address, and phone number for Client members and other individuals from the general public to report invalid provider data information.
12. MultiPlan makes available a printed version of the provider directory.
13. MultiPlan uses an external vendor, Healthlink Dimensions, to supplement the verification of provider directory information.

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

The directory is a function of one of MultiPlan's products and it is not a product or service, but rather an obligation as a part of their network. All providers included in the network are listed on the MultiPlan directory, unless they have not verified their information. MultiPlan performs suppression/exclusion which may result in the KPIC directory not listing all providers within the network.

1. MultiPlan updates the Provider Directory and Network Adequacy Outreach Elements when new or modified state and/or federal laws require additional demographic information to be published in print or electronic directories.
    a. MultiPlan notifies Kaiser Permanente Insurance Company (KPIC) of the change in the Provider Directory.
    b. KPIC incorporates the changes by adding new or revised outreach elements into the data collection processes outlined in the State Specific Directory Policy. Each provider that is not contracted through a large contract entity (groups >150 practitioners, facility contracts > 20 facility affiliations) is contacted if their data has not been verified through any other sources in the prior 90 days.

   c. Updates received from phone outreach are automatically loaded directly to the provider system of record upon completion of the phone call. Updates from fax or email are entered within 2 business days from receiving a request to update provider demographic data if it is complete and accurate at the time of submission. Any information received that is incomplete, missing information, or requires significant manual review to validate the contents will be generally entered within 2 business days from the date the data is validated as complete and accurate or on average 5 business days from the original receipt of the incomplete data submission.

2. MultiPlan utilizes a Roster Procurement process to gather data for large groups (>150 practitioners or > 20 facilities).
   a. MultiPlan's Outbound Contact Center contacts groups that have not submitted a roster within the prior 90 days.
   b. The outreach program includes multiple attempts to gather demographic data via fax and phone.
   c. The information is sent to the KPIC department for processing upon response and updates are made to the system of record. Updates from fax or email are entered within 2 business days from receiving a request to update provider demographic data if it is complete and accurate at the time of submission. Any information received that is incomplete, missing information, or requires significant manual review to validate the contents will be generally entered within 2 business days from the date the data is validated as complete and accurate or on average 5 business days from the original receipt of the incomplete data submission.

3. MultiPlan leverages claim data matching name/address as a verification for directory information.
   a. If MultiPlan processes a claim that matches a provider record (on Name & Address) the location can be considered verified.

4. MultiPlan conducts audits as required by applicable state law, including but not limited to biannual audits of providers
   a. Twice annually, outreach is conducted for all individually contracted providers in the Network(s)
   b. Annual outreach is conducted for all Groups, Corporate Facilities, and Ancillaries with a Network contract
   c. Multiple attempts are made to contact the provider and confirm and/or collect information.
   d. The information is sent to KPIC and updated in the system of record.

5. MultiPlan's Service Operations regularly updates and verifies provider information through their interactions.
   a. Multiplan's SO department will make real-time updates into the system of record while interacting with the provider.
   b. These updates and verifications include address, phone, fax, email, and contact information.
   c. These changes are processed in the system of record immediately and reflected in the directories within one hour.

6. MultiPlan maintains a Directory Suppression process for non-verified locations.
    a. Those not verified in the prior 12 months through any of the above methods are suppressed from the directory until status is confirmed.
        i. MultiPlan will continue to incorporate those suppressed offices in outreach processes to ensure that if new evidence shows a location is valid, it is un-suppressed from the directory.
    b. Roster-based suppression.
        i. KPIC conducts an analysis of rosters submitted by groups- if there are locations in the MultiPlan provider database that are not in the roster, they are sent back to the group for confirmation.
            1. If the location is confirmed as still active, the verification date is updated.
            2. If the location is confirmed inactive, it is terminated.
            3. If no response is received within two weeks, the location will be suppressed from the directory. Requests for timeline extensions are generally accepted, and prior to directory. suppression, internal escalation may take place through Service Operations and Network Development.

7. MultiPlan uses an external vendor, Healthlink Dimensions, to audit, verify, and supplement, as necessary the provider directory information.
    a. On a monthly basis Multiplan will submit a file to Healthlink Dimensions containing all directory displayed provider locations not verified in the last 90 days (NOTE: 90 days is flexible, criteria can be changed on a monthly basis).
    b. Healthlink Dimensions provides audit results via API based on provider information verified through web-based research.
    c. Provider information is updated via scripting, except for net new addresses, which will be reviewed and updated manually.

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

- The language in the verification of accuracy above addresses the process for ensuring accuracy. MultiPlan has not conducted any analysis of MH/SUD versus Med/Surg for the directory.