

Sample Example of a Sufficient NQTL Comparative Analysis

Concurrent Review: Inpatient, in-network

Step 1:

Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder and medical or surgical benefits to which the NQTL applies or for which it does not apply.

Issuer Response: All inpatient MH/SUD and M/S benefits are subject to concurrent review. What varies is when concurrent review will take place within the course of an inpatient stay. This is fully described in steps 2 and 3.

Step 2:

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

Issuer Response: Acme relies on several factors to determine when inpatient benefits will be subject to concurrent review. These factors apply to both MH/SUD benefits and M/S benefits. While all inpatient benefits are subject to concurrent review eventually, these factors determine at what point in time concurrent review will occur initially, and then subsequently in the case of continued stays. When any one of these factors is implicated, concurrent review will occur. The factors are:

- Average length of stay exceeded
- High cost admission
- Previously authorized days have elapsed

Step 3:

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

Issuer Response: Here are the definitions and evidentiary standards for the three factors listed above, including parameters and thresholds:

Average length of stay exceeded – For each inpatient facility type, MH/SUD and M/S, Acme examined internal length of stay data for the previous three years and determined the mean average length of stay for each facility (rounded to the closest whole number). When a member is admitted to a facility, MH/SUD or M/S, initial concurrent review will always occur no later than the day that is the mean average stay for the facility in question (and only earlier if the high-cost admission factor is triggered). We have provided an attachment that contains the various average lengths of stay for each facility type and the internal data we used to identify the mean averages. You do not need to examine this attachment but may if you would like to verify that we did the math properly and the mean averages are all in fact correct.

High cost admission – In addition to determining the mean average length of stay to satisfy the definition for the previous factor, ACME also determined what the mean average cost was for each mean average length of stay per facility. For example, the mean average length of stay for a residential SUD facility was 12 days, we then determined what the mean average cost for a 12-day stay at residential SUD facilities (aggregating cost data from all the different residential SUD facilities for which we provide in-network reimbursement). If a member's stay eclipses 125% of the mean average cost on a day that is before the mean average stay, concurrent review is imposed. Similarly to the previous factor, we have provided an attachment that contains all of the mean average costs per stay for each facility type and the internal data used to identify these means. You do not need to examine this attachment but may if you would like to verify that we did the math properly and the means are all in fact correct.

Previously authorized days have elapsed – Every concurrent review that is approved is approved only for a set number of days that is predetermined and uniform across all benefits. For Acme, that number is 3 days (72 hours). When a concurrent review is approved, the member receives 3 more days at the facility before another review occurs. There is no clinical or data-driven reason for this number. If a continued stay is approved for any facility type, whether it's MH/SUD or M/S, 3 days of additional coverage are automatically covered (however, if the member leaves the facility for any reason before 3 days, we will only reimburse for the actual days of delivered care).

In terms of other evidence or sources, there are no other sources or evidence used to design concurrent review. The three factors listed and defined above are the sole determinants of when concurrent review will occur. Also, as noted, concurrent review applies to all inpatient facility types for MH/SUD and M/S. It is merely the timing of when it is imposed that the three factors come into play.

However, in terms of other evidence and sources that are utilized in the application of concurrent review, there are several.

For M/S we rely upon MCG Care Guidelines for level of care placement and medical necessity determinations.

For MH, we also rely upon MCG guidelines for level of care placement and medical necessity determinations.

For SUD, we utilize ASAM criteria for level of care placement and medical necessity determinations.

We will provide additional information about these guidelines and their use in step 4 in order to demonstrate comparability and no more stringent application.

Step 4:

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

Issuer Response – As Written: In addition to the criteria we mentioned in step 3 (MCG & ASAM) we also have a utilization management manual that is used for MH/SUD and M/S. This manual focuses on detailing the information that must be collected during utilization review (including concurrent review), the timelines involved in making decisions, the protocols for providing authorization determinations to members and providers, the protocols for urgent requests, and information about notifying members of the appeals process in the case of a denial. The exact same manual is used for MH/SUD and M/S, and there is nothing within the manual that would appear to establish different processes for MH/SUD than for M/S. In other words, the UM manual is a series of as written processes and they are the exact same for MH/SUD as they are for M/S. The manual does describe several in-operation processes that are identical in their basic structure for MH/SUD versus M/S, and we will further analyze those processes below in the in-operation section.

As noted in step 3, we use MCG Care Guidelines for M/S level of care and medical necessity determinations, MCG again for MH level of care and medical necessity determinations, and ASAM Criteria for SUD level of care and medical necessity determinations. We will provide during the in-operation portion our analysis of how our reviewers adhered to those criteria.

As we noted in step 2, there are only 3 factors in play that implicate when concurrent review will occur. We believe that our definition and evidentiary standards provided for those 3 factors in step 3 demonstrates comparability and no more stringent application of those factors.

Issuer Response – In Operation: For in operation, we have identified three distinct process that occur during concurrent review: first-level review; physician review; peer-to-

peer review. First-level review happens in every instance of concurrent review and is conducted by a utilization review nurse for both M/S and MH/SUD. The first-level reviewer can only approve an authorization request based on whether the submitted clinical information from the facility appears to meet the criteria for a continued stay. The first-level reviewer is not permitted to deny an authorization request.

If the first-level reviewer is unable to approve the authorization request, the request will then be sent to a physician reviewer to either approve the request or deny the initial request but with an accompanying approval for a lower-level of care. Acme will never outright deny inpatient care without initially subsequently authorizing coverage at a lower level of care. However, we will issue an outright denial, with an accompanying letter explaining why the request was denied if the member or facility requests that for the purpose of filing an appeal. For MH physician reviews, Acme uses board-certified psychiatrists and a child and adolescent psychiatrist. For SUD, Acme uses physicians who are board certified in addiction psychiatry and addiction medicine. For M/S, Acme utilizes dozens of physicians in numerous specialties (however, Acme does not have every single physician specialty type in its employ).

Peer-to-peer review happens under two circumstances: one, when the physician reviewer determines that she needs to speak with the attending physician in order to further obtain and absorb all the clinical information necessary to make a decision on the request. Two, any time an MH/SUD initial authorization request is not approved, peer-to-peer will be offered to the attending physician at the facility so there is an opportunity to state his clinical judgment as to why the authorization should be approved. In some instances, this will result in the physician reviewer changing her decision and approving the initial authorization. For M/S, peer-to-peer is always available upon request after an initial authorization request is not approved, but it is not automatically extended without the request. We do this in order to make it more likely that MH/SUD benefits are not incorrectly denied coverage and to make it more likely that we comply with MHPAEA. We believe other issuers have begun doing this as well.

We believe that what we have just described about these three in-operation processes demonstrates that they are in fact comparable in their design and application for MH/SUD versus M/S. In fact, the structure is identical for both MH/SUD and M/S. However, we understand that we also need to demonstrate that they are in fact no more stringently applied. In order to do that, we performed the following analyses:

First level review:

- 40 M/S continued stay authorization requests selected at random
- 20 MH continued stay authorization requests selected at random
- 20 SUD continued stay authorization requests selected at random

Physician review:

- 40 M/S continued stay authorization requests selected at random

- 20 MH continued stay authorization requests selected at random
- 20 SUD continued stay authorization requests selected at random

Peer-to-peer review:

- 40 M/S continued stay authorization requests selected at random
- 20 MH continued stay authorization requests selected at random
- 20 SUD continued stay authorization requests selected at random

Please note that we identified all requests that included physician review and sorted them into their own category before randomly selecting the requests for our sample. We did the same thing with peer-to-peer. For first-level review, no sorting or identifying was necessary because all requests involve first-level review (whereas not all requests involve physician review and even fewer involve peer-to-peer).

When doing our comparative analyses for each of the three processes, we only examined the process under analysis in each of the request files that were randomly selected. For example, when we were analyzing files for first-level review we did not examine what happened during physician review or peer-to-peer review for files that included one or both of those other processes. Each process is distinct and must be analyzed independently. When analyzing first-level review for stringency between MH/SUD and M/S, what occurs during physician review is irrelevant. Similarly, when analyzing physician review, what occurred during first-level review is irrelevant in determining stringency for physician review.

Here is what our analyses demonstrated:

First-level review – Of the 40 M/S requests reviewed 26 were approved by the utilization review nurse and 14 were sent to physician review. Of the 20 MH requests reviewed, 16 were approved by the utilization review nurse and 4 were sent to physician review. Of the 20 SUD requests reviewed, 15 were approved by the utilization review nurse and 5 were sent to physician review. This means that 65% of the M/S first-level reviews resulted in approval while 77.5% of MH/SUD first-level reviews resulted in approval. Additionally, we found that for both MH and SUD, the reviewer only sent the requests to physician review when it appeared likely that the request did not meet the criteria for a continued stay (MCG for MH and ASAM for SUD). For M/S, while most of the requests sent to physician review appeared likely that they did not meet the criteria for continued stay (MCG) there were several that probably could have been approved by the first-level reviewer but were sent to physician review anyway. We did not see any instances of this for MH or SUD. Given this, we believe that the MH/SUD reviewers were applying the various criteria as intended and no more stringently than the M/S reviewers. Given that a lower percentage MH/SUD first-level reviews went to physician review—which inherently means the request is subject to greater scrutiny—and that MH/SUD requests only were sent to physician review when the criteria was pretty clearly not met, our conclusion is that first-level review for MH/SUD is definitely not more stringently applied.

Physician review – In analyzing physician review, our main objective was to determine if the MH or SUD physician reviewers were applying discretion in a way that was more stringent or arbitrary than how M/S physicians applied discretion and to determine if they were adhering to criteria in a fashion that was no more stringent than M/S physicians' adherence to criteria. What we found was that MH and SUD physician reviewers were generally more generous towards the member in applying discretion than the M/S physician reviewers. For example, of the 40 overall requests reviewed for MH and SUD there were 7 approved (3 for MH and 4 for SUD) in instances in which a denial of inpatient care and an approval at a lower level of care could have been justified. There were no instances of this occurring during any of the M/S requests. Relatedly, there appeared to be greater flexibility afforded in favor of members when applying MCG and ASAM criteria by the MH and SUD physicians than there was when applying MCG criteria by M/S physicians. We believe that this demonstrates not only no more stringent application for MH/SUD compared to M/S, but likely less stringent application.

Peer-to-peer review – In analyzing peer-to-peer review, our objectives were largely the same as when examining physician review, but also examining how ACME's physicians interacted with the attending physician (or other provider) to determine if there was anything more stringent or arbitrary in how our MH and SUD physicians behaved versus our M/S physicians. We did this by reading transcripts of the calls between the physicians. What we found was mostly similar what we found for physician review: for the most part, the MH and SUD physician peers were more likely to defer to the judgment of the attending physician when there was a difference in clinical judgment than what we saw for the M/S physician peers. In fact, there were 7 SUD peer-to-peer reviews that had resulted from an initial denial in which the physician peer ultimately approved the initial request for the continued stay. There were 4 such similar instances for MH. There were only 2 instances of this occurring for M/S.

However, we did find one area for potential improvement. We observed several instances of peer-to-peer for residential treatment for eating disorder in which the physician peer appeared to be relying solely on their discretion and not really relying on the MCG criteria that were supposedly being utilized. We observed this in 3 of the 20 MH requests. Although 2 of the 3 were ultimately approved, we did not see this happen for any SUD requests nor any M/S requests. It was the same physician in all 3 instances and we have established corrective procedures to ensure that this does not occur going forward. Nonetheless, even with this area in need of improvement, we believe that what we have described overall for peer-to-peer review demonstrates no more stringent application.

Step 5:

The specific findings and conclusions reached by the Plan or issuer with respect to the health insurance coverage, including any results of the analyses described in the previous steps that indicate that the Plan or issuer is or is not in compliance with the MHPAEA NQTL requirements.

Issuer Conclusion: As demonstrated in step 1, concurrent review applies to all MH/SUD inpatient benefits and all M/S inpatient benefits. It is only the timing of when concurrent review occurs during an inpatient stay that varies by facility type.

In step 2, ACME identified the 2 factors that determine when an initial concurrent review occurs (average length of stay exceeded; high-cost admission) and the 1 factor that determines when subsequent concurrent review occurs (previously authorized days have elapsed).

In step 3, we provided the definitions and evidentiary standards for the 3 factors. For average length of stay exceeded and high-cost admission, the parameters for the factors are comparable with merely the actual result in terms of mean averages varying based upon the data used to establish the means. For previously authorized days, the threshold is 3 days for all facilities. In other words, a member always has 3 subsequent days approved before another authorization request is required. We also established the evidence and sources we rely upon in making level of care and medical necessity determinations for both MH/SUD and M/S (MCG/ASAM and MCG).

In step 4 we provided detailed comparative analysis both as written and in operation, with a very heavy focus on in operation. As we demonstrated in step 4, the as written requirements are clearly comparable and no more stringently applied. For in operation, our analyses of the three in-operation processes (first-level review; physician review; peer-to-peer review) demonstrated that the three processes are comparable in that they are identical in structure for MH/SUD and M/S. Further, the analyses demonstrated that for first-level review and physician review it is certain that MH/SUD is no more stringently applied and likely less stringently applied than M/S. For peer-to-peer reviews, while we do note that there was an area of concern regarding eating disorder reviews, we believe that we have sufficiently corrected that and the bulk of the other information we provided for peer-to-peer indicated that it is no more stringently applied to MH/SUD than to M/S.

Given what we have shown in steps 1 through 4, the Acme Health Insurance Issuer feels confident in stating that it has met the comparative analysis requirements of 42 U.S.C. 300gg-26(a)(8)(A) and has also demonstrated compliance with the NQTL requirements for concurrent review inpatient, in-network found at 45 CFR 146.136(c)(4)(i).