NEW YORK STATE | Office of Mental Health

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New York Department of Health /Office of Mental Health/Office of Alcoholism and Substance Abuse Services Medicaid Managed Care NQTL Reporting

The basis for the content of the NY DOH/OMH/OASAS required NQTL reporting, as we discussed, is the protocol for NQTL parity analysis stipulated in the Federal Self Compliance Tool (Tool) set forth on pages 12-20. (link to the Tool). The only modification is that the NY reporting format divides Step 4 into a Step 4 and a step 5 to separate the compliance reporting into a section for the "as written" analysis (Step 4) and one for the "in-operation" analysis (Step 5) and requests a summary explanation (Step 6).

Please note that as stipulated in the Tool, MCOs should be prepared to provide any and all, if requested, documentation relied upon to demonstrate the basis for its compliance with requirements of the NQTL test. This would include details on how standards were applied, internal testing, and any other review or analysis done by the MCO to sustain its basis for compliance. This documentation is not to be provided with this reporting but should be noted where applicable.

The Tool was designed to provide a uniform reporting protocol for Mental Health and Substance Use Disorder (MH/SUD) NQTL compliance justification, based on the terms of the nondiscrimination regulatory test for NQTLs. The essential terms of the NQTL are comparability and equity as to application between those NQTLs applied to MH/SUD benefits and those applied to medical/surgical benefits. The following discussion is intended to provide clarification, based on our discussions with the Medicaid MCOs, as to the information required for each Step to ensure a complete response. Some of the comments below may not apply to your MCO. Note that a response deemed complete is not a final determination per se by NY DOH/OMH/OASAS that an NQTL is parity compliant.

The first row for each column requires that the MCO identify the MH/SUD and medical services (M/S) to which the NQTL applies in each respective column. There is a need for some clarification in the reporting for the term "prior authorization". Where prior authorization means pre-certification of medical necessity for the requested service at the point of admission, this should be noted. If the term is intended to mean notification to the MCO with a subsequent determination of medical necessity, this should be noted. The reporting should also note whether the NQTL applies to out-of-network services, especially regarding substance use services, given the NY requirements for OASAS certified facilities. Also please note that there is some reporting variation in how plans treat inpatient psychiatric admissions. Some are treated as post-stabilization admission subsequent to an emergency or urgent care situation, and others regard them as independent of urgent/emergency care situation or both. This should be clarified in the text along with at what point the medical necessity determination is made and with what criteria. In addition, please note, especially in the outpatient column, all services for which the state requires prior authorization or concurrent review. In addition, if there are outpatient services for which prior authorization of concurrent review is not required but the plan does

utilize the protocol, please delineate which services those are. There has been inconsistent reporting in this row for inpatient and outpatient services subject to prior authorization and concurrent review.

Step 1 requires a description of the NQTL procedure as generally applied. The reporting prompt asks for identification of associated triggers, timelines, forms and requirements. Hence, any differences in the procedures, protocols or processes between MH/SUD and M/S should be noted. If prior authorization means notification of the admission to the MCO, are all services reviewed back to the date of admission to determine medical necessity? Are there differences in the procedures and the amount of information required for medical necessity determinations as between the two service categories where prior authorization notification is required?

Step 2 requires an identification of the factors the plan uses to determine whether a service is deemed subject to the NQTL and whether they are comparable. The source of the factor should be noted, and factors considered but not relied upon should be noted as well. The reporting prompt provides illustrations of factors an MCO may use to which services are subject to the NQTL. The factors listed are illustrations and there may be other factors the plan has utilized, which is acceptable. There is not a list of acceptable and nonacceptable factors. The requirement here is that they be identified and discussed as to how they are comparable. As noted in our discussions, the term “comparable” has two meanings: similar or identical. If the factors are identical, there is no need for further discussion as they are identical. Where they are not identical, the plan should provide some rationale as to its determination that they are similar. For example, if a plan uses the factor of high cost to trigger prior authorization for MH/SUD but uses excessive utilization to trigger prior authorization for medical/surgical, there certainly could be a valid explanation as to why and/or how those factors are comparable and it should be explained. The differences should be accounted for. In some cases, it is reported that all MH/SUD and M/S services are subject to the NQTL and, therefore, there would be no need to report factors as there is no differentiation between the two categories as to what triggers the service for the NQTL.

Step 3 has two components and a dual meaning for the term evidentiary standard. In the first instance, it requires the evidentiary standard used to define the factors identified in Step 2; e.g., if variation in length of stay is a factor, how is it defined? If it is defined by a coefficient of variation, then indicate that and the value utilized for the coefficient; e.g., 70%. The basis for requiring this information is to enable a review as to the comparability of the factors and how they were defined and applied in application to determine which services will be subject to the NQTL. For example, if variation in length of stay is a factor and the trigger for application of the NQTL is 60% for all services, then it is identical. However, if the trigger for application is 60% for medical and 30% for MH/SUD, this difference requires some explanation. Also, please note that it is fine if you use a much less-sophisticated definition for the factor of variation in length of stay or any other factor. But you still must provide what that definition is. Another example of a factor utilized to target services is ‘high variability in defining diagnosis.’ While it may be a valid factor Step 3 requires that this be defined. Step 3 also asks for “evidentiary standards” which may be

relied upon but are not a means for defining “factors” identified in Step 2. These types of evidentiary standards include other evidence considered in designing and applying its prior authorization 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 internally developed to supplement national guidelines, and outcome metrics from consulting or other organizations. The source of the evidentiary standard, regardless of type, should always be noted. To report that “nationally recognized standards” are utilized is not an exact identification. Differences in factors, definitions of factors or evidentiary standards between MH/SUD and M/S services utilized to determine application of the NQTL should be clearly delineated.

Step 4 concerns the comparability and application of the NQTL as written. This has several components. Comparability of reviewer qualifications is one element. The written policies and procedures for operationalization of the NQTL are another; i.e., the actual processes utilized to conduct the review. Are provider to MCO teleconferences required as part of the written medical necessity review protocol? Are they identical? If there are differences what is the basis for the difference? If utilization management is conducted by different entities for MH/SUD and M/S services, how are policies and procedures; e.g., manuals, vetted and coordinated to ensure comparability? Also note that measures of in-operation impact and comparability such as inter-rater reliability studies are frequently noted in Step 4 but should be part of the response to Step 5 because they are measures of performance which demonstrate equitable application in operation. Additionally, note that we are not asking that you submit any materials such as medical necessity criteria or criteria hierarchies or the actual written protocols governing provider to MCO teleconferences or utilization manuals themselves. We are only asking for a description of how the plan has gone about determining that these written materials are comparable and applied no more stringently, along with a note indicating that any all analysis and material documentation is available upon request.

Step 5 concerns the comparability of implementation and impact- or application- of the written policies and procedures. The pertinent information which the reporting prompt is requesting concerns evaluation measures which demonstrate comparability of outcomes. A re-articulation of the response in Step 4 is not what is required here. This can include a variety of quality and control measures utilized by a plan: e.g., interrater reliability studies, review of denial rates by service type for assurance of appropriate application of criteria, reviews for correlation between basis for service denials and stated criteria, appeal overturn rates, is clinical judgment ever utilized in lieu of plan criteria and if so how is it comparable respecting both sets of services, frequency of concurrent reviews as between MH/SUD and M/S, frequency of initial reviews that are sent to peer clinical review by the first-line UM reviewer, and so on. Note that disparate results or outcomes are not dispositive of parity noncompliance. What types of corrective action plans are deployed where there are disparities in impact? If utilization review is conducted by different entities, what measures are in place to ensure comparable application of utilization management policies. Where measures of in-operation performance are reported to

substantiate comparability, detailed examples should be noted; e.g., interrater reliability studies were conducted and were found to be 90% for M/S services and 91% for MH/SUD. The availability of documentation to substantiate the measures utilized should be noted.

Step 6 requests a summary statement which explains the rationale for compliance. To the extent there are differences noted as between MH/SUD and M/S in the foregoing steps, delineate these in the summary and note that they were explained in the text. For example, if the review standards for all services are based on MCG criteria and those for MH/SUD include criteria which supplement MCG this should be noted with a notation that the corresponding reason for the difference is provided in the text. Or, for example, different factors were utilized to determine services to which the NQTL would apply.