Instructions for Outlier Review/Management

General guidance applicable to all NQTL analyses: Every comparative analysis for each classification of benefits should be self-contained. In other words, it should not be necessary for the regulator to read through attachments or other separate policy documents to determine if the comparative analysis is sufficient. For any relevant document such as utilization management manuals, clinical policy bulletins, guidelines, criteria, etc., it is the responsibility of the plan/issuer to examine those documents and determine if there is comparability and no more stringent application between MH/SUD and medical/surgical. The is the fundamental expectation of comparative analysis: the plan/issuer examines all relevant materials and data, compares, contrasts, probes, and analyzes them and then explains what was revealed and how or why everything examined did or did not reveal compliance. Attachments and other documents may be submitted so that the regulator can corroborate the plan/issuer's findings and conclusions, but the plan/issuer should avoid responding to any step with "see attachments X, Y, and Z for proof of compliance". There will be select instances when the instructions for a particular step allow for the submission of attachments in lieu of analysis text.

Step 1: The specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder (MH/SUD) and medical or surgical benefits to which each such term applies in each respective benefits classification.

Guidance: This Step requires that the plan/issuer provide the specific coverage terms and policies and procedures regarding outlier review/management and a definitive identification of all MH/SUD and medical/surgical benefits to which each such term applies in each of the respective benefit classifications or subclassifications. The plan/issuer should identify all benefits to which outlier review/management applies.

It is understood that outlier review/management is not necessarily applied based on the benefit in question but rather factors that could come into play for any benefit—e.g. certain billing codes were submitted at a much higher frequency than average, volume of services are greater than expected over a particular time period, etc.—it is still necessary to list in this step which benefits were in fact subject to outlier review/management during the reporting period.

The plan/issuer should indicate and identify any delegate/vendor involvement with MH/SUD benefits. This includes if there are separate operating departments or divisions in the plan/issuer responsible for the management of covered MH/SUD benefits and any contractual arrangements with external entities. The plan/issuer should specifically provide the outlier review/management requirements that are specific to the delegate or vendor and reference their policies and procedures.

Step 2: The factors used to determine that the NQTL will apply to MH/SUD benefits and medical or surgical benefits.

Guidance: The plan/issuer should provide an all-inclusive list of the factors it utilizes to determine if outlier review/management will apply to medical/surgical and MH/SUD services. Again, it is understood that outlier review/management is likely not applied uniformly to any particular MH/SUD or medical/surgical benefit but instead may only occur in select instances that are not dictated by the benefit in question but the circumstances in play.

The plan/issuer should avoid using phrases such as "factors include…" or "factors may include…". The standard for this step is reporting the factors used to determine that the NQTL **will** apply. Phrasing that uses "include" or "may include" introduces uncertainty as to whether the listed factors actually were used

or that there may be unlisted factors used to determine the NQTL will apply. It is recommended, but not required, that the plan/issuer have a grid or chart indicating which factor or factors led to the imposition of outlier review/management for each benefit that ultimately was subject to outlier review/management.

Step 3: 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 MH/SUD benefits and medical or surgical benefits.

Guidance: The plan/issuer must define each factor set forth in Step 2 and identify the applicable evidentiary standard and source for each factor. For example, quantitative factors such as value or excessive utilization must be defined in an appropriate manner and documentation and/or an illustration of the calculation provided as supporting information. When defining a qualitative factor, it is not sufficient to indicate a factor or component of an evidentiary standard such as "opportunity to improve quality" without explaining specifically what that means or how it is determined. In addition, the plan/issuer should identify whether or not certain factors or components of an evidentiary standard are given more weight or value than others and explain the basis to assert they are not weighted. That is, if multiple factors are utilized to determine whether and/or when the NQTL will be applied, are any of them alone sufficient to determine the NQTL applies and/or when? Or are all or a combination of the factors required?

If a factor clearly involves some sort of threshold, such as "outlier compared to similar providers' patterns" or "high-cost admission", those thresholds must be defined and demonstrated to be comparable between MH/SUD and medical/surgical. For example, at what point does a provider's use of certain billing codes reach the point of being "an outlier compared to similar providers"? At what dollar amount does a stay become "high cost"? Please note that there is no expectation that these threshold values must be or should be exactly the same for MH/SUD versus medical/surgical in order to be comparable. However, the plan/issuer must explain how and why the disparate values are in fact comparable. For example, a provider being an outlier when using evaluation and management billing codes will most likely be a lower numerical threshold than a provider being an outlier using psychotherapy billing codes.

Step 4: The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD 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 NQTL to medical or surgical benefits in the benefits classification.

Guidance: This Step requires two distinct comparative analyses: a comparative analysis, as written, and comparative analysis, in operation. The first analysis concerns the plan/issuer's demonstration that its written protocols are comparable and applied no more stringently. The second analysis concerns the plan/issuer's demonstration that the NQTL is applied no more stringently in operation. The reporting must clearly address these two components separately and should not merely provide a conclusory statement that the plan/issuer has done an assessment and determined that the NQTL complies without providing the analysis and explanation as to how and why the plan/issuer has concluded it has met the tests of comparability and no more stringent application.

As Written: The comparative analysis concerning the "as written" component should be inclusive of all the plan/issuer's written policies, procedures, and protocols regarding outlier review/management for MH/SUD and M/S services. These standards determine the basis for whether application of the NQTL is comparable and applied no more stringently with respect to MH/SUD and medical/surgical services. It is not necessary for the plan/issuer to produce an exhaustive dissection of all policies, procedures, protocols, etc. relied upon. However, the plan/issuer should provide persuasive analysis and reasoning that reveals

how it concluded that these materials are comparable and applied no more stringently. If all written materials used in establishing and conducting outlier review/management for MH/SUD and medical/surgical are the same, merely stating as such without further commentary is sufficient.

The as written analysis should specifically account for any differences where the plan/issuer has delegated review functions for MH/SUD services to a third-party vendor or when a separate unit within the plan/issuer is responsible for the MH/SUD NQTL. The plan/issuer documentation here should provide a clear, logical, and comprehensive analysis which illustrates comparability as to the written policies and procedures where the review function is conducted by separate parties.

In Operation: The plan/issuer must also demonstrate that the NQTL is being applied in a comparable and no more stringent manner. The required comparative analysis must account for what happens when outlier review/management is operationalized.

Merely explaining that certain processes exist and that those processes are "the same" for MH/SUD and medical/surgical may demonstrate that there is comparability, but it does not demonstrate no more stringent application. For example, it may be the case that the special investigations unit mines data and observes claims trends to identify outlier patterns. This process may be exactly the same for MH/SUD and medical/surgical. However, further analysis is required to demonstrate that these identical, in-operation processes are applied no more stringently to MH/SUD than to medical/surgical.

The analysis should include reporting on what the plan/issuer has done when outliers are identified. For example, are notifications sent to outliers informing them that they are outliers compared to peers and future billing patterns will be subject to pre-payment audit? Or, may there be an attempt to recoup payment in some instances/ Or both? Or it is possible a completely different approach is taken. But whatever actions the plan/issuer takes after identifying outliers needs to be analyzed comparatively between MH/SUD and medical/surgical.

The plan/issuer should incorporate as part of its analysis, quality assurance oversight reports which include review of the outlier review/management processes, including generalized audits.

Step 5: The specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the analyses described in this step that indicate that the plan or issuer is or is not in compliance with this section.

Guidance: The plan/issuer should provide a reasoned discussion of its findings and conclusions identified in Steps 1 through 4 within the affected classification, including any citations to specific evidence considered and results of analyses which demonstrate that the issuer is or is not in compliance with MHPAEA.

The required information in Step 5 is inclusive of a summary and conclusion. The summary should be a concise statement or account of the principal information and results of the analyses offered to demonstrate compliance. It should not introduce new information or analyses not presented in the foregoing Steps. The conclusion provided should not merely be a summary of the principal supporting information or a re-statement of the plan/issuer's analysis; it should be a synthesis of the basis from the above required information and analyses which definitively demonstrates compliance as written and in operation.

If the plan/issuer has decided that it is not in compliance, it should describe any plan it has for corrective action.