Instructions for Failure to Complete

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 a definition of what it considers a failure to complete a particular service or medication regimen in each classification of benefits. If the definition is the same regardless of the classification of benefits, it is permissible to either copy and paste that into each classification of benefits. **If the plan/issuer does not have any failure to complete limitations in place for MH/SUD, it does not need to perform any further analysis.**

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

Guidance: It is understood that the only factor in play for this NQTL should likely be that the course of treatment was not completed. However, if for some reason other factors are in play, please indicate what they are in this step.

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: Given that there likely are no factors in play other than the fact that the enrollee did not complete the course of treatment, it is not necessary to produce anything further for this step. However, if other factors are in play for some reason, they should be clearly defined in this step.

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:

As written: For this NQTL, the as-written component should consist of demonstrating that the written protocols governing what happens when it determined that an MH/SUD failure to complete has occurred

are comparable to and applied no more stringently than the written protocols governing what happens when a medical/surgical failure to complete has occurred.

In operation: To meet the in operation requirements, the plan/issuer should examine the operationalization of implementing the failure to complete limitation. This should include comparative analysis about notification processes, options presented to complete the treatment regimen, and any payment recoupment efforts, if applicable.

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, 3, and 4 within the affected classification, including any citations to specific evidence considered and results of analyses which demonstrate that the plan/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.