NQTL: Concurrent Review

Classification(s): separate analyses should be submitted for each classification of benefits for which Concurrent Review is applied

Step 1 - Identify the specific plan or coverage terms or other relevant terms regarding Concurrent Review and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification

Step 1(a): Define Concurrent Review

Concurrent Review (CR) is defined as a technique for managing the appropriate utilization of healthcare benefits under which service claims are only eligible for coverage if provider obtains approval or re-approval from the Plan for Medical Necessity of the ongoing delivery of the benefit at the current level of care during a facility stay or course of treatment. Services subject to CR may or may not also be subject to Prior Authorization or Retrospective Review, but the definition of CR does not include Prior Authorization or Retrospective Review strategies.

In this definition and the following analysis, "service" means any healthcare treatment, service, prescription drug, product, or other benefit that is covered under the terms of the Plan.

The present analysis should focus specifically on Concurrent Review, as defined above, and does not require analyses of other related concepts, including Prior Authorization, that do not meet the Plan's definition.

NOTE: If the Plan does not implement Concurrent Review as a separate NQTL from Prior Authorization—i.e. if the factors, processes, and evidentiary standards for designing and implementing benefit authorizations are the same except for the timing of the review, then this analysis may be indicated as "N/A—see Prior Authorization analysis" as long as all relevant information is included in the Prior Authorization analysis, including information regarding the process and frequency of re-authorizations, as described in Step 5.

Note that this NQTL analysis does NOT ask you to define "Medical Necessity," which is analyzed as a separate NQTL.

Step 1(b): Identify the benefits/services for which Concurrent Review is required

List all benefits in this classification that are subject to Concurrent Review. This list may be provided as a link or attachment if desired.

In general, no analysis of comparability and stringency is required for this Step. However:

- If the Plan applies Concurrent Review to all MH/SUD benefits but not all M/S benefits in the classification, then discussion should be provided about how the Plan has determined that this benefit structure complies with Parity.
- If the Plan applies Concurrent Review to some MH/SUD benefits but not to any M/S benefits in the classification, then federal guidance indicates that this benefit structure does not comply with Parity.

Step 2 – Identify the factors used to determine that Concurrent Review will apply to mental health or substance use disorder benefits and medical or surgical benefits

Identify the factors used to determine which benefits are subject to Concurrent Review.

Plans have broad discretion to select factors for determining whether to apply Concurrent Review to a given benefit. Examples of selection factors include:

- Benefits for stays in treatment settings that are commonly determined not to be the least restrictive setting that is appropriate for the patient's care
- Excessive utilization
- Recent medical cost escalation
- Lack of adherence to quality standards
- High levels of variation in length of stay
- High variability in cost per episode of care
- Clinical efficacy of the proposed treatment or service
- Provider discretion in determining diagnoses
- Claims associated with a high percentage of fraud
- Severity or chronicity of the MH/SUD condition

Step 3 – Identify 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 Concurrent Review to mental health or substance use disorder benefits and medical or surgical benefits.

Each factor must be defined with an evidentiary standard that may or may not include a quantitative threshold, but that is set forth with sufficient precision to determine whether a given benefit or service does or does not meet the standard. The data source(s) that are used to evaluate or measure the factor and determine whether or not the factor is met must also be identified for each factor. Plans have broad discretion to select these data sources and evidentiary standards. Examples of data sources include:

- Internal claims or data analyses
- Internal quality standard studies
- Preponderance of the medical literature
- Adherence to identified national standards

For example, a Plan could decide to apply Concurrent Review to all benefits for stays in treatment settings that are commonly determined not to be the least restrictive setting that is

appropriate for the patient's care. The Plan could define "commonly determined not to be the last restrictive setting" to mean treatment settings for which defined minimum number or proportion of service authorization requests lead to a determination that the patient could be treated in a less restrictive setting, based on data from its medical management system.

Note that this step does NOT require Plans to analyze the development process or evidence base for the Medical Necessity guidelines for the Concurrently Authorized benefits. Instead, this step focuses on the factors, data sources, and evidentiary standards that were used to decide to require Concurrent Review for the service.

Step 4 – Provide comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply Concurrent Review 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 Concurrent Review to medical or surgical benefits in the benefits classification

Step 4(a): For each benefit subject to Concurrent Review, identify which of the factor(s) in Step 3 were met

Include a brief summary description of the data or evidence relied upon to determine that the benefit met each factor that it was determined to meet, in addition to a breakdown of which factors apply to each benefit that is subject to Concurrent Review on a benefit-by-benefit basis. **A sample grid is provided below, but any format can be used.** This grid or list may be provided as an attachment if necessary. One or more factors may be indicated for a given benefit. No factors should be applied that are only met by MH/SUD benefits. For the prescription drugs classification, the Plan may indicate that this factor-level analysis for a given drug, formulation, or dosage level is available to regulators upon request in the event of a complaint or suspicion of noncompliance. Where the Plan applies Concurrent Review to a large number of benefits within a classification, it is permissible to list only the top ten benefits by spending. (Nonetheless, this flexibility with regard to the reporting obligation does not affect the Plan's obligation to ensure that all factors, sources, and evidentiary standards are in fact designed and applied consistently and in compliance with parity.) Where the Plan applies Where the Plan has decided to apply Concurrent Review to ALL benefits in a classification (e.g. inpatient), this decision itself may be a factor.

It is not necessary to provide the actual data or evidence relied upon to determine that the benefit met the indicated factors. It is sufficient to provide a brief summary of the data types and/or sources of evidence that are used to apply or implement the factors listed in Step 3. The underlying data or evidence should be collected and documented internally and may be required by the state, including in the case of an audit or investigation.

	Excessive utilization	Recent medical cost escalation	Lack of adherence to quality standards	High variability in length of stay/treatment	High variability in cost per episode
MH/SUD benefits					
ECT					X
TMS	X			X	
Psych testing	X		X		X
IOP		X	X		
Etc.					
M/S benefits					
Home health	X		X	X	
Pain mgt		X	X	X	
Genetic testing	X	X			
Non-emerg CT					X
Etc.					

Step 4(b): Briefly describe the processes by which Concurrent Review is applied.

Provide a brief description of each step of the processes by which the Concurrent Review request is submitted, Medical Necessity and any other factors for authorization are evaluated, and authorizations are approved or denied. The analysis should focus on processes that lead to the approval or denial of the authorization. This should include descriptions of any documented policies and procedures for the processes used to make a determination ("as written"), as well as any additional details, including common exceptions or deviations from the documented policies and procedures, regarding the processes that are used in practice to make a determination ("in operation"). As noted in the general instructions, the underlying policies and procedures and related Plan documents should be identified but do not have to be attached to this report. Instead, key details from these documents should be summarized and analyzed here.

Clearly identify and provide comparative analyses of relevant:

- Timelines and deadlines, including the frequency with which re-authorizations are required
- Forms and/or other information required to be submitted by the provider
- Utilization management manuals and any other documentation of UM processes that are relied upon to make a determination
- In-operation processes in place to make a determination such as distinctions between first and second-level reviews or between administrative and clinical reviews, peer-to-peer reviews, and the use of medical discretion applied in lieu of or in the absence of written criteria and guidelines
- Minimum qualifications for reviewers
- Minimum standards to issue a denial (e.g. sign-off from a physician with relevant board certification)

Information provided for these items should be ordered and formatted to facilitate direct comparisons between M/S and MH/SUD benefits. Discussion of these items should be brief, not comprehensive, but sufficient to enable a high-level comparison between key aspects of CR processes for MH/SUD relative to M/S benefits.

Note that this step focuses on the process by which Medical Necessity and/or other factors are evaluated and treatment is authorized. The design and adoption of the Medical Necessity guidelines themselves is analyzed as a separate NQTL.

Step 4(c) : Identify and define the factors and processes that are used to monitor and evaluate the application of Concurrent Review

This analysis should include a discussion of the quality assurance and oversight processes and metrics that the plan applies to its Concurrent Review program.

The analysis may include data for operations measures and/or other quality assurance or oversight processes such as the following examples:

- Service denial rates
- Internal and/or external appeal rates
- Appeal overturn rates
- Inter-rater reliability scores
- Pass/fail results of an internal audit of the adherence of peer-to-peer reviews to the plan's inpatient admissions policies and Medical Necessity criteria, and key steps of any internal corrective action plan.
- The rough percentages or proportions of covered MH/SUD and M/S benefits and/or claims that are subject to Concurrent Review
- Quantitative data or narrative descriptions of random audit processes for decisions to apply Concurrent Review to a given benefit ("in writing")
- Quantitative data or narrative descriptions of random audit processes for Concurrent Review denials and/or appeals ("in operation")

A brief comparability and stringency analysis should be provided for each factor, process, and/or operations measure that is identified.

Step 5 – Provide 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 that indicate that the plan or coverage is or is not in compliance with this section.

Provide a brief comparability and stringency analysis for any substantive differences in the information provided in each of the preceding steps.

NQTL: Retrospective Review

Classification(s): separate analyses should be submitted for each classification of benefits for which Retrospective Review is applied

Step 1 - Identify the specific plan or coverage terms or other relevant terms regarding Retrospective Review and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification

Define Retrospective Review

Retrospective Review (RR) is a technique for managing the appropriate utilization of healthcare services under which the Medical Necessity of a service is reviewed after the delivery of the service and the service is only eligible for coverage if the Plan determines that the service was Medically Necessary. Services subject to RR may or may not also be subject to Prior Authorization, Concurrent Review, or Outlier Management, but the definition of RR does not include Prior Authorization, Concurrent Review, or Outlier Management strategies.

In this definition and the following analysis, "service" means any healthcare treatment, service, prescription drug, product, or other benefit that is covered under the terms of the Plan.

The present analysis should focus specifically on Retrospective Review, as defined above, and does not require analyses of other related concepts that do not meet the Plan's definition.

NOTE: Plans have broad flexibility to define and distinguish Retrospective Review and Outlier Management, and may apply any reasonable definitions for these terms. Plans also have the option to combine both concepts into a single NQTL analysis that addresses both clinical and administrative claims adjudication processes.

Step 2 – Identify the factors used to determine that Retrospective Review will apply to mental health or substance use disorder benefits and medical or surgical benefits.

Identify the factors used to determine which claims are subject to Retrospective Review

If the Plan applies Retrospective Review to all claims that meet one or more of a set of factors that are used to flag certain claims for review, then those factors should be listed here.

Representative examples of selection factors and definitions that may be used to flag a claim for Retrospective Review include but are not limited to:

- Prior Authorization, Concurrent Review, or other authorization was necessary but was not obtained or documented due to emergency or other extenuating circumstances

- The intensity or duration of the service (e.g. length of stay or level of care) that was delivered exceeds the intensity or duration of the service that was approved
- The service was not subject to Prior Authorization or Concurrent Review and the intensity or duration of the service exceeds the Plan's medical or coverage policy
- Other specified data fields on a claim submitted do not match the authorization
- The claim was flagged for Retrospective Review through an Outlier Management process

Note: If the Plan applies Retrospective Review to all claims for specific benefits, then the Plan should analyze the factors, sources, and evidentiary standards used to determine which benefits to subject to Retrospective Review.

Step 3 – Identify 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 Retrospective Review to mental health or substance use disorder benefits and medical or surgical benefits.

Identify the evidentiary standards and sources applied to the factors listed in Step 2

Each factor must be defined with an evidentiary standard that may or may not include a quantitative threshold, but that is set forth with sufficient precision to determine whether a given benefit or service does or does not meet the standard. The data source(s) that are used to evaluate or measure the factor and determine whether or not the factor is met must also be identified for each factor. Plans have broad discretion to select these data sources and evidentiary standards. Examples of data sources include:

- Claims and authorization data
- Plan documents, including medical or coverage policies

Step 4 – Provide comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply Retrospective Review 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 Retrospective Review to medical or surgical benefits in the benefits classification

Step 4(a): Briefly describe the processes by which Retrospective Review is applied.

Provide a brief description of each step of the processes by which the Retrospective Review request is submitted, Medical Necessity and any other factors for authorization are evaluated, and authorizations are approved or denied. The analysis should focus on processes that lead to the approval or denial of the claim based on the Medical Necessity of the service. This should include descriptions and analyses of any documented policies and procedures for the processes used to make a Medical Necessity determination ("as written"), as well as any additional details, including common exceptions or deviations from the documented policies and procedures,

regarding the processes that are used in practice to make a determination ("in operation"). As noted in the general instructions, the underlying policies and procedures and related Plan documents should be identified but do not have to be attached to this report. Instead, key details from these documents should be summarized and analyzed here.

Clearly identify and provide comparative analyses of relevant:

- Timelines and deadlines for completing the Medical Necessity review and adjudication of the claim
- Forms and/or other information required to be submitted by the provider
- Utilization management manuals and any other documentation of UM processes that are relied upon to make a determination
- In-operation processes in place to make a determination such as distinctions between first and second-level reviews or between administrative and clinical reviews, peer-to-peer reviews, and the use of medical discretion applied in lieu of or in the absence of written criteria and guidelines
- Minimum qualifications for reviewers
- Minimum standards to issue a denial (e.g. sign-off from a physician with relevant board certification)

Information provided for these items should be ordered and formatted to facilitate direct comparisons between the application of Retrospective Review to M/S vs. MH/SUD benefits. Discussion of these items should be brief, not comprehensive, but sufficient to enable a high-level comparison between key aspects of Retrospective Review processes for MH/SUD relative to M/S benefits.

Note that this step focuses on the process by which Medical Necessity and/or other factors are evaluated and treatment is authorized. The design and adoption of the Medical Necessity guidelines themselves is analyzed as a separate NQTL.

Step 4(b): Identify and define the factors and processes that are used to monitor and evaluate the application of Retrospective Review

This analysis should include a discussion of the quality assurance and oversight processes and metrics that the plan applies to its Retrospective Review program.

The analysis may include data for operations measures and/or other quality assurance or oversight processes such as the following examples:

- Post-service denial rates
- Internal and/or external appeal rates
- Appeal overturn rates
- Inter-rater reliability scores
- The rough percentages or proportions of covered MH/SUD and M/S benefits and/or claims that are subject to Retrospective Review (if applicable)

A brief comparability and stringency analysis should be provided for each factor, process, and/or operations measure that is identified.

Step 5 – Provide 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 that indicate that the plan or coverage is or is not in compliance with this section.

Provide a brief comparability and stringency analysis for any substantive differences in the information provided in each of the preceding steps.

NQTL: Outlier Management

Classification(s): separate analyses should be submitted for each classification of benefits for which Outlier Management is applied

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding Outlier Management and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification

Define Outlier Management

Outlier Management (OM) is defined as a process by which unusual patterns of service coding, charges, and/or other claims information are identified and analyzed to detect potential fraud, waste, or abuse. OM does not include Retrospective Review.

In this definition and the following analysis, "service" means any healthcare treatment, service, prescription drug, product, or other benefit that is covered under the terms of the Plan.

The present analysis should focus specifically on Outlier Management, as defined above, and does not require analyses of other related concepts that do not meet the Plan's definition.

Note: Plans have broad flexibility to define and distinguish Retrospective Review and Outlier Management, and may apply any reasonable definitions for these terms. Plans also have the option to combine both concepts into a single NQTL analysis that addresses both clinical and administrative claims adjudication processes.

In general, no analysis of comparability and stringency is required for this Step. However:

- If the Plan applies Outlier Management to all MH/SUD benefits, services, and/or types of claims but not all M/S benefits, services, and/or types of claims in the classification, then discussion should be provided about how the Plan has determined that this benefit structure complies with Parity.
- If the Plan applies Outlier Management to some MH/SUD benefits, services, and/or types of claims but not to any M/S benefits, services, and/or types of claims in the classification, then federal guidance indicates that this benefit structure does not comply with Parity.

Step 2 – Identify the factors used to determine that Outlier Management will apply to mental health or substance use disorder benefits and medical or surgical benefits.

Identify the factors used to determine which claims are subject to Outlier Management.

Plans have broad discretion to select and define factors for determining whether to apply Outlier Management to a given claim. However, each factor must be defined with sufficient precision to determine whether a given claim does or does not meet the definition.

Representative examples of selection factors and definitions that may be used to flag a claim for Outlier Management include but are not limited to:

- Automated claims analyses of coding accuracy
- Consumer/provider hotlines, news media, industry conferences and workgroups, and/or other tips and referrals processes
- High-cost claims (e.g. exceeding a specific dollar amount or other threshold)
- Data mining of intensity, frequency, or cost of the claim or service related to historic trends, market benchmarks, or other standards
- All claims by providers whose claims exceed an identified threshold for one or more of the above factors

Note: If the Plan applies Outlier Management to all claims for specific benefits, then the Plan should analyze the factors, sources, and evidentiary standards used to determine which benefits to subject to Outlier Management.

Step 3 – Identify 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 Outlier Management to mental health or substance use disorder benefits and medical or surgical benefits.

Each factor must be defined with an evidentiary standard that may or may not include a quantitative threshold, but that is set forth with sufficient precision to determine whether a given benefit or service does or does not meet the standard. The data source(s) that are used to evaluate or measure the factor and determine whether or not the factor is met must also be identified for

each factor. Plans have broad discretion to select these data sources and evidentiary standards. Examples of data sources include:

- Claims and billing data
- Claims and coding algorithms or software
- Federal and state law, policies, and guidance
- Medical management system data
- National or state information-sharing organizations such as the National Healthcare Anti-Fraud Association and the Healthcare Fraud Prevention Partnership

Step 4 – Provide comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply Outlier Management 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 Outlier Management to medical or surgical benefits in the benefits classification

Step 4(a): Briefly describe the processes by which Outlier Management is applied.

Provide a brief description of the process by which Outlier Management is carried out. The analysis should focus on key steps of the process that identify claims or providers for review and lead to the approval or denial of the claims.

This should include descriptions and analyses of any documented policies and procedures for Outlier Management in general or for specific factors or components of Outlier Management ("as written"), as well as any additional details, including common exceptions or deviations from the documented policies and procedures, regarding the way Outlier Management is used in practice to make a determination ("in operation"). As noted in the general instructions, the underlying policies and procedures and related Plan documents should be identified but do not have to be attached to this report. Instead, key details from these documents should be summarized and analyzed here.

Information provided for these items should be ordered and formatted to facilitate direct comparisons between the application of Outlier Management to M/S vs. MH/SUD benefits. Discussion of these items should be brief, not comprehensive, but sufficient to enable a high-level comparison between key aspects of Outlier Management processes for MH/SUD relative to M/S benefits.

Step 4(b): Identify and define the factors and processes that are used to monitor and evaluate the application of Outlier Management

This analysis should include a discussion of the quality assurance and oversight processes and metrics that the plan applies to its Outlier Management program.

The analysis may include data for operations measures and/or other quality assurance or oversight processes such as the following examples:

- Administrative denial rates
- Internal and/or external appeal rates
- Appeal overturn rates
- Inter-rater reliability scores
- The rough percentages or proportions of MH/SUD and M/S claims that are subject to Outlier Management
- The number of MH/SUD and M/S providers that are subject to prepayment review or network termination

A brief comparability and stringency analysis should be provided for each factor, process, and/or operations measure that is identified.

Step 5 – Provide 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 that indicate that the plan or coverage is or is not in compliance with this section.

Provide a brief comparability and stringency analysis for any substantive differences in the information provided in each of the preceding steps.

NQTL: Failure to Complete

Classification(s): separate analyses should be submitted for each classification of benefits for which further coverage for a benefit or service is excluded based on a patient's Failure to Complete a course of treatment.

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding Failure to Complete and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification

***Step 1(a): Define the Failure to Complete NQTL*:**

Failure to Complete (FTC) is an exclusion of coverage for further benefits for an identified service for a specified period of time when the patient fails to complete a course of treatment using that service. FTC does not include the use of Medical Necessity criteria that require consideration or trial of alternative treatments before authorizing a service, or that require consideration of the patient's engagement in treatment, receipt of other

Firm:54649456v1

related services, readiness to change, and/or related psychosocial or behavioral factors in determining the Medical Necessity of the service, whether pursuant to Step Therapy, Prior Authorization, Concurrent Review, or otherwise.

In this definition and the following analysis, "service" means any healthcare treatment, service, prescription drug, product, or other benefit that is covered under the terms of the Plan.

Requirements for clinical assessments where the patient's engagement in treatment, readiness to change, and/or related psychosocial or behavioral factors are considered as part of a level or intensity of care evaluation or other determination of Medical Necessity should be analyzed as part of a Step Therapy, Prior Authorization, Concurrent Review, or other relevant NQTL type as necessary.

Step 1(b): Identify the benefits/services for which exclusions based on the Failure to Complete NQTL are applied

List all benefits in this classification that are subject to the Failure to Complete NQTL. This list may be provided as a link or attachment if desired.

In general, no analysis of comparability and stringency is required for this Step. However:

- If the Plan applies Failure to Complete to <u>all</u> MH/SUD benefits but <u>not all</u> M/S benefits in the classification, then discussion should be provided about how the Plan has determined that this benefit structure complies with Parity.
- If the Plan applies Failure to Complete to <u>some</u> MH/SUD benefits but <u>not to any</u> M/S benefits in the classification, then federal guidance indicates that this benefit structure does not comply with Parity.

Step 2 – Identify the factors used to determine that the Failure to Complete NQTL will apply to mental health or substance use disorder benefits and medical or surgical benefits

Each factor must be defined with sufficient precision to determine whether a given benefit or service does or does not meet the definition.

Plans have broad discretion to select and define factors for determining whether to apply the Failure to Complete NQTL to a given benefit. Examples of selection factors and definitions include:

- Lack of clinical efficacy of the proposed treatment or service in the absence of a patient's willingness to change
- Availability of alternative treatments or services for the condition

Step 3 – Identify 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 Failure to Complete NQTL to mental health or substance use disorder benefits and medical or surgical benefits

Each factor must be defined with an evidentiary standard that may or may not include a quantitative threshold, but that is set forth with sufficient precision to determine whether a given benefit or service does or does not meet the standard. The data source(s) that are used to evaluate or measure the factor and determine whether or not the factor is met must also be identified for each factor. Plans have broad discretion to select these data sources and evidentiary standards. Examples of data sources include:

- Preponderance of the medical literature
- Plan data regarding in-network provider capacity for alternative treatments or services

Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the Failure to Complete 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 Failure to Complete NQTL to medical or surgical benefits in the benefits classification

Step 4(a): For each benefit subject to the Failure to Complete NQTL, identify which of the factor(s) in Step 3 were met

Include a brief summary description of the data or evidence relied upon to determine that the benefit met each factor that it was determined to meet, in addition to a breakdown of which factors apply to each benefit that is subject to the Failure to Complete NQTL on a benefit-by-benefit basis. **A sample grid is provided below, but any format can be used.** This grid or list may be provided as an attachment if necessary. One or more factors may be indicated for a given benefit. No factors should be applied that are only met by MH/SUD benefits. For the prescription drugs classification, the Plan may indicate that this factor-level analysis for a given drug, formulation, or dosage level is available to regulators upon request in the event of a complaint or suspicion of noncompliance.

It is not necessary to provide the actual data or evidence relied upon to determine that the benefit met the indicated factors. It is sufficient to provide a brief summary of the data types and/or sources of evidence that are used to apply or implement the factors listed in Step 3. The underlying data or evidence should be collected and documented internally and may be required by the state, including in the case of an audit or investigation.

	Excessive utilization	Recent medical cost escalation	Lack of adherence to quality standards	High variability in length of stay/treatment	High variability in cost per episode

MH/SUD benefits					
ECT					X
TMS	X			X	
Psych testing	X		X		X
IOP		X	X		
Etc.					
M/S benefits					
Home health	X		X	X	
Pain mgt		X	X	X	
Genetic testing	X	X			
Non-emerg CT					X
Etc.					

Step 4(b): Briefly describe the processes by which the Failure to Complete NQTL is applied.

Provide a brief description of each step of the processes by which the Failure to Complete NQTL is applied. This should include descriptions of any documented policies and procedures for the processes used to make a determination that the patient has failed to complete the course of treatment ("as written"), as well as any additional details, including common exceptions or deviations from the documented policies and procedures, regarding the processes that are used in practice to exclude further coverage for the benefit or service type ("in operation"). As noted in the general instructions, the underlying policies and procedures and related Plan documents should be identified but do not have to be attached to this report. Instead, key details from these documents should be summarized and analyzed here.

Clearly identify and provide comparative analyses of relevant:

- Timelines and deadlines
- Medical records and/or other information upon which the determination is based that the patient failed to complete the course of treatment
- Policies and procedures that are relied upon to make a determination to exclude further coverage
- Minimum qualifications for reviewers

Information provided for these items should be ordered and formatted to facilitate direct comparisons between M/S and MH/SUD benefits. Discussion of these items should be brief, not comprehensive, but sufficient to enable a high-level comparison between key aspects of the Failure to Complete NQTL processes for MH/SUD relative to M/S benefits.

Step 4(c): Identify and define the factors and processes that are used to monitor and evaluate the application of the Failure to Complete NQTL

This analysis should include a discussion of the quality assurance and oversight processes and metrics that the plan applies to its Failure to Complete NQTL.

The analysis may include data for operations measures and/or other quality assurance or oversight processes such as the following examples:

- Number of patients determined to Fail to Complete a course of treatment
- Denial rates based on a Failure to Complete policy

A brief comparability and stringency analysis should be provided for each factor, process, and/or operations measure that is identified.

Step 5 – Provide 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 that indicate that the plan or coverage is or is not in compliance with this section.

Provide a brief comparability and stringency analysis for any substantive differences in the information provided in each of the preceding steps.