Compliance Actions Under State and Federal Mental Health and Substance Use Disorder Coverage and Parity Laws

Joint Annual Report to the General Assembly

Produced by:

Illinois Department of Insurance

Illinois Department of Healthcare and Family Services

2022

To the Honorable Members of the General Assembly:

Section 370c.1(h)(3) of the Illinois Insurance Code requires the Department of Insurance, in conjunction with the Department of Healthcare and Family Services, to submit an annual report to the General Assembly regarding the agencies' respective activities in enforcement of Sections 356z.23, 370c, and 370c.1 of the Illinois Insurance Code, as well as the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), and any federal regulations or guidance relating to the compliance and oversight of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and 42 U.S.C. 18031(j). *See* 215 ILCS 5/370c.1(h)(3).

In accordance with Section 370c.1(h)(3) of the Illinois Insurance Code, we are pleased to submit the January 2022 edition of the Joint Annual Report to the General Assembly on Compliance Actions Under State and Federal Mental Health and Substance Use Disorder Coverage and Parity Laws. The report contains significant information from a national and Illinois perspective regarding the current condition of regulated entities' compliance with these important laws.

Respectfully,

Dana Popish Severinghaus
Director of Insurance

Theresa Eagleson
Director of Healthcare and Family Services

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Methodology to Ensure Compliance

Illinois Department of Insurance

The Department of Insurance (DOI) utilizes market conduct examinations in order to verify a health insurance issuer's compliance with mental health and substance use disorder (MH/SUD) coverage and parity laws contained in Sections 356z.14, 356z.23, 370c, and 370c.1 of the Illinois Insurance Code and DOI regulations, which are interpreted consistently with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. The scope of the examination includes, but is not limited to, activities as they pertain to parity in MH/SUD benefits within the company's health insurance business.

The objective of the examinations is to evaluate if the company designed, implemented, and managed MH/SUD benefits no less favorably than medical/surgical benefits. The specific review processes for the examination include, but are not limited to, the following:

1. Review the procedures and guidelines related to utilization review and drug utilization review to ensure that such guidelines and utilization review processes on MH/SUD services are no more stringently applied than those applied to medical/surgical services.

2. Evaluate a sample of MH/SUD claims during the examination to compare services to medical/surgical and to ensure claim payments and denials were appropriate based on medical necessity criteria and specifically American Society of Addiction Medicine (ASAM) criteria for substance use disorder benefits.

3. Evaluate the universe of appeals during the examination to determine if the appeal decisions were based on appropriate clinical criteria and policies.

4. Evaluate the medical necessity criteria, policies, and procedures to ensure the company was not imposing more restrictive requirements and determinations for MH/SUD treatments and services than on medical/surgical treatment and services.

5. Determine if the MH/SUD benefits provided in the classification identified by 45 CFR § 146.136(c)(2)(ii)(A) are paid in parity with benefits in the same medical/surgical classifications.

6. Evaluate financial requirements and quantitative treatment limitations (QTL) to ensure that any such requirements and limitations were consistently applied through MH/SUD and medical/surgical benefits, and that any financial requirements and QTLs imposed meet the two-thirds threshold of "substantially all" requirements outlined in 45 CFR § 146.136(c)(3)(i).

7. Evaluate non-quantitative treatment limitations (NQTL) to ensure that such limitations were consistently applied through MH/SUD and medical/surgical benefits and that the company was not being more restrictive as outlined in 45 CFR § 146.136(c)(4)(i)-(ii).

8. Evaluate pre-certification/prior-authorization, step therapy policies, and procedural requirements for MH/SUD treatments to ensure that any such requirements were no more restrictive than the comparable medical/surgical policies and procedural requirements.

9. Determine if the policies and procedures for the selection, tier placement, and quantity limitations of MH/SUD treatment drugs on the formulary were no less favorable to the insured than policies and procedures used for the selection, placement, and limitations of medical/surgical drugs.

10. Evaluate network adequacy compliance and processes for adding providers to the network to ensure the MH/SUD network is maintained in a comparable manner and requirements are no more restrictive than the medical/surgical processes.

11. Determine if provider reimbursement calculations are made in a comparable manner and that reimbursement methods for MH/SUD are no more restrictive than the methods utilized for medical/surgical.

Outside of market conduct examinations, since 2018, the DOI has required every company to submit information in an MHSUD Supporting Documents Template for every major medical, HMO, or HMO Point-of-Service policy that the company files for approval, both on and off the ACA Health Insurance Marketplace. This template is designed to assist the DOI~~,~~ when deciding whether to approve a policy to be sold in Illinois~~,~~ and in performing an initial, high-level review of the policy for compliance with regulations under the federal Mental Health Parity and Addiction Equity Act. In particular, it instructs companies to explain how their policy complies with parity requirements relating to aggregate lifetime and annual dollar limits, financial

requirements, QTLs, NQTLs, and the ability of healthcare providers and insured individuals to access a company's medical necessity criteria. Although this template was first put into use after the time periods reviewed in the market conduct exams discussed below, the DOI's future exams will be able to compare a company's responses on this template to its actual conduct during the applicable policy periods.

Illinois Department of Healthcare and Family Services

HFS Methodology to Ensure Compliance

The Illinois Medicaid Managed Care Program (HealthChoice Illinois) delivers fully integrated healthcare, inclusive of behavioral health services, to Illinois Medical Assistance Program customers. To provide a base for ensuring compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA), HFS includes specific language regarding MHPAEA compliance in all HealthChoice Illinois contracts. HFS utilizes two primary mechanisms to monitor each health plan's compliance with its contract: 1) internal quality and contract management activities and 2) compliance reviews conducted by HFS' external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

Mental Health Parity Workgroup

The Mental Health Parity Workgroup (Workgroup), established pursuant to 215 ILCS 5/370c.1(j), is comprised of eleven (11) members representing behavioral health parity experts, advocates, insurers, and providers. The Workgroup receives technical support from the Departments of Insurance (DOI) and Healthcare and Family Services (HFS) and meets minimally on a semi-annual basis, with supplemental meetings scheduled as determined necessary by the members.

The purpose of this working group is to provide recommendations to the General Assembly on health plan data reporting requirements that separately break out data on mental, emotional, nervous, or substance use disorder or condition benefits and data on other medical benefits, including physical health and related health services. The working group also is tasked to create reporting instructions and formatting for insurance issuers to report detailed information on their claims practices as it relates to non-quantitative treatment limitations when comparing medical/surgical vs. MH/SUD benefits. The working group broke down the complex information into three phases for data collection:

Phase	NQTLs Analyzed	Submission Date
Phase I	• Medical necessity • Prior authorization	July 1, 2021
Phase II	• Coverage limits • Utilization management	July 1, 2022
Phase III	• Provider network reimbursement	July 1, 2023 (tentative)

Compliance Activities in 2020/2021

Market Conduct Examinations: Illinois Department of Insurance

Since the previous edition of this joint report, market conduct examinations continued to review for compliance with MH/SUD coverage and parity laws, expanding the reviews from targeted to comprehensive for a more robust review for compliance.

Internal quality and contract management activities: Healthcare and Family Services

HFS staff meet with the health plans independently for monthly operations meetings and quarterly business reviews (QBRs) focused on monitoring health plan performance. QBRs include monitoring of areas related to MHPAEA compliance, including: the percent of prior authorization requests denied and top denial reasons, broken down by behavioral health and non-behavioral health benefits; actions the health plan intends to take to reduce prior authorization denials; the percent of claims rejected and denied and top rejection and denial reasons, broken down by behavioral health and non-behavioral health benefits; the timeframes for claims processing, broken down by behavioral health and non-behavioral health benefits; and open systems projects the health plan has impacting claims adjudication. Additionally, HFS maintains dedicated resources for providers and customers to submit complaints regarding health plans directly to HFS. As of January 1, 2022, HFS has established new reporting categories within its Managed Care Provider Resolution Portal to better track and report complaints that may be related to a parity violation. Complaints flagged as a potential parity violation will be routed to staff within the HFS Bureau of Behavioral Health for additional scrutiny to determine if the health plan's policies or operational processes are out of compliance with MHPAEA. Any identified areas of deficiency will require resolution and corrective action from the health plan to come into compliance.

Reviews conducted by the EQRO

HSAG conducts compliance reviews of all HealthChoice Illinois health plans at least once every three years, with additional reviews conducted as requested by HFS. The purpose of the reviews is to determine a health plan's understanding and application of federal regulations and contractually required standards using a variety of methods, depending on the review being completed. In August 2021 HFS engaged HSAG in a special project to design a parity review tool and to complete an audit of the health plans' Phase I NQTL comparative analyses that were submitted to HFS on July 1, 2021. This work is ongoing and is targeted to be completed in the second half of CY 2022. HFS is currently exploring options for establishing the necessary resources to conduct similar audits on the Phase II and Phase III NQTL comparative analyses.

Educational or Corrective Actions Taken in 2020/2021

Illinois Department of Insurance

The DOI has undertaken the following educational and corrective actions since August 2020:

- Under the Access to Care and Treatment Parity Outreach and Education Program, Navigators continued to educate citizens on obtaining coverage and parity. This includes education on consumers' rights and responsibilities, and whom to contact at the DOI when they need assistance navigating insurance or filing a complaint when their rights have been violated.

- A multi-fold "palm card" was distributed to help educate the public on key insurance terms, provide guidance on their primary care physical, and outline all essential health benefits. The palm card was printed in clear language that explains to the consumer how their parity rights may be violated and how they can seek relief through the DOI if they suspect that has occurred.

- An overhaul of the Get Covered Illinois website included updates to the mental health and substance use disorder parity information. GCI also continues to include mental health and substance use disorder messaging through social media, such as Twitter and Facebook.

Attachment I

MHSUD Supporting Documents Template

Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767

Mental Health/Substance Use Disorder – Supporting Documentation Template
TO BE COMPLETED BY COMPANY
Company Name:
SERFF TOI:
SERFF SUB TOI:
SERFF Tracking #:
ELECTRONIC REFERENCES - FEDERAL
Code of Federal Regulations
United States Code
ELECTRONIC REFERENCES - ILLINOIS
Illinois Insurance Code
Administrative Rules
Illinois Company Bulletins

Supporting Documentation Template Directions

- The template must be completed to support the information included in all filings for individual, small group, or large group major medical, Health Maintenance Organization (HMO), or Point-of-Service (POS) products.
- This document is to be downloaded and submitted with this filing in SERFF. Alteration of this document will result in rejection of the filing.

As part of the policy filing review process, the Illinois Department of Insurance (DOI) will conduct a review and analysis of plan mental health/substance use disorder benefits to ensure compliance with State and federal regulations, standards, and to confirm any financial requirement or treatment limitation applied to mental health or substance use disorder benefits is not more restrictive than the predominant financial requirement or treatment limitation applied to substantially all medical/surgical benefits in the same classification.

(Note: Illinois required supporting documentation must be submitted in addition to any template/supporting documentation required by CMS/CCIIO. The DOI understands that there may be some overlap in information provided; however, the State's additional submission requirements for mental health/substance use disorder parity are needed to support the State's independent review for compliance with federal and state standards and regulations.)
Please respond to the following questions and/or request for information:

Aggregate Lifetime and Annual Dollar Limits - 45 CFR 146.136(b)

1) How does your plan comply with the aggregate lifetime and annual dollar limit requirements set forth in 45 CFR 146.136(b)?

If a plan does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

If a plan includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits, it must either— (i) Apply the aggregate lifetime or annual dollar limit both to the medical/ surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical/ surgical benefits and mental health or substance use disorder benefits; or (ii) Not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is less than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits.

Financial/Quantitative Treatment Limitations - 45 CFR 146.136(c)(2)

2) How does your plan comply with the financial and quantitative treatment limitation requirements set forth in 45 CFR 146.136(c)?

A plan that provides both medical/surgical benefits and mental health or substance use disorder benefits may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. Whether a financial requirement or treatment limitation is a predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in a classification is determined separately for each type of financial requirement or treatment limitation.

Attachment II

NQTL REPORTING TEMPLATE INSTRUCTION GUIDE

The instructions in this Guide provide companies that offer health plans, insurance policies, and/or Medicaid and CHIP managed care benefits (collectively referred to in this document as "Plans") with an in-depth description of each step that is delineated for each non-quantitative treatment limit (NQTL) analysis for mental health and substance use disorder Parity ("Parity") compliance reports.

The purpose of federal and state Parity laws is to ensure that Plan benefit design and operations offer beneficiary access to mental health and substance use disorder ("MH/SUD") services that is comparable to and no more stringent than beneficiary access to medical/surgical ("M/S") services. Thus, the guiding principle for NQTL compliance analyses and documentation should be to demonstrate the effect of the Plan design and operations on beneficiary access to services. In developing NQTL compliance analyses using these templates, Plans should focus on features of Plan design and operations for MH/SUD and M/S that ultimately impact beneficiary access to covered treatments services. Differences between Plan design and operations for MH/SUD and M/S that do not meaningfully impact beneficiary access are not a priority for enforcement and should not be a focus of compliance analyses.

For companies that offer multiple commercial health plans or products in Illinois, it is assumed that most policies and procedures that are relevant to most NQTLs are applied consistently across all of the company's product offerings. Where specific data are required, and/or where significant, substantive variations exist among the policies and procedures that are applied for an NQTL across different products, the company may limit its reporting to the required information for the top three largest plans by enrollment.

General Instructions

a) Plans should develop a separate response for each step of each analysis that answers the specific instructions of the prompt for that step, as further explained in this guide. Prompts for each step are designed to be distinct and non-overlapping, and responses should generally avoid repeating information that was provided in a previous step.

b) Information regarding plan design and operations analyzed in this report should be current, not retrospective. In other words, the Plan's analyses should reflect the Plan's current benefits, policies and procedures, operations, data, and related information as of the reporting date. Although operations measure data are by necessity retrospective, the interpretation of these data for the purposes of the compliance analysis should focus on the extent to which these data reflect the current plan design and operations. If changes to the plan design or operations mean that the operations measure data do not reflect the current plan design, this should be noted. Analyses should be maintained internally and updated on a periodic basis, such as annually.

c) Responses may be supplemented by attachments as necessary. For example, Plans may attach lists of benefits subject to a given NQTL, policies and procedures containing full details regarding the response to a given prompt, supporting evidence or operations data for a response, and/or other related information that may be useful for reference. However, a brief summary of the key information contained in the attachment should be provided within the relevant step response. All analyses should be wholly provided within the compliance report itself.

d) Supporting documentation is generally not required to be attached or included in Parity compliance reports. Examples of supporting documentation include relevant policies and procedures, details about how policies and procedures were designed or applied, data used to apply factors/processes in the implementation of NQTLs, operations measure data, and/or any other analysis or documentation used by the Plan to sustain its basis for compliance with a given NQTL. However, Plans should be prepared to provide copies of all internal or public documentation of the factors, processes, evidentiary standards, or other information that is relied upon to implement, analyze, and demonstrate compliance with an NQTL upon request or in the event of a market conduct exam or other enforcement action. (As a best practice for compliance, Plans may find it useful to maintain internal crosswalks or indices of the specific Plan documents that are relevant for each analysis. This practice will create efficiency in keeping the analysis up to date and in responding to any need to provide such supporting documentation.)

e) The term “benefits” is not defined in federal or state statute or regulation, and Plans have flexibility to determine the specificity with which to define benefits for their own coverage and operations. In general, Plans should align their use of the term “benefits” in their Parity analyses with the way this term is defined and applied in other Plan documents. An individual benefit may include a wide range of service codes, or it may be as narrow as a single service code. The analyses in this report do not require you to identify the logic used to define benefits, or to provide specific definitions for specific benefits. However, the logic for defining benefits should be consistent between MH/SUD and M/S coverage, and benefit definitions should be consistent across all Parity analyses.

f) In any Step where the reporting template stipulates that it provides examples of factors, processes, or evidentiary standards, the provided examples are purely illustrative. For these Steps, the Plan is not required to respond or provide information with regard to any of the example factors, processes, or evidentiary standards that are listed, and may instead report on its own factors, processes, or evidentiary standards.

g) Where specific operations measures are required, the plan may apply any technical specifications and/or data definitions that are reasonable and necessary to define and report on the identified measure. The technical specifications and data definitions must

not conflict with the instructions in this Guide, but otherwise should be designed to align as well as possible with the Plan's coverage design and operations, including existing data collections. Plans may also choose to supplement these required operations measures with additional oversight factors, processes, and/or operations measures that provide further context and support for the Plan's determination of compliance for the NQTL.

h) A brief comparability and stringency analysis should be provided for each data point, factor, or process that is reported in the "in operation" analyses in Step 6 of each analysis. If the data provided for a given measure appear to indicate a more stringent design or application of the NQTL to MH/SUD benefits relative to M/S benefits, the Plan should provide an explanation for the disparity in the data or justification for the difference in approach, including the reasons for which it determined that the underlying factors, processes, and evidentiary standards were in fact comparable and no more stringent. For example, a very small denominator or sample size for a given metric may lead to results that are heavily skewed by a small number of idiosyncratic instances or circumstances.

i) A Plan may wish to include, but is not required to provide, a discussion of actions that it is taking to amend processes or outcomes for MH/SUD benefits and services, especially in Step 6 of any given analysis. Such disclosures or actions may not be interpreted to indicate or imply non-compliance with Parity. However, should the State make a determination of non-compliance based on other information provided in a given analysis, the State may decide to consider the Plan's existing improvement actions as a mitigating factor for any resulting non-compliance penalty, requirement for corrective action, or other enforcement action.

j) Although these templates do not require Plans to submit definitions for MH, SUD, and M/S conditions, definitions for benefit classifications, or lists of MH/SUD and M/S benefits by classification, Plans should be prepared to submit such documentation to regulators in instances where such documentation may be necessary to determine compliance.

k) For all analyses of the prescription drugs classification, Plans should identify the evidentiary standard used to classify drugs as M/S drugs or MH/SUD drugs for the purpose of this analysis.

Filling out the Template

l) For each step, the instructions below should be applied separately to the response for M/S benefits and the response for MH/SUD benefits.

- If the information for MH/SUD benefits is substantively identical to the response that is provided for M/S benefits within a given step, write "same" in the

MH/SUD box and "N/A" in the comparability and stringency analysis box for that step.

- If there are any differences between the information for MH/SUD benefits and the information for M/S benefits for a given step, provide an analysis of the comparability and stringency of the responses for that step.

- The comparability and stringency analysis and conclusion provided in step 6 may include a discussion of the weight or probative value that should be given to individual factors, processes, or operations measures that are used to monitor and evaluate compliance. For NQTLs for which certain specific operations measures are required, the Plan's comparability and stringency analysis in step 6 may include a discussion of the reasons why a Plan has determined that any additional factors, processes, or operations measures that it applies should be given more weight or probative value than the operations measures that are required.

- Discussion should be provided to explain why any apparent disparity in operations measure data or other oversight factor or process is misleading or not truly indicative of noncompliance. This discussion should conclusively explain the Plan's rationale and substantive basis for determining that compliance has been achieved.

m) Although the instructions below are not duplicated for each classification, separate reporting must be provided for each classification as set forth in the reporting templates.

- If the NQTL is not applied to any MH/SUD benefits within a classification, stop and do not complete the analysis for that benefit classification. (However, Plans may find it useful to complete and maintain an NQTL analysis for internal purposes as a best practice for compliance.)

- If the NQTL is applied to one or more MH/SUD benefit(s) within a classification but does not apply to any medical/surgical benefits within that classification, the NQTL does not comply with MHPAEA.1

- If the NQTL is applied to all MH/SUD benefits within a classification but does not apply to all medical/surgical benefits within that classification, the NQTL is unlikely to comply with MHPAEA.2

- Plans that sub-classify Outpatient benefits into Outpatient-Office Visit and Outpatient-All Other may create additional templates as needed to reflect these subclassifications.

- Plans that provide benefits through multiple tiers of in-network providers (such as an in-network tier of preferred providers with more generous cost-sharing to participants than a separate in-network tier of all other participating providers) may create additional templates as needed to reflect these provider network tiers.

- Medicaid and CHIP managed care organizations (MCOs) and health plans that do not offer out-of-network benefits (e.g. an Exclusive Provider Organization) can omit all out-of-network classification templates, since the Parity rules for Medicaid and CHIP do not distinguish between in-network and out-of-network classifications.

    i. 1 See 78 FR 68240, 68245 (Nov. 13, 2013). See also FAQs About Affordable Care Act Implementation (Part VII) and Mental Health Parity Implementation (November 17, 2011) at Q&A-2.

    ii. 2 See 78 FR 68240, 68245 (Nov. 13, 2013). See also FAQs About Affordable Care Act Implementation (Part VII) and Mental Health Parity Implementation (November 17, 2011) at Q&A-5.

n) Within each step, please present paragraphs on the same topic for MH/SUD and M/S starting on the same line or row of the page.

- As a general rule, short paragraphs with narrowly-defined topics are preferred, as long narrative paragraphs often sacrifice clarity of thought or ease of analysis. However, the response must sufficiently respond to the step's prompt.

NQTL: Medical Necessity

Classification(s): if the same responses are applicable for all benefit classifications, then a single analysis may be submitted

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL 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 "Medical Necessity" (or "medically necessary" or other such related term that may be used by the Plan) as applied to medical or coverage policies, benefit authorizations, or payment determinations for benefits delivered under the Plan.

This is generally a single, basic definition of "Medical Necessity" that is applied to all benefits and services.

Note that this step does NOT ask you to provide a list of all medical, coverage, or payment policies that may be applied to specific benefits or services.

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.

Step 3 – Identify any source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.

Identify all sources of the standards, criteria, or guidelines that are used to determine Medical Necessity for specific benefits and services in this classification.

- Examples of the types of sources for such tools include:
- Plan-created standards, definitions, or guidelines
- Third-party vendor algorithms or guidelines
- Level of care or service intensity criteria and instruments
- National provider practice association position statements or guidelines
- Medicare National and Local Coverage Determinations
- State regulations or sub-regulatory guidance

The focus of this step is on the types of sources; it is not necessary to provide a comprehensive list of the specific sources for Medical Necessity standards. For example, it is sufficient to state that national provider practice association position statements or guidelines are a type of source that is used for the for medical or coverage policies that are used to determine the Medical Necessity of a service. It is not necessary to name each and every such position statement or guideline that is cited in any medical or coverage policy, nor is it necessary to provide the medical or coverage policies themselves.

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 NQTL to medical or surgical benefits in the benefits classification.

Step 4(a)(i): Identify and define the processes and strategies used to select Medical Necessity standards, definitions, or guidelines.

These strategies and processes should include, but are not limited to:

- The hierarchy of the sources cited in Step 2 that are used to define Medical Necessity for a given service.
- The factors applied to select the primary source for guidelines (e.g. third-party vendor)

- The factors applied to determine when to select from a secondary (or tertiary, quaternary, etc.) source or develop internally

This response should describe the step-by-step decision-making process that leads to the selection or creation of any Medical Necessity standard or clinical coverage guideline. For example, a Plan's primary source for guidelines might be a set of third-party vendor's clinical criteria or guidelines. The Plan should briefly discuss the factors used to select that source to be the primary source. If some of the vendor's guidelines are not adopted, the Plan should identify the factors used to determine which vendor guidelines (if any) to exclude. The Plan's secondary source (to supplement or fill gaps left by the primary source) might be Medicare National and Local Coverage Determinations. The Plan should then briefly discuss the factors used to identify this as the secondary source, and the factors used to determine which of these guidelines (if any) to exclude. Similar discussion should be provided to explain when and how each source of guidelines is selected and used, including the factors used to determine when to develop internal criteria or guidelines for determinations of Medical Necessity.

If the hierarchy of sources varies based on context (e.g. if certain steps in the decision-making process differ by treatment setting or specialty), these differences should be identified and the rationale for these differences should be explained. If any exceptions exist to the general rules described then those exceptions should be identified and explained.

Step 4(a)(ii): Identify and define the processes and strategies used to develop internal Medical Necessity guidelines or modifications to external guidelines that are created by the Plan.

This Step applies to Medical Necessity guidelines that are developed by the Plan. It is not necessary to discuss the processes and strategies used by any external sources of guidelines.

The discussion of Plan strategies and processes to develop Medical Necessity guidelines may include, but is not limited to, brief discussions of:

- The composition of the committee used to develop the internal standards
- The selection and use of external or independent experts
- Key steps in the process for developing the standards

If the Plan uses its own clinical criteria, guidelines, or related standards to determine the Medical Necessity of certain treatments or services, the Plan must identify and define the processes and strategies that are used to develop these guidelines. This includes guidelines that are wholly created by the Plan as well as deviations from or modifications to any external guidelines that are used.

Step 4(b): Identify and describe the evidentiary standards relied upon for Medical Necessity guidelines, or modifications to external guidelines that are created by the Plan.

Evidentiary standards are used to define the level and types of evidence the Plan considers in designing its Medical Necessity criteria. Specific types of evidentiary standards that a Plan may consider include 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, and outcome metrics from consulting or other organizations.

In this step, the Plan should identify and describe the types of evidentiary standards that relevant committees use to develop the Plan's own Medical Necessity guidelines. It may include criteria or factors used to determine whether to consider and/or how much weight to assign to a given research study or publication. It is NOT necessary to list the actual evidence consulted for specific Medical Necessity guidelines.

Step 4(c): Identify and define the factors and processes that are used to monitor and evaluate the efficacy and validity of Medical Necessity guidelines.

This analysis should include a discussion of the quality assurance and oversight processes and metrics that the plan applies to the adoption and development of its Medical Necessity guidelines.

As with steps 1-5, this discussion should focus primarily on the adoption and development of the Plan's Medical Necessity guidelines. For this step, how does the Plan know that it has adopted or developed the right guidelines? (The implementation of these guidelines through various utilization management processes, such as prior authorization and retrospective review, will be analyzed separately.)

Plans have full discretion to select factors and processes for oversight that are efficient and effective to monitor the adoption and development of Medical Necessity definitions within their own operations. Quantitative measures should be listed to the extent that they are used, and specific data should be provided for such measures. However, quantitative measures are not required, and qualitative factors and processes may be used as well. A brief analysis of the relevance of each data point, factor, or process to the Plan's overall determination of Parity compliance should be provided.

Factors, processes, and operations measures that may be considered include:

- Process for oversight of third-party guideline vendors
    - This could include a brief narrative discussion of the process that the Plan uses to monitor a specific vendor's strategy and processes for Parity compliance.
    - This could also include a brief narrative description of the process to re-evaluate the quality, utility, suitability, and/or hierarchy of use of third-party sources of Medical Necessity guidelines.
- Annual policy reviews or Parity compliance audits by relevant staff or committees.

    - This could include a brief narrative discussion of the process to select and review specific Medical Necessity guidelines for Parity or other quality control purposes.
- Consumer and provider complaints or appeals with regard to the content or substance of Medical Necessity guidelines
    - This could include a quantification and analysis of any consumer or provider complaints about Medical Necessity guidelines, and/or a narrative discussion of the process used to monitor, consider, and respond to any such complaints.
- Analyses of inter-rater reliability
    - This could include inter-rater reliability and/or other operations measures data used to ensure that specific utilization management processes (such as prior authorizations or retrospective review) are compliant with Parity.
    - Interpretation of such data should focus on their relevance to the validity, utility, or quality of the underlying guidelines themselves.
    - Note that these measures may duplicate or overlap with measures used for other NQTLs. This is permissible but is not required.

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 the information provided in each of the preceding steps.

NQTL: Prior Authorization

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

Step 1 - Identify the specific plan or coverage terms or other relevant terms regarding the NQTL 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 Prior Authorization

Define “Prior Authorization” as applied by the Plan to benefits in this classification. The Plan’s definition should focus on strategies that impact claims adjudication and payment or may otherwise serve to limit access and utilization.

The Plan’s definition of prior authorization may implicitly or explicitly distinguish among several related concepts or functions that may be required prior to the delivery of the services, including a determination or certification of Medical Necessity by the Plan, notification to the Plan that the service or admission has been scheduled or ordered, and/or other related policies and processes. For example, if a Plan requires prior notification of inpatient admissions but does not require a determination of Medical Necessity prior to admission, then the Plan could

determine that this prior notification requirement is a separate NQTL and exclude it from the definition and analysis of prior authorization. The present analysis should focus specifically on Prior Authorization, as defined by the Plan in this Step, and does not require analyses of other related concepts that do not meet the Plan's definition.

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

Step 1(b): Identify the benefits/services for which Prior Authorization is required

List all benefits in this classification that are subject to Prior Authorization.

This list may be provided as a link or attachment if desired. For prescription drug benefits, a copy of the Plan's formulary that indicates which covered drugs are subject to PA may be provided as a link or attachment.

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

- If the Plan applies Prior Authorization 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 Prior Authorization 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 the NQTL 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 Prior Authorization.

Plans have broad discretion to select and define factors for determining whether to apply Prior Authorization to a given benefit. Examples of selection factors include:

- 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 the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.

Define each factor that is used to determine which benefits are subject to Prior Authorization. Each factor must be defined with sufficient precision to determine whether a given benefit does or does not meet the definition.

Definitions may or may not include a quantitative threshold, but each definition should include a clearly-identified evidentiary standard and/or data source that is used to evaluate or measure the factor and determine whether or not the factor is met. 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 Prior Authorization to all benefits for which there is "excessive utilization." The Plan could define "excessive utilization" to mean benefits for which utilization exceeds some pre-defined benchmark, and then identify this benchmark as the data source for that factor.

If "clinical efficacy of the proposed treatment or service" is used as a factor, then the evidentiary standard could be a "preponderance of the medical literature." In this case, the Plan should provide the definition of "clinical efficacy" that is used and identify the committee that determines whether a preponderance of the literature meets this definition.

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

Step 4 – Provide 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 NQTL to medical or surgical benefits in the benefits classification.

Step 4(a): For each benefit subject to Prior Authorization, 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 Prior Authorization 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 MH/SUD drug, formulation, or dosage level is available to regulators upon request in the event of a complaint or suspicion of noncompliance, including a non-comprehensive set of examples of M/S drugs or drug classes that meet the identified factors.

The grid must include all benefits subject to prior authorization. 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					
Electroconvulsive therapy					X
Transcranial magnetic stimulation	X			X	
Psych testing	X		X		X
Intensive outpatient		X	X		
Etc.					
M/S benefits					
Cardiac rehab	X		X	X	
X-ray		X	X	X	
Genetic testing	X	X			
Non-emerg CT scan					X
Etc.					

Step 4(b): Briefly describe the processes by which prior authorization is applied.

Provide a brief description of each step of the processes by which the prior authorization 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 and analyses 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
- 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
- Review processes, such as administrative reviews, clinical reviews, peer-to-peer reviews, and second-level reviews or sign-offs
- Processes applied in the absence of medical or coverage policies or guidelines
- Reviewer's discretion in departing from written policies and procedures, including medical and coverage policies or 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 PA 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 Prior Authorization.

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

The analysis must include, at minimum, data for the following operations measures:

- Pre- and/or post-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 analysis may also include information on other quality assurance or oversight processes and metrics, such as:

- The rough percentages or proportions of covered MH/SUD and M/S benefits and/or claims that are subject to Prior Authorization
- Comparisons to government programs or other publicly-available formularies
- Quantitative data or narrative descriptions of random audit processes for decisions to apply Prior Authorization to a given benefit ("in writing")
- Quantitative data or narrative descriptions of random audit processes for Prior Authorization 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 the information provided in each of the preceding steps.

NQTL: Experimental and Investigative Treatments

Classification(s): if the same responses are applicable for all relevant benefit classifications, then a single analysis may be submitted. If the Plan's coverage for Experimental or Investigational drugs is based solely on FDA approval, it may indicate "N/A" for this NQTL for the prescription drug classification.

Step 1 - Identify the specific plan or coverage terms or other relevant terms regarding the NQTL 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 "Experimental or Investigational" (or other such related term that may be used by the Plan) as applied to medical or coverage policies, benefit authorizations, or payment determinations for benefits delivered under the Plan.

This is generally a single, basic definition of "Experimental or Investigational" that is applied to all benefits and services.

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

Step 3 – Identify any source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.

Identify the evidentiary standards for determining that a treatment or service meets the definition for E/I Treatments.

Evidentiary standards are used to define the level and types of evidence the Plan considers in designing its E/I criteria. Specific types of evidentiary standards that a Plan may consider include completion of a Phase III trial, approval by the FDA or other relevant regulatory agency, recognized medical literature, recognition by a professional guild association as the accepted standard treatment, 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, and outcome metrics from consulting or other organizations.

In this step, the Plan should identify and describe the types of evidentiary standards that relevant committees use to develop the Plan's E/I criteria. It may include criteria or factors used to determine whether to consider and/or how much weight to assign to a given research study or publication. It is NOT necessary to list the actual evidence consulted for specific E/I determinations.

Step 4 – Provide 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 NQTL to medical or surgical benefits in the benefits classification.

Step 4(a)(i): Identify the conditions or factors, if any, under which E/I treatments or services are covered

Each condition or factor must be defined with sufficient precision to permit an objective determination of whether a given treatment or benefit does or does not meet the factor, including identification of the relevant measure or evidentiary standard for the criterion.

If there are no exceptions to the E/I exclusion, write N/A.

Step 4(a)(ii): Briefly describe the processes by which Treatments are determined to be E/I

Provide a brief description of each step of the processes by which a Treatment is determined to be E/I. The discussion of relevant Plan processes may include, but is not limited to, brief discussions of:

- The establishment of a Plan committee to make E/I determinations
- Consultation with expert reviewers
- The identification and scheduling of treatments or services for evaluation (e.g. for new technologies, or upon request by a beneficiary)
- The selection of information deemed reasonably necessary to make an E/I determination

Step 4(b): Briefly describe the processes by which coverage determinations or exceptions are made for E/I Treatments

If coverage is provided for E/I Treatments under certain conditions or criteria, provide a brief description of each step of the processes by which a coverage determination or exception is made for E/I Treatments.

The discussion of Plan strategies and processes to make coverage determinations or exceptions for E/I Treatments may, but are not required to, include, for example, brief discussions of:

- Timelines and deadlines
- Review committees, including roles and minimum qualifications for members
- Policies and procedures and/or manuals relied upon
- Next steps if coverage for the E/I Treatment is denied

If there are no exceptions to the E/I exclusion, write N/A.

Step 4(c): Identify and define the factors and processes that are used to monitor and evaluate the application of E/I Treatment policies

This analysis should include a discussion of the quality assurance and oversight processes that the plan applies to its E/I Treatment policies. The analysis should address the monitoring and evaluation of determinations of whether a treatment or service meets the E/I Treatment criteria as well as the monitoring and evaluation of any exceptions process.

Examples of relevant factors, processes, and operations measures may include:

- The number and outcomes of E/I determinations within a defined period
- The number and outcomes of E/I exceptions within a defined period
- Timelines and processes for re-evaluating the E/I Treatment policy
- Quantitative data or narrative descriptions of random audit processes for E/I determinations

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 the information provided in each of the preceding steps.

NQTL: Prescription Drug Formulary Tiering

If Formulary Tiers are not used, or if the formulary is determined by a State agency, then this NQTL analysis may be marked N/A.

Classification(s): this analysis is only completed for the Prescription Drug benefits classification

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL 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 Formulary Tiers

Identify and define each separate Formulary Tier applied by the plan to Prescription Drug benefits. For each tier, define all relevant coverage policies and limits that are applied to drugs in that tier, including, any financial requirements and/or any utilization management requirements or other coverage limits.

If the specific levels of financial requirements vary across products or benefit packages offered by a Plan, it is not necessary to identify all specific levels of the financial requirement that may be applied within a given tier. Instead, it may simply be indicated whether the financial requirement type (co-pay and/or coinsurance) is applied to all drugs within the tier, whether the same level of the financial requirement type is applied to all drugs within the tier, and whether the level applied for a given product or benefit package is the same or higher than the preceding tier.

If Formulary Tiers are not used, or if the formulary is determined by a State agency, then all other rows may be marked N/A.

Step 1(b): Identify all drugs covered in each Formulary Tier

This information may be provided in a separate attachment.

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

Identify the factors used to assign drugs to a Formulary Tier

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 NQTL to mental health or substance use disorder benefits and medical or surgical benefits.

Define each factor listed in Step 2 with sufficient precision to determine whether a given drug does or does not meet the definition, including identification of the relevant measure or evidentiary standard for the factor. The response should indicate the general hierarchy or sequence in which these factors and evidentiary standards are applied in assigning a drug to a formulary tier, along with any criteria for determining whether/when to deviate from the general hierarchy or sequence. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up.

Step 4 – Provide 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 NQTL to medical or surgical benefits in the benefits classification.

Step 4(a): Briefly describe the processes by which drugs are assigned to a Formulary Tier.

Provide a brief description of each step of the processes by which drugs are assigned to Formulary Tiers.

The discussion of Plan strategies and processes to assign drugs to Formulary Tiers may, but are not required to, include brief discussions of:

- The composition of and member qualifications for the Pharmacy and Therapeutics and/or other relevant committees
- The selection and use of external or independent experts
- The identification and scheduling of drugs for tiering (e.g. for new drugs, or upon request by a beneficiary)
- Key steps in each relevant committee process

Step 4(b): Identify and define the factors and processes that are used to monitor and evaluate the Formulary Tiering program

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

Examples of relevant information may include:

- The percentages of covered MH/SUD and M/S drugs that are assigned to each tier
- Comparisons to government programs or other publicly-available formularies
- Quantitative data or narrative descriptions of random audit processes for tier assignments

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 the information provided in each of the preceding steps.

NQTL: Step Therapy

Classification(s): this analysis may only need to be completed for the Prescription Drug benefits classification. However, if Step Therapy policies are applied to MH/SUD benefits in any other benefit classifications, such as physician-administered MH/SUD drugs that are classified as inpatient or outpatient benefits, then Parity compliance analyses should be provided for all such classifications.

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL 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 Step Therapy as applied to Prescription Drug benefits

Define "Step Therapy" or fail first policies as applied to Prescription Drug benefits. This definition may implicitly or explicitly distinguish and exclude certain related concepts such as Prior Authorization (which should be analyzed and reported separately), Medical Necessity, exclusions for failure to complete a course of treatment, and other related policies and processes. If the Plan determines that all aspects of its Step Therapy, fail first, and/or related requirements are designed and implemented through its Prior Authorization program (and/or other related NQTLs), then the Step Therapy analysis may be marked N/A.

Step 1(b): Identify the drugs or drug classes to which Step Therapy is applied and define the Step Therapy requirements

List all drugs or drug classes to which Step Therapy is or may be applied and define the Step Therapy requirements that are applied to each drug or drug class. If multiple “steps” are required to be fulfilled before gaining access to a given drug or drug class, each step should be separately defined.

An attachment may be used if necessary.

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

Identify the factors used to determine which drugs or drug classes are subject to Step Therapy

Also identify the factors used to determine the number of "steps" that are required for each drug or drug class. Plans have broad discretion to define and select these factors, data sources, and evidentiary standards.

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 NQTL to mental health or substance use disorder benefits and medical or surgical benefits.

Define each factor listed in Step 2 with sufficient precision to determine whether a given drug does or does not meet the definition. Each definition should include a clearly-identified evidentiary standard and/or data source that is used to evaluate or measure the factor and determine whether or not the factor is met.

Note that this step does NOT require you to submit the evidence base for specific determinations of whether to apply Step Therapy to a given drug.

Step 4 – Provide 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 NQTL to medical or surgical benefits in the benefits classification.

Identify and define the factors and processes that are used to monitor and evaluate the application of Step Therapy.

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

The analysis must include, at minimum, data for the following factors:

- Denial rates for failure to complete the required steps
- Internal and/or external appeal rates
- Appeal overturn rates

The analysis may also include information on other quality assurance or oversight processes and metrics, such as:

- The percentages of covered MH/SUD and M/S drugs that are subject to Step Therapy
- The numbers or percentages of covered MH/SUD and M/S drugs that are subject to multiple "steps" of Step Therapy
- Comparisons to government programs or other publicly-available formularies
- Quantitative data or narrative descriptions of random audit processes for Step Therapy assignments

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 the information provided in each of the preceding steps.

NQTL: Medical Necessity

Classification: ALL

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL 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

Medical/Surgical:	MH/SUD

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

N/A	N/A

Step 3 – Identify any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical or surgical benefits.

Medical/Surgical:	MH/SUD

Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs 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 in the benefits classification

Medical/Surgical:	MH/SUD

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

NQTL: Prior Authorization

Classification:

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL 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

Medical/Surgical:	MH/SUD

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

Medical/Surgical:	MH/SUD

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 NQTL to mental health or substance use disorder benefits and medical or surgical benefits.

Medical/Surgical:	MH/SUD

Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs 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 in the benefits classification

Medical/Surgical:	MH/SUD

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

NQTL: Experimental and Investigational

Classification:

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL 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

Medical/Surgical:	MH/SUD

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

N/A	N/A

Step 3 – Identify any source or evidence relied upon to design and apply the NQTL to mental health or substance use disorder benefits and medical or surgical benefits.

Medical/Surgical:	MH/SUD

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

Medical/Surgical:	MH/SUD

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

NQTL: Prescription Drug Formulary Tiering

Classification:

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL 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

Medical/Surgical:	MH/SUD

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

Medical/Surgical:	MH/SUD

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 NQTL to mental health or substance use disorder benefits and medical or surgical benefits.

Medical/Surgical:	MH/SUD

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 NQTL to medical or surgical benefits in the benefits classification

Medical/Surgical:	MH/SUD

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

NQTL: Step Therapy

Classification:

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the NQTL 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

Medical/Surgical:	MH/SUD

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

Medical/Surgical:	MH/SUD

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 NQTL to mental health or substance use disorder benefits and medical or surgical benefits.

Medical/Surgical:	MH/SUD

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 NQTL to medical or surgical benefits in the benefits classification

Medical/Surgical:	MH/SUD

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

NQTL REPORTING TEMPLATE INSTRUCTION GUIDE

The instructions in this Guide provide companies that offer health plans, insurance policies, and/or Medicaid and CHIP managed care benefits (collectively referred to in this document as "Plans") with an in-depth description of each step that is delineated for each non-quantitative treatment limit (NQTL) analysis for mental health and substance use disorder Parity ("Parity") compliance reports.

The purpose of federal and state Parity laws is to ensure that Plan benefit design and operations offer beneficiary access to mental health and substance use disorder ("MH/SUD") services that is comparable to and no more stringent than beneficiary access to medical/surgical ("M/S") services. Thus the guiding principle for NQTL compliance analyses and documentation should be to demonstrate the effect of the Plan design and operations on beneficiary access to services. In developing NQTL compliance analyses using these templates, Plans should focus on features of Plan design and operations for MH/SUD and M/S that ultimately impact beneficiary access to covered treatments services. Differences between Plan design and operations for MH/SUD and M/S that do not meaningfully impact beneficiary access are not a priority for enforcement and should not be a focus of compliance analyses.

For companies that offer multiple commercial health plans or products in Illinois, it is assumed that most policies and procedures that are relevant to most NQTLs are applied consistently across all of the company's product offerings. Where specific data are required, and/or where significant, substantive variations exist among the policies and procedures that are applied for an NQTL across different products, the company may limit its reporting to the required information for the top three largest plans by enrollment.

General Instructions

a) Plans should develop a separate response for each step of each analysis that answers the specific instructions of the prompt for that step, as further explained in this guide. Prompts for each step are designed to be distinct and non-overlapping, and responses should generally avoid repeating information that was provided in a previous step.

b) Information regarding plan design and operations analyzed in this report should be current, not retrospective. In other words, the Plan's analyses should reflect the Plan's current benefits, policies and procedures, operations, data, and related information as of the reporting date. Although operations measure data are by necessity retrospective, the interpretation of these data for the purposes of the compliance analysis should focus on the extent to which these data reflect the current plan design and operations. If changes to the plan design or operations mean that the operations measure data do not reflect the current plan design, this should be noted. Analyses should be maintained internally and updated on a periodic basis, such as annually.

c) Responses may be supplemented by attachments as necessary. For example, Plans may attach lists of benefits subject to a given NQTL, policies and procedures containing full details regarding the response to a given prompt, supporting evidence or operations data for a response, and/or other related information that may be useful for reference. However, a brief summary of the key information contained in the attachment should be provided within the relevant step response. All analyses should be wholly provided within the compliance report itself.

d) Supporting documentation is generally not required to be attached or included in Parity compliance reports. Examples of supporting documentation include relevant policies and procedures, details about how policies and procedures were designed or applied, data used to apply factors/processes in the implementation of NQTLs, operations measure data, and/or any other analysis or documentation used by the Plan to sustain its basis for compliance with a given NQTL. However, Plans should be prepared to provide copies of all internal or public documentation of the factors, processes, evidentiary standards, or other information that is relied upon to implement, analyze, and demonstrate compliance with an NQTL upon request or in the event of a market conduct exam or other enforcement action. (As a best practice for compliance, Plans may find it useful to maintain internal crosswalks or indices of the specific Plan documents that are relevant for each analysis. This practice will create efficiency in keeping the analysis up to date and in responding to any need to provide such supporting documentation.)

e) The term “benefits” is not defined in federal or state statute or regulation, and Plans have flexibility to determine the specificity with which to define benefits for their own coverage and operations. In general, Plans should align their use of the term “benefits” in their Parity analyses with the way this term is defined and applied in other Plan documents. An individual benefit may include a wide range of service codes, or it may be as narrow as a single service code. The analyses in this report do not require you to identify the logic used to define benefits, or to provide specific definitions for specific benefits. However, the logic for defining benefits should be consistent between MH/SUD and M/S coverage, and benefit definitions should be consistent across all Parity analyses.

f) In any Step where the reporting template stipulates that it provides examples of factors, processes, or evidentiary standards, the provided examples are purely illustrative. For these Steps, the Plan is not required to respond or provide information with regard to any of the example factors, processes, or evidentiary standards that are listed, and may instead report on its own factors, processes, or evidentiary standards.

g) Where specific operations measures are required, the plan may apply any technical specifications and/or data definitions that are reasonable and necessary to define and report on the identified measure. The technical specifications and data definitions must not conflict with the instructions in this Guide, but otherwise should be designed to

align as well as possible with the Plan's coverage design and operations, including existing data collections. Plans may also choose to supplement these required operations measures with additional oversight factors, processes, and/or operations measures that provide further context and support for the Plan's determination of compliance for the NQTL.

h) A brief comparability and stringency analysis should be provided for each data point, factor, or process that is reported in the "in operation" analyses in Step 6 of each analysis. If the data provided for a given measure appear to indicate a more stringent design or application of the NQTL to MH/SUD benefits relative to M/S benefits, the Plan should provide an explanation for the disparity in the data or justification for the difference in approach, including the reasons for which it determined that the underlying factors, processes, and evidentiary standards were in fact comparable and no more stringent. For example, a very small denominator or sample size for a given metric may lead to results that are heavily skewed by a small number of idiosyncratic instances or circumstances.

i) A Plan may wish to include, but is not required to provide, a discussion of actions that it is taking to amend processes or outcomes for MH/SUD benefits and services, especially in Step 6 of any given analysis. Such disclosures or actions may not be interpreted to indicate or imply non-compliance with Parity. However, should the State make a determination of non-compliance based on other information provided in a given analysis, the State may decide to consider the Plan's existing improvement actions as a mitigating factor for any resulting non-compliance penalty, requirement for corrective action, or other enforcement action.

j) Although these templates do not require Plans to submit definitions for MH, SUD, and M/S conditions, definitions for benefit classifications, or lists of MH/SUD and M/S benefits by classification, Plans should be prepared to submit such documentation to regulators in instances where such documentation may be necessary to determine compliance.

k) For all analyses of the prescription drugs classification, Plans should identify the evidentiary standard used to classify drugs as M/S drugs or MH/SUD drugs for the purpose of this analysis.

Filling out the Template

l) For each step, the instructions below should be applied separately to the response for M/S benefits and the response for MH/SUD benefits.

- If the information for MH/SUD benefits is substantively identical to the response that is provided for M/S benefits within a given step, write "same" in the

MH/SUD box and "N/A" in the comparability and stringency analysis box for that step.

- If there are any differences between the information for MH/SUD benefits and the information for M/S benefits for a given step, provide an analysis of the comparability and stringency of the responses for that step.

- The comparability and stringency analysis and conclusion provided in step 6 may include a discussion of the weight or probative value that should be given to individual factors, processes, or operations measures that are used to monitor and evaluate compliance. For NQTLs for which certain specific operations measures are required, the Plan's comparability and stringency analysis in step 6 may include a discussion of the reasons why a Plan has determined that any additional factors, processes, or operations measures that it applies should be given more weight or probative value than the operations measures that are required.

- Discussion should be provided to explain why any apparent disparity in operations measure data or other oversight factor or process is misleading or not truly indicative of noncompliance. This discussion should conclusively explain the Plan's rationale and substantive basis for determining that compliance has been achieved.

m) Although the instructions below are not duplicated for each classification, separate reporting must be provided for each classification as set forth in the reporting templates.

- If the NQTL is not applied to any MH/SUD benefits within a classification, stop and do not complete the analysis for that benefit classification. (However, Plans may find it useful to complete and maintain an NQTL analysis for internal purposes as a best practice for compliance.)

- If the NQTL is applied to one or more MH/SUD benefit(s) within a classification but does not apply to any medical/surgical benefits within that classification, the NQTL does not comply with MHPAEA.1

- If the NQTL is applied to all MH/SUD benefits within a classification but does not apply to all medical/surgical benefits within that classification, the NQTL is unlikely to comply with MHPAEA.2

- Plans that sub-classify Outpatient benefits into Outpatient-Office Visit and Outpatient-All Other may create additional templates as needed to reflect these subclassifications.

- Plans that provide benefits through multiple tiers of in-network providers (such as an in-network tier of preferred providers with more generous cost-sharing to participants than a separate in-network tier of all other participating providers) may create additional templates as needed to reflect these provider network tiers.

- Medicaid and CHIP managed care organizations (MCOs) and health plans that do not offer out-of-network benefits (e.g. an Exclusive Provider Organization) can omit all out-of-network classification templates, since the Parity rules for Medicaid and CHIP do not distinguish between in-network and out-of-network classifications.

    i. 1 See 78 FR 68240, 68245 (Nov. 13, 2013). See also FAQs About Affordable Care Act Implementation (Part VII) and Mental Health Parity Implementation (November 17, 2011) at Q&A-2.
    ii. 2 See 78 FR 68240, 68245 (Nov. 13, 2013). See also FAQs About Affordable Care Act Implementation (Part VII) and Mental Health Parity Implementation (November 17, 2011) at Q&A-5.

n) Within each step, please present paragraphs on the same topic for MH/SUD and M/S starting on the same line or row of the page.

- As a general rule, short paragraphs with narrowly-defined topics are preferred, as long narrative paragraphs often sacrifice clarity of thought or ease of analysis. However, the response must sufficiently respond to the step's pro.

NQTL: Blanket Exclusions of Benefits

Classification(s): separate analyses should be submitted for each classification of benefits for which Blanket Exclusions of Benefits are applied.

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding Blanket Exclusions of Benefits 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 Blanket Exclusions of Benefits

"Blanket Exclusions of Benefits" means exclusions of benefits that apply uniformly to all claims or service requests for identified benefits for all Plan beneficiaries, with no consideration of Medical Necessity or other factors.

"Blanket Exclusions of Benefits" excludes Experimental/Investigational Determinations, Exclusions for Court-Ordered Treatment or Involuntary Holds, Provider-Type Exclusions, Out-of-Network Coverage Standards, and Geographic Restrictions.

Step 1(b): Identify the benefits/services that are subject to a Blanket Exclusion of Benefits List all benefits in this classification that are subject to a Blanket Exclusion of Benefits. In general, no analysis of comparability and stringency is required for this Step.

NOTE: If no Blanket Exclusion of Benefits are applied to any MH/SUD benefit or service (notwithstanding any coverage exclusions that are analyzed under other NQTLs), this NQTL analysis may be marked "N/A".

NOTE: This NQTL type does not apply to blanket exclusions of benefits for a given condition or diagnosis.

Step 2 – Identify the factors used to determine that Blanket Exclusions of Benefits 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 a Blanket Exclusion of Benefits.

Plans have broad discretion to select and define factors for determining whether to apply a Blanket Exclusion of Benefits to a given benefit. Examples of selection factors include:

- Treatments and services for non-covered diagnoses or conditions
- Treatments and services that do not meet the Plan's definition for "medical treatments and services," including dental, cosmetic, lifestyle, and social services
- Treatments and services determined to be high cost and to deliver poor clinical efficacy relative to alternative treatments or placebo
- Treatments and services delivered outside of the United States
- Treatments and services that are rarely covered in the market and for which coverage is determined to create a risk of adverse selection

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 Blanket Exclusions of Benefits 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:

- Plan coverage documents
- Preponderance of the medical literature
- Plan economic projections
- Market analysis of coverage trends

Note that this step does NOT require Plans to analyze the evidence base for any specific service that is subject to a Blanket Exclusion of Benefits. Instead, this step focuses on the factors, data sources, and evidentiary standards that were used to decide to apply a Blanket Exclusion of Benefits.

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

Step 4(a): In Writing: For each benefit subject to a Blanket Exclusion of Benefits, 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 Blanket Exclusion of Benefits on a benefit-by-benefit basis. A sample grid is provided below, but any format can be used. 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.

	Non-covered diagnoses	Non-medical Benefits	High cost/low efficacy
MH/SUD benefits			
Supported employment		X	
Equine therapy			X
Psych testing, except for specified diagnoses	X		
Etc.			
M/S benefits			
Private duty nursing			X
Orthodontic treatment		X	
Massage therapy		X	
Routine foot care, except to treat specified diagnoses	X		
Etc.			

Step 4(b): Briefly describe the processes by which Blanket Exclusions of Benefits are applied.

Provide a brief description of each step of the processes by which the Plan decides to apply a Blanket Exclusion to a service. 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.

Information provided for these items should be ordered and formatted to facilitate direct comparisons between M/S and MH/SUD benefits, and in particular should note any differences between the process for determining to apply a Blanket Exclusion of Benefits to a MH/SUD treatment or service vs. a M/S treatment or service.

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

This analysis should include a discussion of the quality assurance and oversight processes and metrics that the plan applies to its Blanket Exclusions of Benefits.

The analysis may include data for operations measures and/or other quality assurance or oversight processes such as annual reviews of Blanket Exclusion of Benefits exclusions or internal audits of the application of its Blanket Exclusions of Benefits.

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: Exclusions for Court-Ordered Treatment or Involuntary Holds

Classification(s): separate analyses should be submitted for each classification of benefits for which Exclusions for Court-Ordered Treatment or Involuntary Holds are applied.

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding Exclusions for Court-Ordered Treatment or Involuntary Holds 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 Court-Ordered Treatment or Involuntary Holds Exclusions

Exclusions for Court-Ordered Treatment or Involuntary Holds (COT Exclusions) is defined to mean an exclusion of coverage for all court-ordered treatment or involuntary holds for all Plan beneficiaries, with no consideration of Medical Necessity or other factors.

COT Exclusions do not include Blanket Exclusions of Benefits, Experimental/ Investigational Determinations, Provider-type Exclusions, Out-of-Network Coverage Standards, or Geographic Restrictions.

NOTE: If no Court-Ordered Treatment or Involuntary Holds Exclusions are applied to any MH/SUD benefit or service (notwithstanding any coverage exclusions that are analyzed under other NQTLs), this NQTL analysis may be marked “N/A”.

Step 1(b): Identify the benefits/services that are subject to a Court-Ordered Treatment or Involuntary Holds Exclusion

List all benefits in this classification that are subject to a Court-Ordered Treatment or Involuntary Holds Exclusion.

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

Step 2 – Identify the factors used to determine that Exclusions for Court-Ordered Treatment or Involuntary Holds 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 a Court-Ordered Treatment or Involuntary Holds Exclusion. Plans have broad discretion to select and define factors for determining whether to apply a Court-Ordered Treatment or Involuntary Holds Exclusion to a given benefit.

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 Exclusions for Court-Ordered Treatment or Involuntary Holds 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:

- Plan coverage documents
- Preponderance of the medical literature
- Adherence to identified national standards

Note that this step does NOT require Plans to analyze the evidence base for any specific service that is subject to a Court-Ordered Treatment or Involuntary Holds Exclusion. Instead, this step focuses on the factors, data sources, and evidentiary standards that were used to decide to apply a Court-Ordered Treatment or Involuntary Holds Exclusion to the service.

Step 4 – Provide comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply Exclusions for Court-Ordered Treatment or Involuntary Holds 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 Exclusions for Court-Ordered Treatment or Involuntary Holds to medical or surgical benefits in the benefits classification

Step 4(a): For each benefit subject to a Court-Ordered Treatment or Involuntary Holds Exclusion, 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 a Court-Ordered Treatment or Involuntary Holds Exclusion on a benefit-by-benefit basis. A 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.

Step 4(b): Briefly describe the processes by which Court-Ordered Treatment or Involuntary Holds Exclusions are applied.

Provide a brief description of each step of the processes by which the Plan decides to apply a Court-Ordered Treatment or Involuntary Holds Exclusion to a claim or authorization request. 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.

Information provided for these items should be ordered and formatted to facilitate direct comparisons between M/S and MH/SUD benefits, and in particular should note any differences between the process for determining to apply a Court-Ordered Treatment or Involuntary Holds Exclusion to a claim or authorization request for an MH/SUD treatment or service vs. a M/S treatment or service.

Step 4(c): Identify and define the factors and processes that are used to monitor and evaluate the application of Court-Ordered Treatment or Involuntary Holds Exclusions

This analysis should include a discussion of the quality assurance and oversight processes and metrics that the plan applies to the implementation of its Court-Ordered Treatment or Involuntary Holds Exclusions policy.

The analysis may include data for operations measures and/or other quality assurance or oversight processes such as annual reviews of Court-Ordered Treatment or Involuntary Holds Exclusions or internal audits of Court-Ordered Treatment or Involuntary Holds Exclusion determinations.

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: Provider-Type Exclusions

Classification(s): separate analyses should be submitted for inpatient and outpatient benefit classifications for which Provider-Type Exclusions (Provider Type Exclusion) are applied. No analysis is required for prescription drugs or emergency classifications.

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding Provider Type Exclusions 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 Provider-Type Exclusions

"Provider-Type Exclusions" (PT Exclusions) means exclusions of coverage for all covered benefits by any provider of a licensed healthcare provider type, as the provider type is defined by the Plan, without regard to Member-specific considerations such as the Medical Necessity of the service.

Provider-Type Exclusions do not include Experimental/Investigational Determinations, Blanket Exclusions of, Exclusions for Court-Ordered Treatment or Involuntary Holds, Out-of-Network Coverage Standards, and Geographic Restrictions.

NOTE: If no Provider Type Exclusions are applied to any MH/SUD benefit or service (notwithstanding any coverage exclusions that are analyzed under other NQTLs), this NQTL analysis may be marked "N/A".

Step 1(b): Identify the Provider Types that are subject to a Provider Type Exclusion List all Provider Types in this classification that are subject to a Provider Type Exclusion. In general, no analysis of comparability and stringency is required for this Step.

Step 2 – Identify the factors used to determine that Provider Type Exclusions 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 a Provider Type Exclusion to a given benefit. Examples of factors include Provider Types for which:

- State licensing is not available in the Plan state
- The majority of the services delivered by the Provider Type are not covered benefits under the Plan
- Specifically identified concerns regarding service quality and efficacy, patient safety, provider fraud waste and abuse, and/or comparable concerns are documented to be widespread among the Provider Type

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 Provider Type Exclusions 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:

- State licensing programs
- Provider websites and marketing materials
- Plan coverage documents
- Federal or State government reports
- Preponderance of the medical literature

Note that this step does NOT require Plans to analyze the evidence base for any specific Provider Type that is subject to a Provider Type Exclusion. Instead, this step focuses on the factors, data sources, and evidentiary standards that were used to decide to apply a Provider Type Exclusion to the Provider Type.

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

Step 4(a): For each Provider Type subject to a Provider Type Exclusion, 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 Provider Type met each factor that it was determined to meet, in addition to a breakdown of which factors apply to each Provider Type that is subject to a Provider Type Exclusion on a Provider Type-by-Provider Type basis. A 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 Provider Types that primarily deliver MH/SUD treatments and services.

It is not necessary to provide the actual data or evidence relied upon to determine that the Provider Type 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.

Step 4(b): Briefly describe the processes by which Provider Type Exclusions are applied.

Provide a brief description of each step of the processes by which the Plan decides to apply a Provider Type Exclusion to a Provider Type. 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.

Information provided for these items should be ordered and formatted to facilitate direct comparisons between M/S and MH/SUD Provider Types, and in particular should note any differences between the process for determining to apply a Provider Type Exclusion to a Provider Type that primarily delivers MH/SUD treatments and services vs. M/S treatments and services.

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

This analysis should include a discussion of the quality assurance and oversight processes and metrics that the plan applies to the implementation of its Provider Type Exclusions policy.

The analysis may include data for operations measures and/or other quality assurance or oversight processes such as annual reviews of Provider Type Exclusions or internal audits of Provider Type Exclusion determinations.

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: Out-of-Network Coverage Standards

Classification(s): separate analyses should be submitted for each classification of benefits for which limits based on Out-of-Network Coverage Standards are applied.

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding Out- Of-Network Coverage Standards 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 "Out-of-Network Coverage Standards"

"Out-of-Network Coverage Standards" means the standards and processes used by the Plan to authorize coverage for treatments and services delivered by out-of-network providers.

NOTE: This NQTL type is primarily relevant for Medicaid Managed Care Organizations, given the absence of out-of-network benefit classifications for Medicaid parity analyses.

Commercial Plans should generally analyze limits on coverage for out-of-network benefits under the out-of-network benefit classifications for other NQTL types. Commercial health plans that do not apply any specific Out-of-Network Coverage Standards that are not addressed under other reported NQTL analyses may mark this NQTL "N/A."

Commercial health plans that offer Out-of-Network coverage only for covered MH/SUD benefits that are medically necessary and not available in-network and that do not offer Out-of-Network coverage for M/S benefits may indicate "N/A" for this NQTL.

Step 1(b): Identify all limits on coverage that are based on Out-of-Network Coverage Standards.

For example, the Plan may apply:

- Pre-service notice or administrative approval of all non-emergent out-of-network services

- Exclusions of coverage for all non-authorized out-of-network services

Step 2 – Identify the factors used to determine that Out-Of-Network Coverage Standards will apply to mental health or substance use disorder benefits and medical or surgical benefits

Plans have broad discretion to select and define factors for determining how to design and apply Out-of-Network Coverage Standards, though limits on OON coverage must comply with federal and state laws and guidance, particularly for Medicaid programs. Examples of factors include:

- The treatment or service is Medically Necessary
    - NOTE: strategies and processes for making the Medical Necessity determination itself may be analyzed under a separate NQTL, e.g. Prior Authorization or Concurrent Review
- No contracted providers are available to deliver the service, including any definitions the used to determine "availability" (e.g. with regard to cultural competence)
- A member who is presently located outside the service area requires services
- Treatment by an OON provider with whom the member has an existing treatment provider relationship is necessary to ensure continuity of care in transitioning to an in-network provider
- Urgent or emergency treatments and services

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 Out-Of-Network Coverage Standards 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 authorization request or claim for OON coverage will be approved. 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:

- Plan data regarding network adequacy and/or in-network provider availability
- Medical management system data regarding the member's treatment needs and/or existing provider relationships

Step 4 – Provide comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply Out-Of-Network Coverage Standards 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 Out-Of-Network Coverage Standards to medical or surgical benefits in the benefits classification

Step 4(a): Briefly describe the processes by which Out-of-Network Coverage Standards are applied.

Provide a brief description of each step of the processes by which Out-of-Network Coverage Standards are applied. This should include descriptions of any documented policies and procedures for the processes used to make the OON coverage 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 apply Out-of-Network Coverage Standards ("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.

This analysis may include discussion of relevant:

- Timelines and deadlines for making an OON coverage determination
- Processes to determine the Medical Necessity of the service
- Processes to verify the lack of availability of in-network treatment providers

Authorization processes based on Medical Necessity (prior, concurrent, and/or retrospective) that are described and analyzed under another NQTL and are applied in the same manner to OON coverage determinations may be incorporated here by reference. However, administrative approval processes not based on Medical Necessity that occur before, during, or after the service delivery (such as processes to verify the lack of availability of in-network treatment providers) should be described.

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 any differences between the process of applying Out-of-Network Coverage Standards to MH/SUD benefits 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 Out-of-Network Coverage Standards

This analysis should include a discussion of the quality assurance and oversight processes and metrics that the plan applies to its Out-of-Network Coverage Standards.

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

- Denial rates for OON coverage requests
- Internal audits of OON coverage determinations

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: Geographic Restrictions

Classification(s): separate analyses should be submitted for each classification of benefits for which coverage limits are applied based on Geographic Restrictions.

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding Geographic Restrictions 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 "Geographic Restrictions"

"Geographic Restrictions" means coverage limits based only on the geographic location of the provider, such as limits on coverage for treatments and services delivered by out-of- area or out-of-state providers on an in-person (non-telehealth) basis, where such limit is applied differently to MH/SUD providers from the application to M/S providers.

Geographic Restrictions does not include limits on coverage for out-of-network services that are analyzed under the out-of-network benefit classifications for other reported NQTLs.

NOTE: if all Geographic Restrictions apply to all MH/SUD and M/S benefits, without regard to the condition being treated, the Plan may indicate "N/A" for this NQTL.

NOTE: if no limits or exclusions based on the geographic location of the provider are applied that are not analyzed under another NQTL analysis, the Plan may indicate "N/A" for this NQTL.

NOTE: Medicaid Managed Care Organizations that do not apply any Geographic Restrictions that are not addressed their Out-of-Network Coverage Standards NQTL analysis may indicate "N/A" for this NQTL.

Step 1(b): Identify the Geographic Restrictions that are applied to the Plan's coverage

Identify all limits on coverage that are based on Geographic Restrictions. For example, the Plan may apply:

- Pre-service notice or administrative approval of all non-emergent out-of-area services for identified MH/SUD benefits

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

If only specific benefits are subject to Geographic Restrictions, the factors used to determine which benefits are subject to Geographic Restrictions should be listed here. 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 exclusions based on Geographic Restrictions to a given benefit. Examples of selection factors and definitions include:

- The treatment or service is determined to be Medically Necessary
    - NOTE: strategies and processes for making the Medical Necessity determination itself may be analyzed under a separate NQTL, e.g. Prior Authorization or Concurrent Review
- No contracted providers are available within the service area to deliver the service, including any definitions for:
    - the geographic area within which in-network provider availability is assessed
    - the capacity of in-area providers to accept new patients
    - acceptable appointment wait times for in-area providers
- A member who is presently located outside the service area requires services
- Treatment by an out-of-area provider with whom the member has an existing treatment provider relationship is necessary to ensure continuity of care in transitioning to an in-area provider
- Urgent or emergency treatments and services

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 Geographic Restrictions 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:

- Plan data regarding in-area network adequacy and/or provider availability
- Medical management system data regarding the member's treatment needs and/or existing provider relationships

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

Step 4(a): Briefly describe the processes by which Geographic Restrictions are applied.

Provide a brief description of each step of the processes by which Geographic Restrictions are applied. This should include descriptions of any documented policies and procedures for the processes used to make the OON coverage 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 apply Geographic Restrictions ("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.

This analysis may include discussion of relevant:

- Timelines and deadlines for making coverage determinations for benefits subject to Geographic Restrictions
- Processes to determine the Medical Necessity of the service
- Processes to verify the lack of availability of in-area treatment providers

Authorization processes based on Medical Necessity (prior, concurrent, and/or retrospective) that are described and analyzed under another NQTL and are applied in the same manner to OON coverage determinations may be incorporated here by reference. However, administrative approval processes not based on Medical Necessity that occur before, during, or after the service delivery (such as processes to verify the lack of availability of in-area treatment providers) should be described.

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 any differences between the process of applying Geographic Restrictions to MH/SUD benefits 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 Geographic Restrictions

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

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

- Denial rates based on Geographic Restrictions
- Internal audits of coverage determinations based on Geographic Restrictions

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: Blanket Exclusions of Services

Classification(s):

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding Blanket Exclusions of Services 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 Blanket Exclusions of Services:

"Blanket Exclusions of Services" means exclusions of benefits that apply uniformly to all claims or service requests for identified services for all Plan beneficiaries, with no consideration of Medical Necessity or other factors.

"Blanket Exclusions of Services" excludes Experimental/Investigational Determinations, Exclusions for Court-Ordered Treatment or Involuntary Holds, Provider-Type Exclusions, Out-of-Network Coverage Standards, and Geographic Restrictions.

Step 1(b): Identify the M/S benefits/services for which a Blanket Exclusions of Services is required:	***Step 1(b): Identify the MH/SUD benefits/services for which a Blanket Exclusion of Services is required***:
Step 2 – Identify the factors used to determine that Blanket Exclusions of Services will apply to mental health or substance use disorder benefits and medical or surgical benefits	
Step 2: Identify the factors used to determine which M/S benefits are subject to a Blanket Exclusion of Services	***Step 2: Identify the factors used to determine which MH/SUD benefits are subject to a Blanket Exclusion of Services***
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 Blanket Exclusions of Services to mental health or substance use disorder benefits and medical or surgical benefits.	
Step 3: Identify the evidentiary standards and sources applied to the factors listed for M/S benefits in Step 2	***Step 3: Identify the evidentiary standards and sources applied to the factors listed for MH/SUD benefits in Step 2***

Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs 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 Blanket Exclusions of Services to medical or surgical benefits in the benefits classification	
Step 4(a) Where some but not all benefits in a classification are subject to a Blanket Exclusion of Services, identify which of the factor(s) in Step 3 were met for each M/S benefit.	***Step 4(a) Where some but not all benefits in a classification are subject to a Blanket Exclusion of Services, identify which of the factor(s) in Step 3 were met for each MH/SUD benefit.***
Step 4(b) : Identify and define the factors and processes that are used to monitor and evaluate the application of Blanket Exclusions of Services for M/S benefits:	***Step 4(b) : Identify and define the factors and processes that are used to monitor and evaluate the application of Blanket Exclusions of Services for MH/SUD benefits***:
Step 4(c): Identify and define the factors and processes that are used to monitor and evaluate the application of Blanket Exclusions of Services:	***Step 4(c): Identify and define the factors and processes that are used to monitor and evaluate the application of Blanket Exclusions of Services***:
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	

NQTL: Exclusions for Court-Ordered Treatment or Involuntary Holds

Classification(s):

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding Exclusions for Court-Ordered Treatment or Involuntary Holds 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 Exclusions for Court-Ordered Treatment or Involuntary Holds:

Exclusions for Court-Ordered Treatment or Involuntary Holds (COT Exclusions) is defined to mean an exclusion of coverage for all court-ordered treatment or involuntary holds for all Plan beneficiaries, with no consideration of Medical Necessity or other factors.

COT Exclusions do not include Blanket Exclusions of Services, Experimental/ Investigational Determinations, Provider-type Exclusions, Out-of-Network Coverage Standards, or Geographic Restrictions.

Step 1(b): Identify the M/S benefits/services for which Exclusions for Court-Ordered Treatment or Involuntary Holds are required:	***Step 1(b): Identify the MH/SUD benefits/services for which Exclusions for Court-Ordered Treatment or Involuntary Holds are required***:

Step 2 – Identify the factors used to determine that Exclusions for Court-Ordered Treatment or Involuntary Holds will apply to mental health or substance use disorder benefits and medical or surgical benefits

Step 2: Identify the factors used to determine which M/S <u>benefits</u> are subject to Exclusions for Court-Ordered Treatment or Involuntary Holds	***Step 2: Identify the factors used to determine which MH/SUD <u>benefits</u> are subject to Exclusions for Court-Ordered Treatment or Involuntary Holds***

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 Exclusions for Court-Ordered Treatment or Involuntary Holds to mental health or substance use disorder benefits and medical or surgical benefits.

Step 3: Identify the evidentiary standards and sources applied to the factors listed for M/S benefits in Step 2	***Step 3: Identify the evidentiary standards and sources applied to the factors listed for MH/SUD benefits in Step 2***
Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs 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 Exclusions for Court-Ordered Treatment or Involuntary Holds to medical or surgical benefits in the benefits classification	
Step 4(a) Where some but not all benefits in a classification are subject to Exclusions for Court-Ordered Treatment or Involuntary Holds, identify which of the factor(s) in Step 3 were met for each M/S benefit.	***Step 4(a) Where some but not all benefits in a classification are subject to Exclusions for Court-Ordered Treatment or Involuntary Holds, identify which of the factor(s) in Step 3 were met for each MH/SUD benefit.***
Step 4(b) : Identify and define the factors and processes that are used to monitor and evaluate the application of Exclusions for Court-Ordered Treatment or Involuntary Holds for M/S benefits:	***Step 4(b) : Identify and define the factors and processes that are used to monitor and evaluate the application of Exclusions for Court-Ordered Treatment or Involuntary Holds for MH/SUD benefits***:
Step 4(c): Identify and define the factors and processes that are used to monitor and evaluate the application of Exclusions for Court-Ordered Treatment or Involuntary Holds:	***Step 4(c): Identify and define the factors and processes that are used to monitor and evaluate the application of Exclusions for Court-Ordered Treatment or Involuntary Holds***:
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	

NQTL: Provider Type Exclusions

Classification(s):

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding Provider Type Exclusions 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 Provider Type Exclusions:

"Provider-Type Exclusions" (PT Exclusions) means exclusions of coverage for all covered services by any provider of a licensed healthcare provider type, as the provider type is defined by the Plan, without regard to Member-specific considerations such as the Medical Necessity of the service.

Provider-Type Exclusions do not include Experimental/Investigational Determinations, Blanket Exclusions of Services, Exclusions for Court-Ordered Treatment or Involuntary Holds, Out-of-Network Coverage Standards, and Geographic Restrictions.

Step 1(b): Identify the M/S benefits/services for which Provider Type Exclusions are required:	***Step 1(b): Identify the MH/SUD benefits/services for which Provider Type Exclusions are required***:

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

Step 2: Identify the factors used to determine which M/S benefits are subject to Provider Type Exclusions	***Step 2: Identify the factors used to determine which MH/SUD benefits are subject to Provider Type Exclusions***

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 Provider Type Exclusions to mental health or substance use disorder benefits and medical or surgical benefits.

Step 3: Identify the evidentiary standards and sources applied to the factors listed for M/S benefits in Step 2	***Step 3: Identify the evidentiary standards and sources applied to the factors listed for MH/SUD benefits in Step 2***
Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs 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 Provider Type Exclusions to medical or surgical benefits in the benefits classification	
Step 4(a) Where some but not all benefits in a classification are subject to Provider Type Exclusions, identify which of the factor(s) in Step 3 were met for each M/S benefit.	***Step 4(a) Where some but not all benefits in a classification are subject to Provider Type Exclusions, identify which of the factor(s) in Step 3 were met for each MH/SUD benefit.***
Step 4(b) : Identify and define the factors and processes that are used to monitor and evaluate the application of Provider Type Exclusions for M/S benefits:	***Step 4(b) : Identify and define the factors and processes that are used to monitor and evaluate the application of Provider Type Exclusions for MH/SUD benefits***:
Step 4(c): Identify and define the factors and processes that are used to monitor and evaluate the application of Provider Type Exclusions:	***Step 4(c): Identify and define the factors and processes that are used to monitor and evaluate the application of Provider Type Exclusions***:
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	

NQTL: Out-Of-Network Coverage Standards

Classification(s):

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding Out-Of-Network Coverage Standards 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 Out-Of-Network Coverage Standards*:**

"Out-of-Network Coverage Standards" means the standards and processes used by the Plan to authorize coverage for treatments and services delivered by out-of-network providers.

Step 1(b): Identify the M/S benefits/services for which Out-Of-Network Coverage Standards is required:	***Step 1(b): Identify the MH/SUD benefits/services for which Out-Of-Network Coverage Standards is required***:

Step 2 – Identify the factors used to determine that Out-Of-Network Coverage Standards will apply to mental health or substance use disorder benefits and medical or surgical benefits

Step 2: Identify the factors used to determine whether M/S <u>benefits</u> are subject to Out-Of-Network Coverage Standards	***Step 2: Identify the factors used to determine whether MH/SUD <u>benefits</u> are subject to Out-Of-Network Coverage Standards***

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 Out-Of-Network Coverage Standards to mental health or substance use disorder benefits and medical or surgical benefits.

Step 3: Identify the evidentiary standards and sources applied to the factors listed for M/S benefits in Step 2	***Step 3: Identify the evidentiary standards and sources applied to the factors listed for MH/SUD benefits in Step 2***

Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs 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 Out-Of-Network Coverage Standards to medical or surgical benefits in the benefits classification

Step 4(a) : Identify and define the factors and processes that are used to monitor and evaluate the application of Out-Of-Network Coverage Standards for M/S benefits:	***Step 4(a) : Identify and define the factors and processes that are used to monitor and evaluate the application of Out-Of-Network Coverage Standards for MH/SUD benefits***:
Step 4(b): Identify and define the factors and processes that are used to monitor and evaluate the application of Out-Of-Network Coverage Standards:	***Step 4(b): Identify and define the factors and processes that are used to monitor and evaluate the application of Out-Of-Network Coverage Standards***:
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	

NQTL: Geographic Restrictions

Classification(s):

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding Geographic Restrictions 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 Geographic Restrictions:

"Geographic Restrictions" means coverage limits based only on the geographic location of the provider, such as limits on coverage for treatments and services delivered by out-of-area or out-of-state providers on an in-person (non-telehealth) basis, where such limit is applied differently to MH/SUD providers from the application to M/S providers.

Geographic Restrictions does not include limits on coverage for out-of-network services that are analyzed under the out-of-network benefit classifications for other reported NQTLs.

Step 1(b): Identify the M/S benefits/services for which Geographic Restrictions is required:	***Step 1(b): Identify the MH/SUD benefits/services for which Outlier Management is required***:

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

Step 2: Identify the factors used to determine whether M/S <u>benefits</u> are subject to Geographic Restrictions	***Step 2: Identify the factors used to determine whether MH/SUD <u>benefits</u> are subject to Geographic Restrictions***

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 Geographic Restrictions to mental health or substance use disorder benefits and medical or surgical benefits.

Step 3: Identify the evidentiary standards and sources applied to the factors listed for M/S benefits in Step 2	***Step 3: Identify the evidentiary standards and sources applied to the factors listed for MH/SUD benefits in Step 2***
Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs 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 Geographic Restrictions to medical or surgical benefits in the benefits classification	
Step 4(a) : Identify and define the factors and processes that are used to monitor and evaluate the application of Geographic Restrictions for M/S benefits:	***Step 4(a) : Identify and define the factors and processes that are used to monitor and evaluate the application of Geographic Restrictions for MH/SUD benefits***:
Step 4(b): Identify and define the factors and processes that are used to monitor and evaluate the application of Geographic Restrictions:	***Step 4(b): Identify and define the factors and processes that are used to monitor and evaluate the application of Geographic Restrictions***:
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	

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

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 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 Failure to Complete 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 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.

NQTL: Concurrent Review

Classification(s):

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 services 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 service 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.

Step 1(b): Identify the M/S benefits/services for which Concurrent Review is required:	***Step 1(b): Identify the MH/SUD benefits/services for which Concurrent Review is required***:

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

Medical/Surgical:	**MH/SUD**:

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.

Medical/Surgical:	**MH/SUD**:
Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs 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 in the benefits classification	
Step 4(a): For each M/S benefit subject to Concurrent Review, identify which of the factor(s) in Step 3 were met:	***Step 4(a): For each MH/SUD benefit subject to Concurrent Review, identify which of the factor(s) in Step 3 were met***:
Step 4(b): Briefly describe the processes by which Concurrent Review is applied to M/S benefits: *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*:	***Step 4(b): Briefly describe the processes by which Concurrent Review is applied to MH/SUD benefits***: *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:	*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 qualifications for reviewers*:
Minimum standards to issue a denial (e.g. sign-off from a physician with relevant board certification):	*Minimum standards to issue a denial (e.g. sign-off from a physician with relevant board certification)*:
Step 4(c) : Identify and define the factors and processes that are used to monitor and evaluate the application of Concurrent Review for M/S benefits:	***Step 4(c) : Identify and define the factors and processes that are used to monitor and evaluate the application of Concurrent Review for MH/SUD benefits***:

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

NQTL: Retrospective Review

Classification(s):

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 sevice 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.

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 M/S <u>claims</u> are subject to Retrospective Review	*Identify the factors used to determine which MH/SUD <u>claims</u> are 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 for M/S benefits in Step 2(b)	*Identify the evidentiary standards and sources applied to the factors listed for MH/SUD benefits in Step 2(b)*

Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs 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) : Identify and define the factors and processes that are used to monitor and evaluate the application of Retrospective Review for M/S benefits:	***Step 4(a) : Identify and define the factors and processes that are used to monitor and evaluate the application of Retrospective Review for MH/SUD benefits***:
Timelines and deadlines for completing the Medical Necessity review and adjudication of the claim:	*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:	*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:	*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	*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*

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

NQTL: Outlier Management

Classification(s):

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

Step 1(a): 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.

Step 1(b): Identify the M/S benefits/services for which Outlier Management is required:	***Step 1(b): Identify the MH/SUD benefits/services for which Outlier Management is required***:

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

Step 2: Identify the factors used to determine which M/S benefits are subject to Outlier Management	***Step 2: Identify the factors used to determine which MH/SUD benefits are 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.

Step 3: Identify the evidentiary standards and sources applied to the factors listed for M/S benefits in Step 2	***Step 3: Identify the evidentiary standards and sources applied to the factors listed for MH/SUD benefits in Step 2***
Step 4 – Provide the comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs 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) : Identify and define the factors and processes that are used to monitor and evaluate the application of Outlier Management for M/S benefits:	***Step 4(a) : Identify and define the factors and processes that are used to monitor and evaluate the application of Outlier Management for MH/SUD benefits***:
Step 4(b): Identify and define the factors and processes that are used to monitor and evaluate the application of Outlier Management:	***Step 4(b): Identify and define the factors and processes that are used to monitor and evaluate the application of Outlier Management***:
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	

NQTL: Failure to Complete

Classification(s):

Step 1 – Identify the specific plan or coverage terms or other relevant terms regarding the Failure to Complete NQTL 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 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.

Step 1(b): Identify the M/S benefits/services for which the Failure to Complete NQTL is applied:	***Step 1(b): Identify the MH/SUD benefits/services for which the Failure to Complete NQTL is applied:***

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

Medical/Surgical:	**MH/SUD**:

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.

Medical/Surgical:	**MH/SUD**:
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 NQTLs to medical or surgical benefits in the benefits classification	
Step 4(a): For each M/S benefit subject to the Failure to Complete NQTL, identify which of the factor(s) in Step 3 were met:	***Step 4(a): For each MH/SUD benefit subject to the Failure to Complete NQTL, identify which of the factor(s) in Step 3 were met***:
Step 4(b): Briefly describe the processes by which the Failure to Complete NQTL is applied to M/S benefits: *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*:	***Step 4(b): Briefly describe the processes by which the Failure to Complete NQTL is applied to MH/SUD benefits***: *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:	*Minimum qualifications for reviewers:*
Step 4(c) : Identify and define the factors and processes that are used to monitor and evaluate the application of Failure to Complete for M/S benefits:	***Step 4(c) : Identify and define the factors and processes that are used to monitor and evaluate the application of Failure to Complete for MH/SUD benefits***:
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	