NQTL: Concurrent Review

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

Step 1 - In Writing: Define Concurrent Review

Define "Concurrent Review" 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 Concurrent Review may implicitly or explicitly distinguish among several related concepts or functions that may be required concurrent to the delivery of the services, including determination of the Medical Necessity of additional days or services beyond a pre-determined period or existing authorization.

The present analysis should focus specifically on Concurrent Review, as defined by the Plan in this Step, 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. However, this note does not apply to step 5, "In Operation". The plan must complete a separate step 5 In Operation analysis that demonstrates that the plan has performed and summarized analyses of the relevant in operation processes that occur during concurrent review. This is necessary because even if the processes are identical in nature to those that occur during prior authorization, it is important to determine if the actual operationalization of those processes are comparable and applied no more stringently for MH/SUD as compared to M/S during concurrent review. -

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

Step 2 - In Writing: 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 3 - In Writing: Identify and define the factors used to determine which benefits are subject to Concurrent Review

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 Concurrent Review to a given benefit. Examples of selection factors and definitions 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

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 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 services. 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 - In Writing: 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.

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 5 - In Operation: 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 ~~PA~~ 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 6 - In Operation: 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 intemal 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.

NQTL: Retrospective Review

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

Step 1 - In Writing: Define Retrospective Review

Define "Retrospective Review" 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 Retrospective Review should focus on processes, factors, and evidentiary standards that are used to approve or deny a claim based on the Medical Necessity of the service, generally relying on clinical judgment based on the medical record. This may include claims that are flagged for review through an administrative process that is analyzed under Outlier Management.

For example, a Plan could define Retrospective Review to be a utilization management process to ensure that the quantity and/or intensity of the service was Medically Necessary at a time that is subsequent to the service delivery, for benefits and claims not subject to ~~Concurrent Review~~Prior authorization or Concurrent Review. The Plan's definition for Retrospective Review could distinguish and exclude administrative claims analyses and post-service denials that do not involve clinical determinations of Medical Necessity.

The present analysis should focus specifically on Retrospective Review, 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: If the Plan does not implement Retrospective 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. However, if selecting the option to indicate N/A, please make sure that the factors identified in step 3 used to apply RR are in fact the same factors that used to apply PA before selecting N/A.

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 - In Writing: Identify the benefits and/or services for which Retrospective Review is applied

List all benefits, services, and/or types of claims for which Retrospective Review is applied. This list may be provided as a link or attachment if desired.

If all benefits are subject to Retrospective Review as long as the claim meets the factors identified in Step 3, then the Plan may simply state "all" for Step 2.

Alternatively, if the Plan applies Retrospective Review by benefit type—i.e. if the Plan applies Retrospective Review to claims for some benefits within a classification but not for other benefits—then the benefits for which Retrospective Review may be applied should be listed.

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

- If the Plan applies Retrospective Review to <u>all</u> MH/SUD benefits, services, and/or types of claims but <u>not all</u> 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 Retrospective Review to <u>some</u> MH/SUD benefits, services, and/or types of claims but <u>not to any</u> 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 3 - In Writing: Identify and define the factors used to determine which benefits and/or claims are subject to Retrospective Review

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

(a) **Identify and define the factors used to determine which *benefits* are subject to Retrospective Review**

If the Plan applies Retrospective Review to claims for some benefits but not others, then the Plan must identify the selection factors and definitions that are used to identify the benefits for which claims may be subject to Retrospective Review.

Examples of selection factors and definitions that may be used to identify benefits include:

- Reimbursement type (e.g. benefits reimbursed on the basis of Diagnosis Related Group)
- 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

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

NOTE: if the Plan applies Retrospective Review to all benefits in the classification, as long as the claims meet certain factors, then it is not necessary to explain why all benefits in the classification are subject to Retrospective Review, and Step 3(a) may be marked "N/A."

(b) **Identify and define 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

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. Representative examples of data sources include but are not limited to:

- Claims data
- Medical management system data
- Medical and/or coverage policies, including those licensed from a third-party vendor
- Outlier management policies

NOTE: if the Plan applies Retrospective Review to all claims for the benefits identified in Step 3(a), then it is not necessary to explain why all claims for those benefits are subject to Retrospective Review, and Step 3(b) may be marked "N/A."

Step 4 - In Writing: Where some but not all benefits in a classification are subject to Retrospective Review, identify which of the factor(s) in Step 3(a) were met for each benefit.

Where some but not all benefits in a classification meet the factors identified in step 3(a), 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 Retrospective Review on a benefit-by-benefit basis.

NOTE: If the Plan indicates in Step 3(a) that all benefits in the classification are subject to Retrospective Review, then Step 4 may be marked "N/A." Step 4 may also be marked "N/A" with regard to the claims review factors listed in Step 3(b).

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.

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(a). 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 5 - In Operation: 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 6 - In Operation: 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.

NQTL: Outlier Management

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

Step 1 - In Writing: Define Outlier Management

Define "Outlier Management" 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 Outlier Management should focus on processes, factors, and evidentiary standards based on administrative review of payment claims and related administrative records that are used to approve or deny a claim, or to forward the claim for a clinical review of the Medical Necessity of the service through a Retrospective Review process.

For example, a Plan could define Outlier Management to be an administrative review process that includes analyses of payment claims to ensure that service coding, charges, and other claims information are appropriate and to identify and deter fraud, waste, and abuse. The Plan's definition for Outlier Management could distinguish and exclude processes to make clinical determinations of Medical Necessity.

The present analysis should focus specifically on Outlier Management, 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: 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 - In Writing: Identify the benefits and/or services for which Outlier Management is applied

List all benefits and/or services for which Outlier Management is applied. This list may be provided as a link or attachment if desired.

If all benefits are subject to Outlier Management as long as the claim meets the factors identified in Step 3, then the Plan may simply state "all" for Step 2.

Alternatively, if the Plan applies Outlier Management to claims for some benefits within a classification but not others, then the benefits for which Outlier Management may be applied should be listed.

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 3 - In Writing: Identify and define the factors used to determine which benefits and/or 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 benefit and/or claim. However, each factor must be defined with sufficient precision to determine whether a given benefit and/or 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

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. Representative examples of data sources include but are not limited to:

- 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 - In Writing: Where some but not all benefits in a classification are subject to Outlier Management, identify which of the factor(s) in Step 3 were met for each benefit.

Where some but not all benefits in a classification meet the factors identified in step 3, 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 Outlier Management on a benefit-by-benefit basis.

NOTE: If the Plan indicates in Step 3 that all benefits in the classification are subject to Outlier Management, then Step 4 may be marked "N/A."

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.

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 5 - In Operation: 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 6 - In Operation: 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.

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 - In Writing: Define "Failure to Complete"

Define "Failure to Complete" as applied by the Plan to benefits in this classification. The Plan's definition should focus on exclusions of further coverage for a benefit or service due to the patient's Failure to Complete a course of treatment.

Plans may distinguish Failure to Complete exclusions from 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. If such assessments are done as part of a Prior Authorization and/or Concurrent Review process, they should be included on those NQTL analyses.

Step 2 - In Writing: Identify the benefits/services for which exclusions based on Failure to Complete are applied

List all benefits in this classification that are subject to Failure to Complete. 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 3 - In Writing: Identify and define the factors used to determine which benefits are subject to Failure to Complete

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 Failure to Complete 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

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:

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

Step 4 - In Writing: For each benefit subject to Failure to Complete, 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 Failure to Complete 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 5 - In Operation: Briefly describe the processes by which Failure to Complete is applied.

Provide a brief description of each step of the processes by which the Failure to Complete exclusion 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 Failure to Complete processes for MH/SUD relative to M/S benefits.

Step 6 - In Operation: Identify and define the factors and processes that are used to monitor and evaluate the application of Failure to Complete

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

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.