HFS

Illinois Department of
Healthcare and Family Services

2024 Mental Health Parity Analysis Summary Report

December 2025

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Overview

Certain mental health and substance use disorder parity provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) apply to the coverage provided to the enrollees of the Medicaid program and Children's Health Insurance Program (CHIP) to ensure that financial requirements (such as copays and coinsurance) and treatment limitations (such as visit limits) on mental health and substance use disorder benefits generally are no more restrictive than the requirements and limitations that apply to medical and surgical benefits in these programs. In accordance with the MHPAEA and its implementing regulations (including Title 42 of the Code of Federal Regulations [CFR] Parts 438, 440, and 457; and 45 CFR Part 146.136) and Illinois statute 215 ILCS 5/370c.1,[1] the Illinois Department of Healthcare and Family Services (HFS) and Department of Insurance (DOI) complete oversight activities related to compliance with the State and federal parity laws.

To meet Mental Health Parity (MHP) requirements in 42 CFR §438 Subpart K and Illinois statute 215 ILCS 5/370c.1, HFS contracted with Health Services Advisory Group, Inc. (HSAG), to conduct a MHP analysis of all HealthChoice Illinois health plans (health plans). The purpose of the review is to provide meaningful information to HFS, DOI, and the health plans regarding the evaluation of each health plan's processes to ensure compliance with MHPAEA requirements.

For each health plan, HSAG made a determination as to whether the health plan demonstrated how it designs and applies nonquantitative treatment limitations (NQTLs), both as written and in operation, for mental, emotional, nervous, or substance use disorder or condition (MH/SUD) benefits as compared to how it designs and applies NQTLs, as written and in operation, for medical and surgical (M/S) benefits. This report provides a summary of the findings from the 2024 MHP Analysis across all health plans.

Methodology

HSAG collaborated with HFS to define the scope of the MHP review to include applicable federal and State regulations and laws and the requirements set forth in the contract, as they relate to the scope of the review. HSAG developed a protocol and tools in alignment with guidance outlined in the toolkit provided by the Centers for Medicare & Medicaid Services (CMS): *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*.[2]

[1] Illinois General Assembly. Illinois Compiled Statutes, 215 ILCS 5/370c.1. Available at: https://www.ilga.gov/Documents/legislation/ilcs/documents/021500050K370c.1.htm. Accessed on: Sep 19, 2025.

[2] The CMS *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs* and additional CMS resources related to MHP are available at https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/parity/index.html. Accessed on: June 16, 2022.

The MHP analysis consisted of:

- Review of the health plans' NQTL Reports and comparative analyses, which were submitted to HFS on September 2, 2025.
- Review of the health plans' utilization management (UM) policies, procedures, and information.
- Analysis of M/S and MH/SUD prior authorization (PA) denial data, which are self-reported to HFS.
- File review of adverse benefit determination (ABD) records encompassing both M/S and MH/SUD denials.

Table 1-1 lists the health plans included in the 2024 MHP Analysis and the associated health plan abbreviations.

Table 1-1—List of Health Plan Names and Abbreviations

Health Plan Name	Health Plan Abbreviation
HealthChoice Health Plans	
Aetna Better Health of Illinois	Aetna
Blue Cross Community Health Plans	BCBSIL
CountyCare	CountyCare
Meridian	Meridian
Molina Healthcare of Illinois	Molina
Specialty Foster Care Plan	
YouthCare Specialty Plan	YouthCare

Results

HSAG used the results of all components assessed to determine final parity ratings of *Compliant*, *Partially Compliant*, and *Not Compliant* to indicate the degree to which each health plan's performance was compliant with parity requirements. Detailed information regarding the methodology is included in Section 2 of this report.

Overall, HSAG determined that the health plans demonstrated parity between M/S and MH/SUD services, with opportunity for improvement related to comparative analyses documentation. Implementation of the health plans' processes demonstrated compliance with State and federal MHP requirements and standards, as demonstrated in Table 1-2.

Table 1-2—Overall MHP Assessment Rating

Health Plan	Comparative Analyses Review	Percentage of Denials Deviation Rating	ABD File Review Compliance	Final Parity Rating
Aetna	*Partially Compliant*	*Moderate*	100%	*Partially Compliant*
BCBSIL	*Partially Compliant*	*Substantial*	100%	*Partially Compliant*
CountyCare	*Compliant*	*Moderate*	100%	*Compliant*
Meridian	*Partially Compliant*	*None*	100%	*Partially Compliant*
Molina	*Partially Compliant*	*None*	100%	*Partially Compliant*
YouthCare	*Partially Compliant*	*None*	100%	*Partially Compliant*

Of the six health plans, only CountyCare received a final parity rating of *Compliant*. The remaining health plans that received a rating of *Partially Compliant* demonstrated that they had the systems and processes in place to effectively compile and analyze data and information related to parity. However, those health plans had an opportunity for improvement related to supplying HFS with thorough, quantitative summaries necessary to provide evidence of their ability and efforts to assess the design, development, and/or application of the NQTLs. While the lack of complete information narratively included in comparative analyses does not necessarily indicate concerns with parity, it raises questions about the health plans' thoroughness in analyzing all available data and information when determining whether their processes meet comparability and stringency requirements.

Detailed results for each health plan are included in Appendix A.

Recommendations

Based on the results of the MHP analysis, HSAG offered the following recommendations.

- HFS should provide its review findings related to completeness of NQTL comparative analyses to the health plans that demonstrated opportunities for improvement. The health plans must implement actions to ensure that future comparative analyses address HFS' findings and include consistent and thorough documentation that provides qualitative and quantitative evidence of all efforts to ensure MHP.
- HFS should consider inclusion of access-related data and information in future reviews.
  - HFS should consider review of access-related grievances to identify potential areas of opportunity related to the availability of MH/SUD providers within each health plan's network.
  - HFS should continue using appointment availability surveys to evaluate enrollees' access to providers and whether access demonstrates parity. HSAG also recommends incorporating encounter data to assess enrollees' utilization of services to identify the active provider network and assess whether access to care among those providers actively delivering services to enrollees still meets the defined access standards for both M/S and MH/SUD.

- HFS should develop and select special investigation topics for future single-year analyses. Qualitative assessments and frameworks should be incorporated alongside quantitative assessments as necessary and appropriate for MHP evaluation.

2. Methodology

The 2024 MHP Analysis identified and addressed differences between the policies and standards governing limitations applied to MH/SUD services compared to M/S services. Differences in how limits were applied to MH/SUD services as compared to M/S services were evaluated for continued compliance with MHP regulations to ensure evidence-based, quality MH/SUD care.

Process

The 2024 MHP Analysis activities are illustrated in Figure 2-1 and described below.

Figure 2-1—2024 MHP Analysis Activities

Activity 1: Desk Review

HFS provided HSAG with each health plan's response to HFS' NQTL Reports and health plan self-reported PA authorization approval and denial data. HSAG leveraged documents from each health plan's administrative compliance review to inform HSAG's review team of each health plan's internal processes for management of NQTLs, including its UM policies, procedures, and information.

Definitions referenced by HSAG during the desk review process are included in Appendix B.

A description of HSAG's process to perform desk review is detailed in Table 2-1.

Table 2-1—Activity 1: Perform Desk Review

For this step,	HSAG will…
Step 1:	**Receive health plan documentation.**
	HSAG receives comparative analyses from HFS, and leverages health plan administrative compliance review UM submissions.

For this step,	HSAG will…
Step 2:	**Receive policy and procedure documentation and data.**
	HSAG reviews all documentation submitted.
Step 3:	**Conduct reviews of health plan policies and procedures.**
	This includes review of all documents provided by the health plans and HFS.

Quarterly Business Review (QBR) Data Assessment

The health plans self-report data related to M/S and MH/SUD PA approvals and denials to HFS. These data are reported for, and limited to, overall medical[3] and behavioral health categories and are not segmented by benefit classification. HSAG analyzed the health plans' data to determine parity between M/S and MH/SUD denials. Analyses included Chi-square to determine if there was association between denial rates, and evaluation of the extent to which UM metrics differed between M/S and MH/SUD services. HSAG used deviation ratings of *None*, *Moderate*, and *Substantial*, as defined in Table 2-2, to indicate the degree to which each health plan's reported metrics differed across MH/SUD and M/S services.

Table 2-2—Deviation Rating Definitions

Rating	Definition
None	Difference between MH/SUD and M/S metric is **less than** 5 percentage points.
Moderate	Difference between MH/SUD and M/S metric is: • **Greater than or equal** to 5 percentage points, and • **Less than** 10 percentage points.
Substantial	Difference between MH/SUD and M/S metric is **greater than or equal to** 10 percentage points.

Activity 2: File Review

HSAG leveraged the results of each health plan's administrative compliance file review of 2024 denials to evaluate components of PA authorization decisions. HSAG's file review process is described in Table 2-3.

[3] Medical denials, as defined by the HFS Monthly Progress Report (MPR) Playbook, include Non-Behavioral Health, Nursing Facility, Rehab, Durable Medical Equipment, Home Health, Imaging, and Pain Management. Definitions are included in Appendix B.

Table 2-3—Activity 2: Conduct File Review

For this step,	HSAG will…
Step 1:	**Leverage the results of administrative denials file reviews.**
	HSAG conducted file reviews of health plan denials as a component of administrative compliance reviews conducted in 2025. The MHP review leveraged the results of those file reviews to inform the MHP report.
Step 2:	**Analyze results of elements related to timeliness of decisions and readability of ABD enrollee letters.**
	HSAG evaluated the results of the compliance review file reviews, which were assessed for compliance against the following elements: • The ABD notice was sent within the required time frame. • The ABD notice met the readability protocol. HSAG identified health plan successes and/or opportunities for improvement.

Activity 3: Compile and Analyze Findings

HSAG documented components of the review and the final compliance determinations for each health plan.

HSAG used the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant*, as defined in Table 2-4, to indicate the degree to which each health plan's performance was compliant with parity requirements, based on whether the organization's procedures and results affected the comparability and stringency of processes, strategies, or evidentiary standards used in administering MH/SUD and M/S benefits. This scoring methodology aligned with CMS' Parity Compliance Toolkit.[4]

Table 2-4—Rating Definitions of Compliance to MHP

Rating	Definition
Compliant	Indicates that the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency*.
Partially Compliant	Indicates that the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was: • *Comparable,* but were applied with different *stringency,* or • *Not comparable* but were applied with equivalent *stringency*.
Not Compliant	Indicates that the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *not comparable* and applied with different *stringency*.

[4] Centers for Medicare & Medicaid Services. Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs. Available at: https://www.apna.org/wp-content/uploads/2021/03/parity_toolkit_CMS.pdf. Accessed on: Sept 19, 2025.

Activity 4: Report Results

HSAG prepared a draft report that describes its MHP findings, the scores it assigned for each requirement, its assessment of the health plans' compliance, and recommendations for improvement. Following HFS' approval of the draft report, HSAG will issue the final report to HFS.

3. Results

HSAG derived 2024 MHP Analysis results from its assessment of information received from the health plans, including:

- Review of the health plans' MHP NQTL Reports and comparative analyses, which were submitted to HFS on September 2, 2025.
- Review of the health plans' UM policies, procedures, and information.
- Analysis of M/S and MH/SUD PA denial data, which are self-reported to HFS.
- File review of ABD records encompassing both M/S and MH/SUD denials.

Results Summary

Review of UM and MHP Procedures

Overall, documentation demonstrated that the health plans have established standardized processes to support the implementation of MH/SUD and M/S benefits, including pharmacy. Among the most prevalent treatment limitations were UM processes; medical necessity criteria; provider credentialing requirements; and drug utilization review mechanisms (e.g., formulary design, step therapy).

The health plans reported consistent use of appropriate clinical guidelines for UM decision-making, including:

- Physical Health: CMS National Coverage Determinations, MCG®, American Society of Addiction Medicine (ASAM®) Criteria, InterQual®, federal and State law and guidelines, internal clinical policies, professional standards or medical association publications, and peer-reviewed literature
- Behavioral Health: CMS National Coverage Determinations, MCG®, ASAM®, federal and State law and guidelines, internal clinical policies, professional standards or medical association publications, and peer-reviewed literature
- Pharmacy: State guidelines (including the Preferred Drug List [PDL]), the Food and Drug Administration (FDA), CMS-endorsed compendia, professional organization guidelines, clinical trials, and internal clinical policies

All six health plans demonstrated ongoing processes and procedures to analyze MHP. The health plans had MHP review teams including local health plan representatives, enterprise-level representatives, delegates, and outside legal counsel. Each health plan completed, minimally, an annual MHP analysis; none of the six health plans reported any opportunities for improvement resulting from the most recent analyses.

Review of HFS NQTL Comparative Analyses

NQTLs represent a key mechanism to manage and ensure members' health care is necessary and appropriate. To facilitate the comprehensive review of NQTLs implemented by the health plans, HFS provided the health plans with comparative analyses documents for the following NQTLs:

- Concurrent Review
- Experimental Investigation
- Formulary Tiering
- Medical Necessity Criteria
- Outlier Review
- Prior Authorization
- Reimbursement
- Retrospective Review
- Step Therapy

All six health plans provided their comparative analyses for the selected NQTLs. Table 3-1 presents HSAG's findings related to the health plans' comparative analyses.

Table 3-1—MHP Comparative Analyses Review Results

Health Plan	Opportunity for Improvement	Rating
Aetna	The health plan had an opportunity for improvement related to consistent reporting of data and information in its NQTL comparative analyses.	*Partially Compliant*
BCBSIL	The health plan had an opportunity for improvement related to consistent reporting of data and information in its NQTL comparative analyses.	*Partially Compliant*
CountyCare	None identified.	*Compliant*
Meridian	The health plan had an opportunity for improvement related to consistent reporting of data and information in its NQTL comparative analyses.	*Partially Compliant*
Molina	The health plan had an opportunity for improvement related to consistent reporting of data and information in its NQTL comparative analyses.	*Partially Compliant*
YouthCare	The health plan had an opportunity for improvement related to consistent reporting of data and information in its NQTL comparative analyses.	*Partially Compliant*

In general, most of the health plans demonstrated compliance with parity requirements when sufficient information and supporting documentation were provided for the implemented NQTL. The *Partially*

Compliant findings resulted from insufficient information or documented evidence of parity related to the selection of NQTLs and the consistency and stringency with which they were applied to MH/SUD and M/S benefits across service types, as described in the comparative analyses. For example, some health plans limited responses to listing references to regulatory requirements and coverage guidelines when defining the NQTLs used to manage members' health care services, and some health plans did not provide thorough data for each benefit classification. Without supporting documentation included in the comparative analyses to demonstrate how the treatment limitations were implemented and applied to MH/SUD and M/S benefits, the health plans were unable to fully demonstrate that NQTLs were comparable and not applied more stringently for MH/SUD benefits compared to M/S benefits. In the absence of complete responses, the evaluation of parity between MH/SUD and M/S benefits was limited, resulting in parity compliance ratings less than *Compliant*.

QBR Data Assessment

HSAG assessed the health plans' data to determine evidence of parity between M/S and MH/SUD authorization denials, as self-reported as part of HFS' QBR process. Table 3-2 displays the results of the assessment.

Table 3-2—QBR Data Assessment: Total Requests Denied—CY 2024

Health Plan	Medical* PA Requests: Denial Rate	Behavioral Health PA Requests: Denial Rate	Deviation Rating
Aetna	13%	4%	*Moderate*
BCBSIL	14%	0.45%	*Substantial*
CountyCare	6%	1%	*Moderate*
Meridian	7%	4%	*None*
Molina	8%	7%	*None*
YouthCare	3%	1%	*None*

*Non-Behavioral Health, Nursing Facility, Rehab, Durable Medical Equipment, Home Health, Imaging, and Pain Management

All six health plans denied M/S authorization requests at a higher rate than MH/SUD requests; four of the six health plans denied M/S authorization requests at a statistically significantly higher rate than MH/SUD requests. Additionally, HSAG analyzed the difference in the percentage of denials. Although two health plans demonstrated *Moderate* differences and one health plan demonstrated a *Substantial* difference, the differences were driven by a lower denial rate for MH/SUD services compared to M/S services, suggesting no concerns with parity.

QBR Data Assessment: 2021 and 2024 Comparison

As part of the 2021 MHP review, HSAG assessed the health plans' data to determine evidence of parity between M/S and MH/SUD authorization denials, as self-reported as part of HFS' QBR process. HSAG

compared the 2021 and 2024 denial rates to determine the success of the health plans' efforts to continuously assess and enhance service authorizations. Table 3-3 displays the results of the assessment.

Table 3-3—QBR Data Assessment: Denial Rate Comparison between CY 2021 and CY 2024

Health Plan	2021 PA Requests: Denial Rate	2024 PA Requests: Denial Rate	Denial Rate Difference	Deviation Rating
Medical*				
Aetna	19%	13%	-6%	*Moderate*
BCBSIL	13%	14%	+1%	*None*
CountyCare	5%	6%	+1%	*None*
Meridian	15%	7%	-8%	*Moderate*
Molina	14%	8%	-6%	*Moderate*
YouthCare	5%	3%	-2%	*None*
Behavioral Health				
Aetna	6%	4%	-2%	*None*
BCBSIL	0.3%	0.5%	+0.2%	*None*
CountyCare	6%	1%	-5%	*Moderate*
Meridian	0.2%	3%	+2.8%	*None*
Molina	3%	7%	+4%	*None*
YouthCare	5%	1%	-4%	*None*

*Non-Behavioral Health, Nursing Facility, Rehab, Durable Medical Equipment, Home Health, Imaging, and Pain Management.

HSAG analyzed the absolute change in denial rates between CY 2021 and CY 2024 for each health plan to determine differences. HSAG noted that:

- For medical denials, three of the six health plans (Aetna, Meridian, and Molina) demonstrated *Moderate* differences, all resulting in a lower denial rate in CY 2024 when compared to CY 2021.
- For behavioral health denials, one of the six health plans (CountyCare) demonstrated a *Moderate* difference, resulting in a lower denial rate in CY 2024 when compared to CY 2021.

Comparisons between CY 2021 and CY 2024 indicate that the health plans' efforts to evaluate service authorization processes resulted, overall, in stable or reduced denial rates.

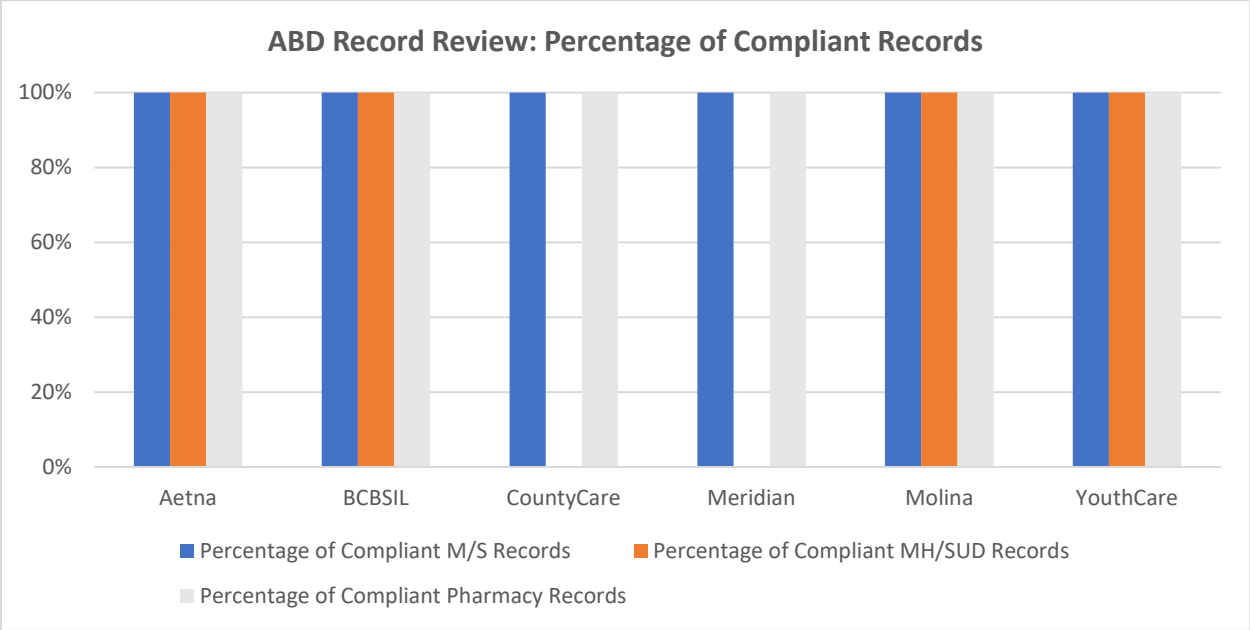
ABD File Review

HSAG reviewed a random sample of 10 ABD records for each health plan to determine compliance with authorization denial processes and evidence of parity between M/S and MH/SUD authorization denial processes. The file review included:

- Assessing compliance with federal and State regulations governing the processing of member notice of adverse benefit decisions (NOABDs) for service authorization denials, including accessibility.
- Assessing the timeliness of service authorization denials.

The health plans demonstrated a high level of compliance with ABD record elements for both M/S and MH/SUD, as displayed in Figure 3-1. Individual health plan results are presented in Appendix A.

Figure 3-1—ABD File Review Results



The file reviews demonstrated compliance with federal and State regulatory requirements surrounding the processing of NOABDs.

HSAG's review did not suggest any parity concerns.

Conclusions

Based on a review of the NQTL comparative analyses and response documents, QBR data, and review of PA denials, the administration of MH/SUD and M/S benefits were found to be in parity for the health plans, although individual differences in performance are reviewed for each organization in the appendices. These differences should be reviewed by each respective organization to support and ensure continued compliance with parity standards.

Overall, the health plans demonstrated parity in policies and procedures across M/S and MH/SUD services and implementation of those policies and procedures. HSAG's observations included the following:

- All health plans used nationally recognized utilization review criteria.
- The health plans demonstrated ongoing review of M/S and MH/SUD data and information to inform MHP.
- The health plans demonstrated stable or reduced denial rates when 2021 data were compared to 2024 data.
- The health plans demonstrated consistent application of UM processes and compliance with NOABD requirements.
- Most health plans demonstrated opportunities for improvement related to the thoroughness of the qualitative and quantitative summaries in their comparative analyses.

Appendix A. Health Plan-Specific Findings

This appendix provides detailed findings from the 2024 MHP Review, and general observations for each health plan.

Aetna Better Health of Illinois (Aetna)

Review of UM and MHP Procedures

Aetna applied a collaborative approach to review and maintain MHP. Local market business units worked together to review and assess data, and a national enterprise team conducts additional review. M/S, MH/SUD, and Pharmacy are involved in analyses of data and information, which are reported to quality management and UM committees. In 2024, Aetna reported minimal changes to its UM program, which included new processes for reviewing policies, system migration to a new inbound/outbound fax system, and increased staffing.

Aetna confirmed that processes are the same for executing M/S and MH/SUD authorization decisions. A national medical management policy committee reviews all PA requirements, while UM leaders review code lists to determine if any changes need to be made. Pharmacy completes required quarterly PA reporting to HFS; changes to PAs are made due to HFS requirements.

Aetna reported the use of the following evidence-based clinical criteria to evaluate the necessity of care:

- Physical Health: MCG® and Aetna Clinical Policy Bulletins
- Behavioral Health: MCG®, ASAM®, and Aetna Clinical Policy Bulletins
- Pharmacy: State guidelines (including the PDL), Aetna Medicaid Pharmacy Guidelines, CVS Health Pharmacy and Therapeutics (P&T) Committee, and HFS Drug and Therapeutic Committee

The health plan reported that it had not identified any parity issues or opportunities for improvement.

Review of NQTL Comparative Analyses

HSAG and HFS reviewed the health plan's comparative analyses for completeness. HSAG reviewed the health plan's supporting documentation and the information submitted by the health plan for its administrative compliance review, which provided additional context, data, and information that were not supplied in the comparative analyses.

Review of Aetna's NQTL comparative analyses identified the following opportunities:

- The health plan's analyses were not comprehensive enough to assess compliance with all steps without review of additional supporting documentation.
- The health plan did not consistently submit separate analyses for each benefit classification (e.g., inpatient, outpatient, pharmacy, emergency).
- The health plan did not provide significant details related to the data and information that were used to assess and support its comparative analyses.

While the information provided on its NQTL analyses and the additional supporting documentation indicated that Aetna had the systems and processes in place to effectively compile and analyze data and

information related to parity, the health plan had an opportunity to supply HFS with thorough, quantitative summaries necessary to provide evidence of its ability and efforts to assess the design, development, and/or application of the NQTLs to MH/SUD and M/S by benefit classification. HFS provided the health plans with instruction documents specific to each NQTL, which described the expectations for completion of the analyses, including instructions that attachments or other separate policy documents should not have to be reviewed to determine if the comparative analysis is sufficient.

HSAG found the health plan to be *Partially Compliant* due to the insufficient information provided.

QBR Data Assessment

The health plans report on the total number of PA request denials as part of HFS' QBR process. HSAG assessed the health plans' data to determine evidence of parity between M/S and MH/SUD authorization denials. Table A-1 presents the results of the assessment.

Table A-1—QBR Data Assessment: Total Requests Denied—CY 2024

QBR Data Assessment: Total Denied	Numerator	Denominator	Percent
PA requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging, and Pain Management	11,478	88,445	13%
PA (Behavioral Health Only)	535	11,950	4%

HSAG completed a Chi-square analysis to determine statistically significant differences between the health plan's denial rates for M/S and MH/SUD services. The health plan denied M/S authorization requests at a statistically significantly higher rate than MH/SUD requests. Additionally, HSAG analyzed the difference in the percentage of denials. While the difference was *Substantial*, the differences were driven by a lower denial rate for MH/SUD services compared to M/S services, suggesting no concerns with parity.

QBR Data Assessment: 2021 and 2024 Comparison

HSAG analyzed the difference in the percentage of denials reported by the health plan between 2021 and 2024 to determine the success of the health plan's efforts to continuously assess and enhance service authorizations. Table A-2 displays the results of the analysis.

Table A-2—QBR Data Assessment: Denial Rate Comparison—CY 2021 and 2024

QBR Data Assessment: Percent Denied	2021 Denial Rate	2024 Denial Rate	Denial Rate Difference	Deviation Rating
PA requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging, and Pain Management	19%	13%	-6%	*Moderate*
PA (Behavioral Health Only)	6%	4%	-2%	*None*

Aetna demonstrated a *Moderate* deviation rating for medical denials and a rating of *None* for behavioral health denials. Both denial rates demonstrated a decrease in 2024 when compared to 2021, suggesting stable and/or enhanced denial processes.

ABD File Review

HSAG reviewed a random sample of 10 ABD records for each health plan to determine compliance with authorization denial processes. Table A-3 presents the results of the record review.

Table A-3—ABD Compliance Review Results

ABD Evaluation Element	Percent of Compliant* M/S Records	Percent of Compliant* MH/SUD Records	Percent of Compliant* Pharmacy Records	MHP
1. Notice sent within required time frame	100% (7/7)	100% (1/1)	100% (2/2)	Yes
2. The health plan used the HFS template to provide notice	100% (7/7)	100% (1/1)	100% (2/2)	Yes
3. Notice of denial met readability protocol (sixth-grade reading level)	100% (7/7)	100% (1/1)	100% (2/2)	Yes
Overall Compliance	**100% (7/7)**	**100% (1/1)**	**100% (2/2)**	**Yes**

* Percent of Compliant Records is the percentage of Met elements (Met/Met + Not Met) excluding any Not Applicable elements.

M/S, MH/SUD, and Pharmacy records demonstrated 100 percent compliance. Overall, the results of the ABD record review did not suggest any parity concerns.

Final Parity Rating

Although review of supporting documentation and independent review of data did not demonstrate parity concerns, HSAG assigned a rating of ***Partially Compliant*** due to the health plan's opportunity for improvement related to completion of its comparative analyses.

Findings and Recommendations

Finding #1 The health plan had an opportunity for improvement related to consistent reporting of data and information in its NQTL comparative analyses.

Recommendation #1 Aetna must review its NQTL comparative analyses to ensure that benefit classifications and quantitative data are distinct and clearly reported. The health plan should review the FAQ Guidance provided within the NQTL reporting documents and the Instruction documents for each NQTL to inform its future submissions.

Blue Cross Community Health Plans (BCBSIL)

Review of UM and MHP Procedures

BCBSIL applied a collaborative approach to review and maintain MHP. The local market group worked with legal, business unit owners, internal stakeholders, and with the company's enterprise MHP Operations team. M/S, MH/SUD, and Pharmacy are involved in analyses of data and information. A MHP Governance Committee meets monthly, and an annual MHP analysis is conducted.

BCBSIL confirmed that processes are the same for executing M/S and MH/SUD decisions. The health plan maintains a NQTL Medicaid Library, which provides a crosswalk of M/S and MH/SUD benefits for internal and external customers and is updated continuously. The health plan reviews UM rates from the perspective of total population, M/S compared to MH/SUD, and in network and out of network providers. Timeliness is reviewed, and interrater reliability is conducted. The health plan's Pharmacy has access to its pharmacy benefits manager (PBM) database. Review is conducted monthly and the Pharmacy team is able to address any changes needed to the PDL.

BCBSIL reported the use of the following evidence-based clinical criteria to evaluate the necessity of care:

- Physical Health: CMS National Coverage Determinations, MCG®, ASAM®, and BCBSIL's (and its delegates') clinical guidelines
- Behavioral Health: CMS National Coverage Determinations, MCG®, ASAM®, and BCBSIL's clinical guidelines
- Pharmacy: State guidelines (including the PDL), FDA, CMS-endorsed compendia, professional organization guidelines, clinical trials

The health plan reported that it had not identified any parity issues or opportunities for improvement.

Review of NQTL Comparative Analyses

HSAG and HFS reviewed the health plan's comparative analyses for completeness. HSAG reviewed the health plan's supporting documentation and the information submitted by the health plan for its administrative compliance review, which provided additional context, data, and information that were not supplied in the comparative analyses.

Review of BCBSIL's NQTL comparative analyses identified the following opportunities:

- The health plan's analyses were not comprehensive enough to assess compliance with all steps without review of additional supporting documentation.
- The health plan had an opportunity for describing ASAM® as part of the evidentiary standards. For example, the health plan did not describe its process for escalation to a provider when MH/SUD PA requests did not meet ASAM® criteria.

- The health plan did not provide an analysis of the comparison between the PA request forms for M/S and MH/SUD. The analysis noted that the health plan maintains one PA form for M/S requests, and six for MH/SUD.

While the information provided on its NQTL analyses and the additional supporting documentation indicated that BCBSIL had the systems and processes in place to effectively compile and analyze data and information related to parity, the health plan had an opportunity to supply HFS with thorough, quantitative summaries necessary to provide evidence of its ability and efforts to assess the design, development, and/or application of the NQTLs to MH/SUD and M/S. HFS provided the health plans with instruction documents specific to each NQTL, which described the expectations for completion of the analyses, including instructions that attachments or other separate policy documents should not have to be reviewed to determine if the comparative analysis is sufficient.

HSAG found the health plan to be *Partially Compliant* due to the insufficient information provided.

QBR Data Assessment

The health plans report on the total number of PA request denials as part of HFS' QBR process. HSAG assessed the health plans' data to determine evidence of parity between M/S and MH/SUD authorization denials. Table A-4 presents the results of the assessment.

Table A-4—QBR Data Assessment: Total Requests Denied—CY 2024

QBR Data Assessment: Total Denied	Numerator	Denominator	Percent
PA requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging, and Pain Management	15,036	109,450	14%
PA (Behavioral Health Only)	114	25,345	0.5%

HSAG completed a Chi-square analysis to determine statistically significant differences between the health plan's denial rates for M/S and MH/SUD services. The health plan denied M/S authorization requests at a statistically significantly higher rate than MH/SUD requests. Additionally, HSAG analyzed the difference in the percentage of denials. While the difference was *Substantial*, the differences were driven by a lower denial rate for MH/SUD services compared to M/S services, suggesting no concerns with parity.

QBR Data Assessment: 2021 and 2024 Comparison

HSAG analyzed the difference in the percentage of denials reported by the health plan between 2021 and 2024 to determine the success of the health plan's efforts to continuously assess and enhance service authorizations. Table A-5 displays the results of the analysis.

Table A-5—QBR Data Assessment: Denial Rate Comparison—CY 2021 and 2024

QBR Data Assessment: Percent Denied	2021 Denial Rate	2024 Denial Rate	Denial Rate Difference	Deviation Rating
PA requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging, and Pain Management	13%	14%	+1%	*None*
PA (Behavioral Health Only)	0.3%	0.5%	+0.2%	*None*

BCBSIL demonstrated a deviation rating of *None* for both medical and behavioral health denials. Both denial rates demonstrated an insignificant increase in 2024 when compared to 2021, suggesting stable denial processes.

ABD File Review

HSAG reviewed a random sample of 10 ABD records for each health plan to determine compliance with authorization denial processes. Table A-6 presents the results of the record review.

Table A-6—ABD Compliance Review Results

ABD Evaluation Element	Percent of Compliant* M/S Records	Percent of Compliant* MH/SUD Records	Percent of Compliant* Pharmacy Records	MHP
1. Notice sent within required time frame	100% (7/7)	100% (1/1)	100% (2/2)	Yes
2. The health plan used the HFS template to provide notice	100% (7/7)	100% (1/1)	100% (2/2)	Yes
3. Notice of denial met readability protocol (sixth-grade reading level)	100% (7/7)	100% (1/1)	100% (2/2)	Yes
Overall Compliance	**100% (7/7)**	**100% (1/1)**	**100% (2/2)**	**Yes**

* Percent of Compliant Records is the percentage of Met elements (Met/Met + Not Met) excluding any Not Applicable elements.

M/S, MH/SUD, and Pharmacy records demonstrated 100 percent compliance. Overall, the results of the ABD record review did not suggest any parity concerns.

Final Parity Rating

Although review of supporting documentation and independent review of data did not demonstrate parity concerns, HSAG assigned a rating of ***Partially Compliant*** due to the health plan's opportunity for improvement related to completion of its comparative analyses.

Findings and Recommendations

Finding #1	The health plan had an opportunity for improvement related to consistent reporting of data and information in its NQTL comparative analyses.
Recommendation #1	BCBSIL must review its NQTL comparative analyses to ensure that all steps and analyses are distinct and clearly reported. The health plan should review the FAQ Guidance provided within the NQTL reporting documents and the Instruction documents for each NQTL to inform its future submissions.

CountyCare

Review of UM and MHP Procedures

CountyCare applied a collaborative approach to review and maintain MHP, including partnership with outside counsel for evaluation of MHP analyses. The health plan's UM MHP policy described the process for its UM delegate to conduct its annual analysis of compliance with the MHPAEA. The health plan reported that it had not identified any parity issues or opportunities for improvement.

CountyCare confirmed that processes are the same for executing M/S and MH/SUD decisions. The health plan reviews UM rates from the perspective of total population, M/S compared to MH/SUD, concurrent and retrospective reviews, and in network and out of network providers. Timeliness is reviewed, and interrater reliability and quality audits are conducted.

CountyCare reported the use of the following evidence-based clinical criteria to evaluate the necessity of care:

- Physical Health: InterQual®
- Behavioral Health: ASAM® for all SUD services; InterQual® for non-SUD MH services
- Pharmacy: State guidelines (including the PDL), peer-reviewed medical literature.

In order to determine whether policies are comparable for MH and SUD compared to MS benefits, the health plan utilized evidentiary standards, federal and state requirements, InterQual, and created health-plan specific policies if not otherwise addressed. For pharmacy, CountyCare's Pharmacy Benefit Manager, CVS Caremark, was responsible for guidelines, management, and application of guidelines.

The health plan reported that it had not identified any parity issues or opportunities for improvement.

Review of NQTL Comparative Analyses

HSAG and HFS reviewed the health plan's comparative analyses for completeness. HSAG reviewed the health plan's supporting documentation and the information submitted by the health plan for its administrative compliance review, which provided additional context, data, and information that were not supplied in the comparative analyses. Review of CountyCare's NQTL comparative analyses identified that the health plan provided thorough and quantitative evidence of analysis. The information provided indicated that the health plan had the systems and processes in place to effectively compile and analyze data and information related to parity. HSAG determined the health plan to be *Compliant*.

QBR Data Assessment

The health plans report on the total number of PA request denials as part of HFS' QBR process. HSAG assessed the health plans' data to determine evidence of parity between M/S and MH/SUD authorization denials. Table A-7 presents the results of the assessment.

Table A-7—QBR Data Assessment: Total Requests Denied—CY 2024

QBR Data Assessment: Total Denied	Numerator	Denominator	Percent
PA requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging, and Pain Management	1,805	31,495	6%
PA (Behavioral Health Only)	33	3,308	1%

HSAG completed a Chi-square analysis to determine statistically significant differences between the health plan's denial rates for M/S and MH/SUD services. There was no statistically significant difference in the rates of the health plan's denied M/S authorization requests when compared to MH/SUD requests. Additionally, HSAG analyzed the difference in the percentage of denials. While the difference was *Moderate*, the differences were driven by a lower denial rate for MH/SUD services compared to M/S services, suggesting no concerns with parity.

QBR Data Assessment: 2021 and 2024 Comparison

HSAG analyzed the difference in the percentage of denials reported by the health plan between 2021 and 2024 to determine the success of the health plan's efforts to continuously assess and enhance service authorizations. Table A-8 displays the results of the analysis.

Table A-8—QBR Data Assessment: Denial Rate Comparison—CY 2021 and 2024

QBR Data Assessment: Percent Denied	2021 Denial Rate	2024 Denial Rate	Denial Rate Difference	Deviation Rating
PA requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging, and Pain Management	5%	6%	+1%	*None*
PA (Behavioral Health Only)	6%	1%	-5%	*Moderate*

CountyCare demonstrated a deviation rating of *None* for medical denials and a rating of *Moderate* for behavioral health denials. Medical denial rates demonstrated an insignificant increase in 2024 when compared to 2021 and behavioral health denial rates demonstrated a decrease in 2024 when compared to 2021, suggesting stable and/or enhanced denial processes.

ABD File Review

HSAG reviewed a random sample of 10 ABD records for each health plan to determine compliance with authorization denial processes. Table A-9 presents the results of the record review.

Table A-9—ABD Compliance Review Results

ABD Evaluation Element	Percent of Compliant* M/S Records	Percent of Compliant* MH/SUD Records	Percent of Compliant* Pharmacy Records	MHP
1. Notice sent within required time frame	100% (9/9)	NA (0/0)	100% (1/1)	Yes
2. The health plan used the HFS template to provide notice	100% (9/9)	NA (0/0)	100% (1/1)	Yes
3. Notice of denial met readability protocol (sixth-grade reading level)	100% (9/9)	NA (0/0)	100% (1/1)	Yes
Overall Compliance	**100% (9/9)**	**NA (0/0)**	**100% (1/1)**	**Yes**

* Percent of Compliant Records is the percentage of Met elements (Met/Met + Not Met) excluding any Not Applicable elements.

M/S and Pharmacy records demonstrated 100 percent compliance. Although no MH/SUD records were assessed in the final random sample, HSAG noted that the health plan reported and demonstrated consistent ABD processes regardless of the request type. Overall, the results of the ABD record review did not suggest any parity concerns.

Final Parity Rating

Review of analyses, supporting documentation, and data did not demonstrate parity concerns; therefore, HSAG assigned a rating of ***Compliant***.

Findings and Recommendations

Based on the results of the review, HSAG did not identify any findings or recommendations for CountyCare.

Meridian

Review of UM and MHP Procedures

Meridian utilized a collaborative approach to review and maintain MHP, with MHP analyses inclusive of local and enterprise subject matter experts and teams. Quantitative processes and measures were identified, and analyses developed.

Meridian confirmed that processes are the same for executing M/S and MH/SUD decisions, including Pharmacy. The health plan reviews UM rates from the perspective of total population, M/S compared to MH/SUD, concurrent and retrospective reviews, and in-network and out-of-network providers. Timeliness is reviewed, and interrater reliability is conducted.

Meridian reported the use of the following evidence-based clinical criteria to evaluate the necessity of care:

- Physical Health: InterQual®, federal and State law and guidelines, internal clinical policies, professional standards or medical association publications, and peer-reviewed literature
- Behavioral Health: ASAM® for all SUD services; InterQual® for non-SUD MH services, federal and State law and guidelines, internal clinical policies, professional standards or medical association publications, and peer-reviewed literature
- Pharmacy: State guidelines (including the PDL), national drug compendia, federal and State law and guidelines, internal clinical policies, professional standards or medical association publications, and peer-reviewed literature

The health plan reported that it had not identified any parity issues or opportunities for improvement.

Review of NQTL Comparative Analyses

HSAG and HFS reviewed the health plan's comparative analyses for completeness. HSAG reviewed the health plan's supporting documentation and the information submitted by the health plan for its administrative compliance review, which provided additional context, data, and information that were not supplied in the comparative analyses. Review of Meridian's NQTL comparative analyses identified the following opportunities:

- The health plan submitted its analyses using a retired template, which does not meet the current recommended reporting and is missing applicable guidance intended to assist the health plan with the completion of the reporting requirements.
- The health plan did not submit its Concurrent Review analysis.
- The health plan did not consistently submit separate analyses for each benefit classification (e.g., inpatient, outpatient, pharmacy, emergency).

- The health plan did not provide significant details related to the data and information that were used to assess and support its comparative analyses.

While the information provided on its NQTL analyses and the additional supporting documentation indicated that Meridian had the systems and processes in place to effectively compile and analyze data and information related to parity, the health plan had an opportunity to supply HFS with thorough, quantitative summaries necessary to provide evidence of its ability and efforts to assess the design, development, and/or application of the NQTLs to MH/SUD and M/S by benefit classification. HFS provided the health plans with instruction documents specific to each NQTL, which described the expectations for completion of the analyses, including instructions that attachments or other separate policy documents should not have to be reviewed to determine if the comparative analysis is sufficient.

HSAG found the health plan to be *Partially Compliant* due to the insufficient information provided.

QBR Data Assessment

The health plans report on the total number of PA request denials as part of HFS' QBR process. HSAG assessed the health plans' data to determine evidence of parity between M/S and MH/SUD authorization denials. Table A-10 presents the results of the assessment.

Table A-10—QBR Data Assessment: Total Requests Denied—CY 2024

QBR Data Assessment: Total Denied	Numerator	Denominator	Percent
PA requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging, and Pain Management	2,458	35,196	7%
PA (Behavioral Health Only)	5	138	4%

HSAG completed a Chi-square analysis to determine statistically significant differences between the health plan's denial rates for M/S and MH/SUD services. The health plan denied M/S authorization requests at a statistically significantly higher rate than MH/SUD requests. Additionally, HSAG analyzed the difference in the percentage of denials. Additionally, HSAG analyzed the difference in the percentage of denials and found there was no difference, suggesting no concerns with parity.

QBR Data Assessment: 2021 and 2024 Comparison

HSAG analyzed the difference in the percentage of denials reported by the health plan between 2021 and 2024 to determine the success of the health plan's efforts to continuously assess and enhance service authorizations. Table A-11 displays the results of the analysis.

Table A-11—QBR Data Assessment : Denial Rate Comparison—CY 2021 and 2024

QBR Data Assessment: Percent Denied	2021 Denial Rate	2024 Denial Rate	Denial Rate Difference	Deviation Rating
PA requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging, and Pain Management	15%	7%	-8%	*Moderate*
PA (Behavioral Health Only)	0.2%	4%	+3.8%	*None*

Meridian demonstrated a deviation rating of *Moderate* for medical denials and a rating of *None* for behavioral health denials. Medical denial rates demonstrated a decrease in 2024 when compared to 2021 and behavioral health denial rates demonstrated an insignificant increase in 2024 when compared to 2021, suggesting stable and/or enhanced denial processes.

ABD File Review

HSAG reviewed a random sample of 10 ABD records for each health plan to determine compliance with authorization denial processes. Table A-12 presents the results of the record review.

Table A-12—ABD Compliance Review Results

ABD Evaluation Element	Percent of Compliant* M/S Records	Percent of Compliant* MH/SUD Records	Percent of Compliant* Pharmacy Records	MHP
1. Notice sent within required time frame	100% (8/8)	NA (0/0)	100% (2/2)	Yes
2. The health plan used the HFS template to provide notice	100% (8/8)	NA (0/0)	100% (2/2)	Yes
3. Notice of denial met readability protocol (sixth-grade reading level)	100% (8/8)	NA (0/0)	100% (2/2)	Yes
Overall Compliance	**100% (8/8)**	**NA (0/0)**	**100% (2/2)**	**Yes**

* Percent of Compliant Records is the percentage of Met elements (Met/Met + Not Met) excluding any Not Applicable elements.

M/S and Pharmacy records demonstrated 100 percent compliance. Although no MH/SUD records were assessed in the final random sample, HSAG noted that the health plan reported and demonstrated consistent ABD processes regardless of the request type. Overall, the results of the ABD record review did not suggest any parity concerns.

Final Parity Rating

Although review of supporting documentation and independent review of data did not demonstrate parity concerns, HSAG assigned a rating of ***Partially Compliant*** due to the health plan's opportunity for improvement related to completion of its comparative analyses.

Findings and Recommendations

Finding #1	The health plan had an opportunity for improvement related to consistent reporting of data and information in its NQTL comparative analyses.
Recommendation #1	Meridian must review its NQTL comparative analyses to ensure that all NQTLs and benefit classifications are distinct and clearly reported using the correct reporting templates. The health plan should review the FAQ Guidance provided within the NQTL reporting documents and the Instruction documents for each NQTL to inform its future submissions.

Molina Healthcare of Illinois, Inc. (Molina)

Review of UM and MHP Procedures

Molina's MHP review is conducted by its enterprise compliance division. An annual enterprise-wide review is conducted, with comparison to national results. Molina's Illinois health plan representatives participate in the enterprise level analysis and conduct independent analyses to determine if any issues need to be escalated to the enterprise team. Their pharmacy partner also conducts an annual parity analysis.

Molina reported the use of the following evidence-based clinical criteria to evaluate the necessity of care:

- Physical Health: MCG® and internal clinical policies
- Behavioral Health: ASAM® and internal clinical policies
- Pharmacy: State guidelines (including the PDL), FDA-approved drug labeling, accepted clinical compendia, professional medical society guidelines, available clinical literate and expert reviews, and internal clinical policies

Molina reviews UM data as part of its ongoing oversight and monitoring, which includes interrater reliability. The health plan has an inpatient dashboard that allows for review of rates and captures both M/S and MH/SUD.

The health plan reported that it had not identified any parity issues or opportunities for improvement.

Review of NQTL Comparative Analyses

HSAG and HFS reviewed the health plan's comparative analyses for completeness. HSAG reviewed the health plan's supporting documentation and the information submitted by the health plan for its administrative compliance review, which provided additional context, data, and information that was not supplied in the comparative analyses. Review of Molina's NQTL comparative analyses identified the following opportunities:

- The health plan's analyses were not comprehensive enough to assess compliance with all steps without review of additional supporting documentation.
- The health plan included conflicting time frames for routine authorization request decisions, with reports of four days for M/S and five days for MH/SUD.
- The health plan noted that there were no MH/SUD benefits subject to PA; however, review of the Molina PA Lookup Tool identified that PA was required for Medically Monitored Withdrawal Management (H0010) and Adolescent SUD Residential (H2036).
- The health plan did not provide significant details related to the data and information that were used to assess and support its comparative analyses.

While the information provided in its NQTL analyses and the additional supporting documentation indicated that Molina had the systems and processes in place to effectively compile and analyze data and information related to parity, the health plan had an opportunity to supply HFS with thorough, quantitative summaries necessary to provide evidence of its ability and efforts to assess the design, development, and/or application of the NQTLs to MH/SUD and M/S. HFS provided the health plans with instruction documents specific to each NQTL, which described the expectations for completion of the analyses, including instructions that attachments or other separate policy documents should not have to be reviewed to determine if the comparative analysis is sufficient.

HSAG found the health plan to be *Partially Compliant* due to the insufficient information provided.

QBR Data Assessment

The health plans report on the total number of PA request denials as part of HFS' QBR process. HSAG assessed the health plans' data to determine evidence of parity between M/S and MH/SUD authorization denials. Table A-13 presents the results of the assessment.

Table A-13—QBR Data Assessment: Total Requests Denied—CY 2024

QBR Data Assessment: Total Denied	Numerator	Denominator	Percent
PA requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging, and Pain Management	2,352	29,481	8%
PA (Behavioral Health Only)	1	105	3%

HSAG completed a Chi-square analysis to determine statistically significant differences between the health plan's denial rates for M/S and MH/SUD services. There was no statistically significant difference in the rates of the health plan's denied M/S authorization requests when compared to MH/SUD requests. Additionally, HSAG analyzed the difference in the percentage of denials. While the difference was *Moderate*, the differences were driven by a lower denial rate for MH/SUD services compared to M/S services, suggesting no concerns with parity.

QBR Data Assessment: 2021 and 2024 Comparison

HSAG analyzed the difference in the percentage of denials reported by the health plan between 2021 and 2024 to determine the success of the health plan's efforts to continuously assess and enhance service authorizations. Table A-14 displays the results of the analysis.

Table A-14—QBR Data Assessment: Denial Rate Comparison—CY 2021 and 2024

QBR Data Assessment: Percent Denied	2021 Denial Rate	2024 Denial Rate	Denial Rate Difference	Deviation Rating
PA requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging, and Pain Management	14%	8%	-6%	*Moderate*

QBR Data Assessment: Percent Denied	2021 Denial Rate	2024 Denial Rate	Denial Rate Difference	Deviation Rating
PA (Behavioral Health Only)	3%	7%	+4%	*None*

Molina demonstrated a deviation rating of *Moderate* for medical denials and a rating of *None* for behavioral health denials. Medical denial rates demonstrated a decrease in 2024 when compared to 2021 and behavioral health denial rates demonstrated an insignificant increase in 2024 when compared to 2021, suggesting stable and/or enhanced denial processes.

ABD File Review

HSAG reviewed a random sample of 10 ABD records for each health plan to determine compliance with authorization denial processes. Table A-15 presents the results of the record review.

Table A-15—ABD Compliance Review Results

ABD Evaluation Element	Percent of Compliant* M/S Records	Percent of Compliant* MH/SUD Records	Percent of Compliant* Pharmacy Records	MHP
1. Notice sent within required time frame	100% (7/7)	100% (1/1)	100% (2/2)	Yes
2. The health plan used the HFS template to provide notice	100% (7/7)	100% (1/1)	100% (2/2)	Yes
3. Notice of denial met readability protocol (sixth-grade reading level)	100% (7/7)	100% (1/1)	100% (2/2)	Yes
Overall Compliance	**100% (7/7)**	**100% (1/1)**	**100% (2/2)**	**Yes**

* Percent of Compliant Records is the percentage of Met elements (Met/Met + Not Met) excluding any Not Applicable elements.

M/S, MH/SUD, and Pharmacy records demonstrated 100 percent compliance. Overall, the results of the ABD record review did not suggest any parity concerns.

Final Parity Rating

Although review of supporting documentation and independent review of data did not demonstrate parity concerns, HSAG assigned a rating of ***Partially Compliant*** due to the health plan's opportunity for improvement related to completion of its comparative analyses.

Findings and Recommendations

Finding #1	The health plan had an opportunity for improvement related to consistent reporting of data and information in its NQTL comparative analyses.
Recommendation #1	Molina must review its NQTL comparative analyses to ensure that all NQTLs and benefit classifications are distinct and clearly reported. The health plan should review the FAQ Guidance provided within the NQTL reporting documents and the Instruction documents for each NQTL to inform its future submissions.

YouthCare Specialty Plan (YouthCare)

Review of UM and MHP Procedures

YouthCare utilized a collaborative approach to review and maintain MHP, with MHP analyses inclusive of local and enterprise subject matter experts and teams. Quantitative processes and measures were identified, and analyses developed.

YouthCare confirmed that processes are the same for executing M/S and MH/SUD decisions, including Pharmacy. The health plan reviews UM rates from the perspective of total population, M/S compared to MH/SUD, concurrent and retrospective reviews, and in-network and out-of-network providers. Timeliness is reviewed, and interrater reliability is conducted.

YouthCare reported the use of the following evidence-based clinical criteria to evaluate the necessity of care:

- Physical Health: InterQual®, federal and State law and guidelines, internal clinical policies, professional standards or medical association publications, and peer-reviewed literature
- Behavioral Health: ASAM® for all SUD services; InterQual® for non-SUD MH services, federal and State law and guidelines, internal clinical policies, professional standards or medical association publications, and peer-reviewed literature
- Pharmacy: State guidelines (including the PDL), national drug compendia, federal and State law and guidelines, internal clinical policies, professional standards or medical association publications, and peer-reviewed literature

The health plan reported that it had not identified any parity issues or opportunities for improvement.

Review of NQTL Comparative Analyses

HSAG and HFS reviewed the health plan's comparative analyses for completeness. HSAG reviewed the health plan's supporting documentation and the information submitted by the health plan for its administrative compliance review, which provided additional context, data, and information that were not supplied in the comparative analyses. Review of YouthCare's NQTL comparative analyses identified the following opportunities:

- The health plan submitted its analyses using a retired template, which does not meet the current recommended reporting and is missing applicable guidance intended to assist the health plan with the completion of the reporting requirements.
- The health plan did not submit a Pharmacy comparative analysis.
- The health plan did not consistently submit separate analyses for each benefit classification (e.g., inpatient, outpatient, pharmacy, emergency).

- The health plan did not provide significant details related to the data and information that were used to assess and support its comparative analyses.

While the information provided in its NQTL analyses and the additional supporting documentation indicated that YouthCare had the systems and processes in place to effectively compile and analyze data and information related to parity, the health plan had an opportunity to supply HFS with thorough, quantitative summaries necessary to provide evidence of its ability and efforts to assess the design, development, and/or application of the NQTLs to MH/SUD and M/S by benefit classification. HFS provided the health plans with instruction documents specific to each NQTL, which described the expectations for completion of the analyses, including instructions that attachments or other separate policy documents should not have to be reviewed to determine if the comparative analysis is sufficient.

HSAG found the health plan to be *Partially Compliant* due to the insufficient information provided.

QBR Data Assessment

The health plans report on the total number of PA request denials as part of HFS' QBR process. HSAG assessed the health plans' data to determine evidence of parity between M/S and MH/SUD authorization denials. Table A-16 presents the results of the assessment.

Table A-16—QBR Data Assessment: Total Requests Denied—CY 2024

QBR Data Assessment: Total Denied	Numerator	Denominator	Percent
PA requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging, and Pain Management	34	1,196	3%
PA (Behavioral Health Only)	1	105	1%

HSAG completed a Chi-square analysis to determine statistically significant differences between the health plan's denial rates for M/S and MH/SUD services. There was no statistically significant difference in the rates of the health plan's denied M/S authorization requests when compared to MH/SUD requests. Additionally, HSAG analyzed the difference in the percentage of denials and found there was no difference, suggesting no concerns with parity.

QBR Data Assessment: 2021 and 2024 Comparison

HSAG analyzed the difference in the percentage of denials reported by the health plan between 2021 and 2024 to determine the success of the health plan's efforts to continuously assess and enhance service authorizations. Table A-17 displays the results of the analysis.

Table A-17—QBR Data Assessment: Denial Rate Comparison—CY 2021 and 2024

QBR Data Assessment: Percent Denied	2021 Denial Rate	2024 Denial Rate	Denial Rate Difference	Deviation Rating
PA requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging, and Pain Management	5%	3%	-2%	*None*
PA (Behavioral Health Only)	5%	1%	-4%	*None*

YouthCare demonstrated a deviation rating of *None* for medical denials and behavioral health denials. Both medical and behavioral health denial rates demonstrated a decrease in 2024 when compared to 2021, suggesting stable and/or enhanced denial processes.

ABD File Review

HSAG reviewed a random sample of 10 ABD records for each health plan to determine compliance with authorization denial processes. Table A-18 presents the results of the record review.

Table A-18—ABD Compliance Review Results

ABD Evaluation Element	Percent of Compliant* M/S Records	Percent of Compliant* MH/SUD Records	Percent of Compliant* Pharmacy Records	MHP
1. Notice sent within required time frame	100% (7/7)	100% (1/1)	100% (2/2)	Yes
2. The health plan used the HFS template to provide notice	100% (7/7)	100% (1/1)	100% (2/2)	Yes
3. Notice of denial met readability protocol (sixth-grade reading level)	100% (7/7)	100% (1/1)	100% (2/2)	Yes
Overall Compliance	**100% (7/7)**	**100% (1/1)**	**100% (2/2)**	**Yes**

* Percent of Compliant Records is the percentage of Met elements (Met/Met + Not Met) excluding any Not Applicable elements.

M/S, MH/SUD, and Pharmacy records demonstrated 100 percent compliance. Overall, the results of the ABD record review did not suggest any parity concerns.

Final Parity Rating

Although review of supporting documentation and independent review of data did not demonstrate parity concerns, HSAG assigned a rating of ***Partially Compliant*** due to the health plan's opportunity for improvement related to completion of its comparative analyses.

Findings and Recommendations

Finding #1	The health plan had an opportunity for improvement related to consistent reporting of data and information in its NQTL comparative analyses.
Recommendation #1	YouthCare must review its NQTL comparative analyses to ensure that all NQTLs and benefit classifications are distinct and clearly reported using the correct reporting templates. The health plan should review the FAQ Guidance provided within the NQTL reporting documents and the Instruction documents for each NQTL to inform its future submissions.

Appendix B. Definitions

Department of Labor (DOL) MHPAEA Definitions[5]

Aggregate lifetime dollar limit means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan or health insurance coverage for any coverage unit.

Annual dollar limit means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a group health plan or health insurance coverage for any coverage unit.

Cumulative financial requirements are financial requirements that determine whether or to what extent benefits are provided based on certain accumulated amounts, and they include deductibles and out-of-pocket maximums. (However, cumulative financial requirements do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements.)

Cumulative quantitative treatment limitations are treatment limitations that determine whether or to what extent benefits are provided based on certain accumulated amounts, such as annual or lifetime day or visit limits.

Financial requirements include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

Medical/surgical benefits means benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law, but not including MH/SUD benefits. Any condition defined by the plan or coverage as being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases [ICD] or state guidelines).

Mental health benefits means benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law. Any condition defined by the plan or coverage as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders [DSM], the most current version of the ICD, or state guidelines).

Note: If a plan defines a condition as a mental health condition, it must treat benefits for that condition as mental health benefits for purposes of MHPAEA. For example, if a plan defines autism spectrum disorder (ASD) as a mental health condition, it must treat benefits for ASD as mental health benefits.

[5] Self-Compliance Tool of the Mental Health Parity and Addiction Equity Act (MHPAEA). Department of Labor. Available at: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf. Accessed on: Sept 19, 2025.

Therefore, for example, any exclusion by the plan for experimental treatment that applies to ASD should be evaluated for compliance as a nonquantitative treatment limitation (NQTL) (and the processes, strategies, evidentiary standards, and other factors used by the plan to determine whether a particular treatment for ASD is experimental, as written and in operation, must be comparable to and no more stringently applied than those used for exclusions of experimental treatments of medical/surgical conditions in the same classification). See *FAQs About Mental Health And Substance Use Disorder Parity Implementation And the 21st Century Cures Act Part 39, Q1*, available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf. Additionally, if a plan defines ASD as a mental health condition, any aggregate annual or lifetime dollar limit or any quantitative treatment limitation (QTL) imposed on benefits for ASD (for example, an annual dollar cap on benefits for Applied Behavioral Analysis [ABA] therapy for ASD of $35,000, or a 50-visit annual limit for ABA therapy for ASD) should also be evaluated for compliance with MHPAEA.

Substance use disorder benefits means benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or state guidelines).

Treatment limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both QTLs, which are expressed numerically (such as 50 outpatient visits per year), and NQTLs, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition.

HFS MPR Playbook Definitions[6]

Prior Authorization Request Report—HCI Contract

The MCO [managed care organization] shall have in place and follow written policies and procedures when processing requests for PAs of Covered Services. To ensure appropriate utilization, the MCO may determine which Covered Services shall require PAs unless otherwise prohibited under the MCO Contract, the Department's PDL [Medicaid Preferred Drug List], or state law (e.g., MCO cannot require PA for Emergency Services). MCO shall authorize or deny Covered Services that require PA, including pharmacy services, as expeditiously as the Enrollee's health condition requires but no later than certain turnaround times specified in this MCO Handbook, MCO Contract, policy, or law. Prior authorization procedures and processes must be compliant with this MCO Handbook, MCO Contract, policy, law, and

[6] Excerpts from HFS MPR Playbook and MPR Quick Guide, December 2021.

MCO's Provider Handbook (for Covered Services requiring PA, not turnaround times). MCOs are required to submit reports on turnaround times for Ordinary/Routine and Expedited Prior Authorization Requests for Enrollees. (Per Contract eff. 1/1/2018)

Note: Non- Rx (pharmacy) Requests are counted by the type of request, for a specific member, for a date of service, or a consecutive series of dates of service.

Note: Pharmacy requests are counted on a per prescription basis.

Approved: MCO agrees to authorize Covered Services in the amount, scope, or duration requested.

Partially Approved: MCO agrees to authorize a portion of the Covered Services in the amount, scope, or duration requested.

Ordinary/Routine Prior Authorization Request: Prior Authorization Request reviewed and approved or denied within a Turnaround Time (TAT) of 4 days after receiving the request for authorization from a Provider, with a possible extension of up to 4 additional days if the Enrollee requests the extension or the MCO informs the Provider that there is a need for additional written justification demonstrating that the Covered Service is Medically Necessary and the Enrollee will not be harmed by the extension. Exception: Pharmacy.

Decision: MCO oral or written notification of an Approved, Partially Approved, or Denied Prior Authorization Request. Contractor shall notify the Provider orally or in writing and shall furnish the Enrollee with written notice of such decision. Such notice shall meet the requirements set forth in 42 CFR §438.404.

Denied: MCO declines to authorize the Covered Service(s) requested.

Electronic vs Non-Electronic (form of Prior Authorization request): A Prior Authorization request is categorized as "electronic" if the request was received in a manner that enables the request being automatically entered into the MCO's PA database/system.

Expedited Prior Authorization Request: Prior Authorization Request approved or denied within a TAT of 48 hours after receiving the request. Expedited Prior Authorizations shall occur if the Provider indicates, or MCO determines, that following the Ordinary/Routine Prior Authorization TAT could seriously jeopardize the Enrollee's life or health. Exception: This Expedited section does not apply to Pharmacy; the established TAT for Pharmacy is within 24 hours.

Pending: Prior Authorization Request for which the MCO has not issued a Decision.

Pharmacy Prior Authorization Request: Prior Authorization Request for Pharmacy services. The established TAT for Pharmacy is within 24 hours after receipt of the request.

Prior Authorization Request: A request by a Provider on behalf of an Enrollee for the provision of a Covered Service prior to receipt of the Covered Service.

Concurrent Review/Authorization is not included in the Prior Authorization report.

Turnaround Time (TAT): The number of hours or days between the MCO's receipt of a Prior Authorization Request and the date of the Decision. TAT varies per Ordinary/Routine Prior Authorization Request, Expedited Prior Authorization Request, and Pharmacy Prior Authorization Request.

Service Category Definitions

Behavioral Health Service: Covered Service for conditions related to emotional wellness, trauma, mental disorders, and substance use disorders and the services and supports found within the network of providers, or otherwise developed by the MCO, specifically encompassing the prevention, identification, treatment, and provision of recovery support for such conditions for the expressed purpose of increasing the stability of the Enrollee's functioning levels across various life domains.

Covered Service: Benefits and services agreed to by HFS and the MCO as described in Contract eff. 1/1/2018.

Dental Service: Covered Services related to dentistry; dentistry meaning the healing art which is concerned with the examination, diagnosis, treatment planning, and care of conditions within the human oral cavity and its adjacent tissues and structure, including orthodontia and dentures.

Durable Medical Equipment: Covered Service by a Provider for medical equipment, supplies, prosthetic devices, and orthotic devices.

Home Health Service: Covered Services rendered by a Provider (e.g., home health agency) at the Enrollee's residence according to a plan of treatment for illness or infirmity prescribed by a Provider (e.g., physician). Covered Services include part-time and intermittent nursing services and other therapeutic services such as physical therapy, occupational therapy, speech therapy, medical social services, or services provided by a home health aide.

Imaging (Advanced and Specialty): Covered Services of technologies used to view the human body in order to diagnose, monitor, or treat medical conditions such as MRI [magnetic resonance imaging] and CT [computed tomography].

Inpatient: Covered Services provided in a hospital or an institutional setting.

Medical (not Behavioral Health): Covered Services not otherwise listed herein for which the MCO requires PA.

Mental Health: Covered Services for mental health services such as mental health services provided under the Medicaid Clinic Option, Medicaid Rehabilitation Option, and Targeted Case Management Option. Utilize prior HFS guidance for BH [behavioral health] services: CMHC [Community Mental Health Center] Fee Schedule Verification, MCO Billing Guidelines CMHC Services, DASA [Division of Alcoholism and Substance Abuse] IL MCO Billing Guide for Encounter Data Reporting, Behavioral

Health Combined (Mental Health and Substance Use) Drugs, Behavioral Health Mental Health Drugs, and Behavioral Health Substance Abuse Drugs.

Occupational Therapy: A medically prescribed Covered Service identified in the Individualized Plan of Care that is designed to increase independent functioning through adaptation of a patient's tasks and environment, and that is provided by a licensed occupational therapist who meets Illinois licensure standards.

Outpatient: Covered Services not provided in an inpatient setting.

Pain Management: Covered Services for the diagnosing, monitoring, or treatment of pain. If pain management is delivered via Pharmacy or Therapy services, please utilize the Pharmacy and Therapy services area of the report to report the activity.

Pharmacy/Prescriptions: Covered Services for outpatient drugs.

Pharmacy—billed under the medical benefit via a "J code": include these requests in the reported metrics in the applicable delivery of care setting: Inpatient Medical—Expedited, or the Outpatient Medical—Expedited Prior Authorization section of the report (report in the Behavioral Health section of the report if the prescription is for a BH condition—refer to BH Rx guidance).

Note: PA requests (including pharmacy) are not double counted and therefore a request should not appear in more than one category.

Physical Therapy: A medically prescribed Covered Service that is provided by a licensed physical therapist and identified in the Individualized Plan of Care that utilizes a variety of methods to enhance an Enrollee's physical strength, agility, and physical capacity for ADL [activities of daily living].

Provider: Medicaid enrolled provider authorized to render the Covered Service.

Rehabilitation: Covered Service for the process of restoration of skills to an individual who has had an illness or injury to regain maximum self-sufficiency and function in a normal or near-normal manner in therapeutic, social, physical, behavioral, and vocational areas.

Skilled Nursing Facility (SNF): Covered Services rendered by a group care facility Provider as follows: Skilled Nursing care, continuous Skilled Nursing observations, restorative nursing, and other Covered Services under professional direction with frequent medical supervision, during the post-acute phase of illness or during recurrences of symptoms in long-term illness.

Speech Therapy: A medically prescribed speech or language-based Covered Service that is provided by a licensed speech therapist and identified in the Individualized Plan of Care, and that is used to evaluate or improve an Enrollee's ability to communicate.

Substance Use Prevention and Recovery (SUPR): Covered Services for subacute alcoholism and substance abuse services. Utilize prior HFS guidance for BH services: CMHC Fee Schedule Verification, MCO Billing Guidelines CMHC Services, Division of SUPR [Substance Use Prevention

and Recovery] IL MCO Billing Guide for Encounter Data Reporting, Behavioral Health Combined (Mental Health and Substance Use) Drugs, Behavioral Health Mental Health Drugs, and Behavioral Health Substance Abuse Drugs.

Therapy: Covered Services including Occupational Therapy, Physical Therapy, or Speech Therapy.

Transportation: Ambulance (emergency and nonemergency), Medicar, Taxi, Service Car, Private Auto, and Other (Commercial Train, Air, and Helicopter) Covered Services. When a member/enrollee is given a "pass" that is worth a single or multiple rides (and/or days) for the bus, subway, or other vehicle, when counting the number of requests and identifying the mode of transportation, please identify the number of "passes" as opposed to the number of "rides."