Department of Healthcare & Family Services
HealthChoice Illinois
Your Health. Your Choice.

2021 Mental Health Parity Analysis Summary Report

July 2022

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 to 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 2022 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/legislation/ilcs/fulltext.asp?DocName=021500050K370c.1. Accessed on: June 13, 2022.

[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' MHP Parity Analysis Template and comparative analyses, which were submitted to HFS on July 1, 2021.
- An attestation of continued compliance with MHP requirements and documentation of any related policy or procedural changes since the July 1, 2021, submission.
- Review of the health plans' utilization management (UM) documents and information.
- Review of the availability of prior authorization (PA) and clinical practice guideline (CPG) information on each health plan's website.
- Analysis of M/S and MH/SUD 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.

Detailed information regarding the methodology is included in Section 2 of this report.

Results

Overall, HSAG determined that the health plans demonstrated parity between M/S and MH/SUD services. Documentation and implementation of the health plans' processes demonstrated compliance with State and federal MHP requirements and standards.

Each health plan achieved parity overall on the ABD record reviews. The overall average for health plan compliance with scored elements of M/S and MH/SUD ABD records was 85 percent. For both M/S and MH/SUD records, the highest percentage scores were associated with UM policies and procedures, while the lowest percentage scores (including fully noncompliant) were associated with the timeliness and readability of notices of ABD.

Recommendations

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

- **Readability:** All six health plans had an opportunity for improvement related to readability levels for denial letters. HSAG recommends that all health plans review the systems and processes responsible for letter creation and ensure that all relevant information is written in easily understandable language. HSAG noted that HFS provided all HealthChoice health plans with a readability protocol in February 2022, which provided guidance to achieve compliance with sixth-grade reading levels. HSAG's recommendation may be achieved through revisions the health plans make to processes subsequent to receipt of the HFS readability protocol.
- **Notice sent within required time frame:** All six health plans had an opportunity for improvement related to compliance with timely notifications of ABD. The health plans should ensure and

demonstrate that decisions and communications are processed in a timely manner, including decisions made by delegates (as applicable).

- **Non-parity between M/S and MH/SUD denial rates:** One health plan, CountyCare, demonstrated non-parity when self-reported denial data were analyzed; however, results are limited to data analysis and do not reflect review of appropriateness of decisions. The health plan should continue its efforts with high-volume MH/SUD providers to reduce overturns (cases that were reversed in the providers' favor once documentation was received) and identify strategies to address provider barriers to submission of clinical documentation during the PA process.
- **Continued assessment of MHP:** HSAG noted that HFS has requested Phase II MHP documentation from the health plans, which includes reporting of M/S and MH/SUD NQTL exclusion criteria, out-of-network coverage standards, and geographic restrictions, which will be reported in June 2022. HFS may also consider the following assessments to inform HFS of MHP:
  - Review of appropriateness of health plan denial decisions
  - Focused review of M/S and MH/SUD records, subcategorized by outpatient and inpatient services

2. Methodology

The 2022 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.

Table 2-1 lists the health plans included in the 2022 MHP Analysis and the associated health plan abbreviations.

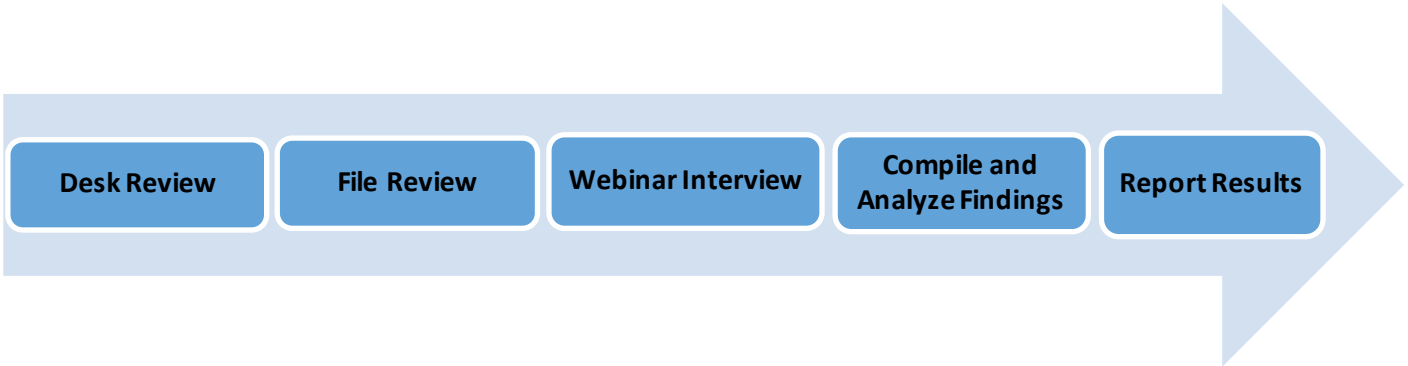
Table 2-1—List of Health Plan Names and Abbreviations

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

Process

The 2022 MHP Analysis activities are illustrated in Figure 2-1 and described below.

Figure 2-1—2022 MHP Analysis Activities



Activity 1: Desk Review

HSAG requested MHP documents from each health plan to inform HSAG's review team of each health plan's internal processes for management of NQTLs. HSAG provided a documentation submission checklist to the health plans.

The documentation submission checklist contained items including but not limited to:

- UM program documents
  - Program Description
  - Policies and Procedures
  - UM Committee meeting minutes
  - Policies or internal protocols that describe which inpatient and outpatient services require PA
  - The criteria used for each service type (the narrative description for each service type represented in the sample)
- NQTL processing documents
  - A listing of all MH/SUD benefits that are subject to NQTLs as defined in 45 CFR §146.136(a) and (c)(4)(ii), with a description of the applicable NQTLs.
  - Any relevant form(s) and page number(s) of NQTL requirements not expressed in policy form.
  - A listing of MH/SUD NQTLs applicable to in-network and out-of-network Inpatient and Outpatient classifications.

Depending on the information provided, HSAG requested additional information regarding the processes, strategies, evidentiary standards, and other factors the health plan used to determine which benefits were subject to NQTLs.

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

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

Table 2-2—Activity 1: Perform Desk Review

For this step,	HSAG will…
Step 1:	**Notify health plans of review.**
	Health plans are provided a timeline, review methodology, review tools, documentation submission checklist, and data file layouts, as applicable. HSAG provides assistance to all health plans prior to the review. This assistance includes clear instructions regarding the scope of the review, timeline and logistics of the webinar review, identification of expected review participants, and any other expectations or responsibilities. Health plans will be invited to attend an introductory webinar to discuss the scope of this review.
Step 2:	**Receive policy and procedure documentation and data universes from health plans.**
	HSAG reviews all documentation submitted and generates unique file review samples.

For this step,	HSAG will…
Step 3:	**Conduct reviews of health plan policies and procedures.**
	This includes review of all documents provided by the health plans according to the documentation submission checklist.

MHP Attestation Review Elements

In addition to documentation submission, the health plans were required to submit an attestation, confirming whether MHP policies and procedures had been revised since the July 2021 MHP Parity Analysis Template submission to HFS. For the attestation component of the 2021 MHP Analysis, results were reported by two factors—i.e., whether changes were identified and whether those changes were compliant with parity standards. If a change was reported in the attestation, HSAG referenced the corresponding supporting documentation to make a determination of compliance.

Prior Authorization (PA) and Clinical Practice Guideline (CPG) Website Review

HSAG assessed each health plan's enrollee- and provider-facing websites to assess the availability of information related to M/S and MH/SUD CPGs and requirements for PAs for M/S and MH/SUD services. Availability of information can serve to supplement enrollee and provider knowledge of the expectations and processing of services which may be subject to NQTLs.

Quarterly Business Review (QBR) Data Assessment

Monthly, the health plans self-report data related to M/S and MH/SUD PA approvals and denials to HFS. HSAG analyzed the health plans' data to determine parity between M/S and MH/SUD denials.

Activity 2: File Review

As documentation was submitted by the health plans, HSAG reviewers reviewed the documentation to gather data. In addition, HSAG requested that each health plan submit a complete list of inpatient and outpatient denials (ABDs) made between July through December 2021. Using a random sampling technique, HSAG selected 30 ABDs for each health plan (15 Med/Surg and 15 MH/SUD). The health plans submitted records and pertinent documentation related to each ABD chosen. HSAG's file review process is described in Table 2-3.

Table 2-3—Activity 2: Conduct File Review

For this step,	HSAG will…
Step 1:	**Provide health plans with file review samples.**
	HSAG provides health plans with file review samples. The health plans submit documentation for each sample selected.

For this step,	HSAG will…
Step 2:	**Identify the number and types of reviewers needed.**
	HSAG assigns review team members who are content area experts with in-depth knowledge of MHP requirements who also have extensive experience and proven competency conducting compliance and file reviews. To ensure interrater reliability, HSAG reviewers are trained on the review methodology to ensure that the determinations for each element of the review are made in the same manner.
Step 3:	**Conduct file reviews for all denial submissions.**
	HSAG reviewers use the HFS-approved file review tools to review records and to document findings regarding compliance with contract requirements and the health plans' policies and procedures.
Step 4:	**Compare data gathered from submissions with health plan policies and procedures.**
	Review data and compare with health plan policies and procedures to determine if the data are congruent with the health plan's MHP requirements.
Step 5:	**Identify any elements that need further information or clarification from the health plan to review during the webinar.**
	Compile questions and elements that require follow-up to submit to the health plan prior to the scheduled webinar.

ABD Record Review Elements

M/S and MH/SUD ABD records were assessed for compliance against the following evaluation elements:

- Determination of whether the denial followed internal policies related to PAs.
- The ABD notice was sent within the required time frame.
- The requested provider was contacted for additional information or consulted (as applicable) when denied for lack of information.
- The health plan followed its peer-to-peer review policy/procedure/process (as applicable).
- The decision was based on established authorization criteria.
- The health plan used the HFS template to provide the ABD.
- The notice of denial met the readability protocol.

During the file review, the HSAG review team reviewed documentation for the selected ABD cases. The review team determined evidence of case compliance with each of the scored elements. A score of *Met*, *Not Met*, or *Not Applicable* (*N/A*) was assigned to each requirement under review.

HSAG used a two-point scoring methodology. Each requirement was scored as *Met* or *Not Met* according to the criteria identified below. HSAG also used a designation of *N/A* if the requirement was not applicable to a record; *N/A* findings were not included in the two-point scoring methodology.

Met indicates full compliance defined as the following:

- Cases reviewed met the scoring criteria assigned to each requirement.

Not Met indicates noncompliance defined as either of the following:

- Cases reviewed did not meet the scoring criteria assigned to each requirement.
- Not all documentation was present.

Not Applicable (N/A) indicates a requirement that will not be scored for compliance based on the criteria listed for the specific element in the Evaluation Criteria document.

HSAG calculated the overall percentage-of-compliance score for each of the requirements. HSAG calculated the score for each requirement by adding the score from each case, indicating either a score of *Met* (value: 1 point) or *Not Met* (value: 0 points), and dividing the summed scores by the total number of applicable cases. HSAG calculated a total compliance score for each record and an aggregate ABD record review compliance score for each health plan.

Activity 3: Webinar Interview

HSAG collaborated with the health plans and HFS to schedule and conduct webinar interviews with key health plan staff members to:

- Ensure understanding of documents submitted.
- Clarify and confirm organizational implementation of policies, procedures, and related documents.
- Discuss the records reviewed with regard to findings, opportunities for improvement (if any), and recommendations for process improvement, if applicable.

The steps of the webinar review process are described in Table 2-4 below.

Table 2-4—Activity 3: Conduct Webinar Review

For this step,	HSAG will…
Step 1:	**Provide the health plans with webinar date options.**
	HSAG provides the health plans with scheduling options requiring first and second choice of the webinar date on a first come, first serve basis. The webinar schedule will be finalized in advance of the reviews.
Step 2:	**Conduct the webinar review.**
	During the webinar, HSAG will set the tone, expectations, and objectives for the review. Health plan staff members who participate in the webinar reviews are available to answer questions and to assist the HSAG review team in locating specific documentation. As a final step, HSAG meets with health plan staff members and HFS to provide a high-level summary and next steps for receipt of findings.

Activity 4: Compile and Analyze Findings

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

Activity 5: 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 2022 MHP Analysis results from its assessment of information received from the health plans, including:

- Review of the health plans' MHP Analysis Template and comparative analyses, which were submitted to HFS on July 1, 2021.
- An attestation of continued compliance with MHP requirements and documentation of any related policy or procedural changes since the July 1, 2021, submission.
- Review of the health plans' UM documents and information.
- Review of the availability of PA and CPG information on each health plan's website.
- 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.
- Webinar review with each health plan.

Results Summary

MHP Attestation Review

Of the six health plans reviewed, three reported changes to their July 2021 MHP NQTL Template submission to HFS. HSAG's review confirmed that all changes to M/S and MH/SUD services implemented by the health plans were found compliant with parity standards. Table 3-1 presents HSAG's findings related to the health plan attestation review.

Table 3-1—MHP Attestation Review Results

Have there been any changes to the health plan's responses in the July 2021 submission to HFS of the Phase I Mental Health Parity NQTL Form?	Change(s) Noted	Change(s) Compliant With Parity Standards
Aetna	No	N/A
BCBSIL	No	N/A
CountyCare	Yes	Yes
Meridian	Yes	Yes
Molina	No	N/A
YouthCare	Yes	Yes

During webinar reviews, the health plans confirmed their UM processes for review and decisions of M/S and MH/SUD authorization requests. HSAG had no concerns regarding the attestations submitted or the health plans' UM processes.

PA and CPG Website Review

HSAG reviewed each health plan's enrollee- and provider-facing websites to determine the availability of information related to PAs and CPGs, which can serve to supplement enrollee and provider knowledge of the expectations and processing of services which may be subject to NQTLs. Table 3-2 presents the results of the assessment.

Table 3-2—PA and CPG Assessment

PA and CPG Assessment	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
Does the health plan include CPGs for medical/surgical conditions?	Yes	Yes	Yes	Yes	Yes	No
Does the health plan include CPGs for mental health/substance abuse disorders?	Yes	Yes	Yes	Yes	Yes	Yes
Does the health plan include information about how often the CPGs are reviewed/updated?	No	Yes	No	Yes	Yes	No
Does the health plan include information on whom to contact if providers have questions/comments about the CPGs?	No	Yes	No	Yes	No	Yes
Does the health plan include information for providers regarding PAs?	Yes	Yes	Yes	Yes	Yes	Yes
Does the health plan have links/information about CPGs available for members/enrollees?	No	Yes	Yes	No	Yes	No
Does the health plan include information for members regarding PAs?	Yes	Yes	Yes	Yes	Yes	Yes

Opportunities to provide additional or more robust information on enrollee- or provider-facing websites were identified for four of the six health plans; however, those opportunities did not demonstrate lack of parity for mental health services.

HSAG did not identify any MHP concerns related to availability of CPG and PA information for enrollees and providers.

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 3-3 displays the results of the assessment.

Table 3-3—QBR Data Assessment: Total Requests Denied—CY 2021

Health Plan	PA Requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME,* Home Health, Imaging, and Pain Management	PA (Behavioral Health Only)	MHP Compliance
Aetna	15%	3%	Yes
BCBSIL	14%	0.3%	Yes
CountyCare	5%	10%	No
Meridian	18%	0.2%	Yes
Molina	16%	2%	Yes
YouthCare (Youth in Care)	5%	0%	Yes
YouthCare (Former Youth in Care)	11%	1%	Yes

*DME = durable medical equipment

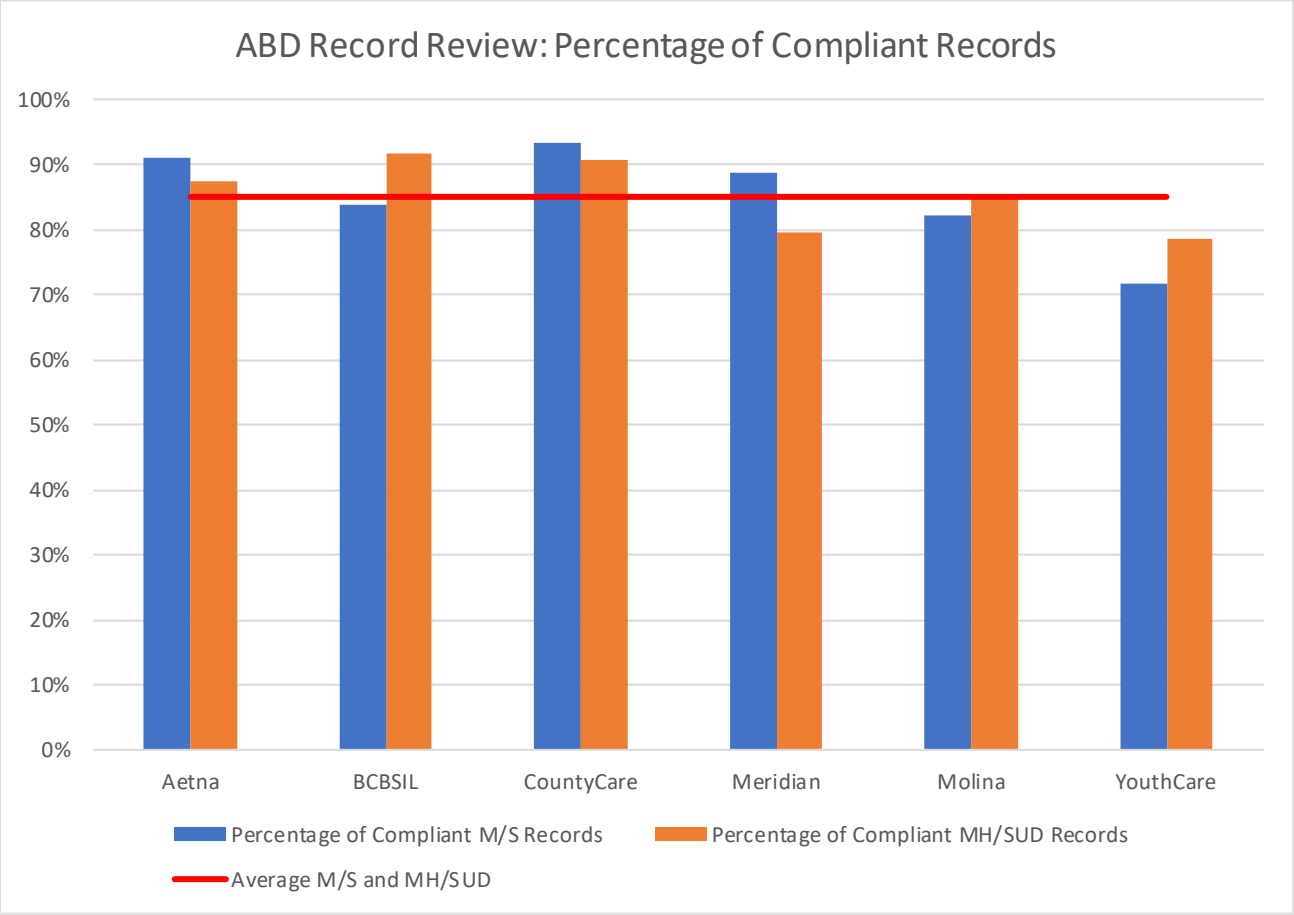
HSAG completed a Chi-square analysis to determine statistically significant differences between the health plan's denial rates for M/S and MH/SUD services. Five of the six health plans denied M/S authorization requests at a statistically significantly higher rate than MH/SUD requests. Results demonstrated MHP.

CountyCare's results demonstrated non-parity: the health plan denied MH/SUD authorization requests at a statistically significantly higher rate than M/S requests. CountyCare also denied MH/SUD authorization requests at a statistically significantly higher rate than the other four HealthChoice health plans. HSAG noted that non-parity may be due to provider opportunities rather than appropriateness of clinical decisions. The health plan reported that previous to HSAG's assessment, it conducted an internal review of MH/SUD denials to assess and document stringency and comparability and noted a high volume of overturned cases (i.e., cases for which the initial denial is reversed in favor of the provider after additional information is received), which may explain the statistically significant differences identified by HSAG. During webinar review, the health plan reported processes to target providers with a high volume of overturned cases to improve submission of documentation during the PA stage and reduce denial turnovers and appeals.

ABD Record Review

HSAG reviewed a random sample of 15 M/S and 15 MH/SUD ABD records for each health plan to determine evidence of parity between M/S and MH/SUD authorization denial processes. In general, 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—Overall Record Review Compliance Percentage Results



On average, the health plans exhibited compliance with 85 percent of M/S ABD record elements, demonstrating a high level of compliance. Two of the health plans (Aetna and CountyCare) scored greater than 90 percent overall. Across the seven ABD record elements reviewed, the highest compliance scores were associated with the health plans following internal PA policies and procedures and making determinations based on established authorization criteria, while the lowest scores were associated with the timeliness of notices of ABD and readability.

On average, the health plans exhibited compliance with 85 percent of MH/SUD ABD record elements, demonstrating a high level of compliance. Two of the health plans (BCBSIL and CountyCare) scored greater than 90 percent overall. Across the seven ABD record elements reviewed, the highest

compliance scores were associated with the health plans following internal PA policies and procedures and making determinations based on established authorization criteria, while the lowest scores were associated with the timeliness of notices of ABD and readability.

Chi-square analysis of each health plan's overall record review results demonstrated parity for all health plans. HSAG also completed a Chi-square analysis for each of the seven record review elements. One health plan, Meridian, demonstrated non-parity related to readability of its notice of ABD for MH/SUD denials. HSAG noted that HFS provided all HealthChoice health plans with a readability protocol in February 2022, which provided guidance to achieve compliance with sixth-grade reading levels.

Conclusions

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.
- All health plans' policies and procedures described an appropriate level of expertise required for UM staff members making denial determinations, and record reviews demonstrated that all health plans followed these guidelines.
- All health plans had appropriate processes in place to complete ongoing review of services to determine potential revisions to PA requirements.
- All health plans that delegated UM activities described adequate monitoring and oversight activities.
- All health plans had adequate enrollee- and provider-facing information related to PAs and the CPGs used to make decisions.
- All health plans had opportunity for improvement related to the timeliness and quality of communication with members for both M/S and MH/SUD services.

Appendix A. Health Plan-Specific Findings

This appendix provides detailed findings from the MHP Attestation Review, PA and CPG Information Review, QBR Data Assessment, and ABD Record Review for each health plan.

Aetna Better Health of Illinois (Aetna)

MHP Attestation Review

HSAG reviewed the health plan's attestation form submission. Table A-1 provides the results of the review.

Table A-1—MHP Attestation Review Results

MHP Attestation Form Review	Change(s) Noted	Change(s) Compliant With Parity Standards
Have there been any changes to the health plan's responses in the July 2021 submission to HFS of the Phase I Mental Health Parity NQTL Form?	No	N/A

Aetna's attestation form confirmed that the health plan made no changes to MHP policies and procedures since its submission to HFS in July 2021.

During the webinar review, the health plan confirmed its UM processes for review and decisions of M/S and MH/SUD authorization requests. The health plan reported using four delegates to process M/S requests; delegates do not review any MH/SUD or pharmacy requests. The health plan reported that it had not identified any parity issues or opportunities for improvement.

HSAG had no concerns regarding the attestation submitted or the health plan's UM processes.

PA and CPG Information Review

HSAG assessed each health plan's enrollee- and provider-facing websites to assess the availability of information related to M/S and MH/SUD CPGs and requirements for PAs for M/S and MH/SUD services. Table A-2 presents the results of the assessment.

Table A-2—PA and CPG Assessment

PA and CPG Assessment	Assessment Result
Does the health plan include CPGs for medical/surgical conditions?	Yes
Does the health plan include CPGs for mental health/substance abuse disorders?	Yes
Does the health plan include information about how often the CPGs are reviewed/updated?	No
Does the health plan include information on whom to contact if providers have questions/comments about the CPGs?	No
Does the health plan include information for providers regarding PAs?	Yes

PA and CPG Assessment	Assessment Result
Does the health plan have links/information about CPGs available for members/enrollees?	No
Does the health plan include information for members regarding PAs?	Yes

The review of Aetna's PA and CPG websites revealed that the CPGs for M/S and MH/SUD were not accessible on the health plan's website for enrollees; however, the health plan's Quality Improvement Program webpage instructed enrollees to contact member services to request a copy of the CPGs. For providers, the health plan's website linked to a portal which included a search for CPGs. The frequently asked questions page on the portal stated that CPGs do not have a specific review frequency and can be changed at any time.

HSAG did not identify any MHP concerns related to availability of CPG and PA information for enrollees and providers.

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-3 presents the results of the assessment.

Table A-3—QBR Data Assessment: Total Requests Denied—CY 2021

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	17,511	114,014	15%
PA (Behavioral Health Only)	437	12,955	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. The health plan denied M/S authorization requests at a statistically significantly higher rate than MH/SUD requests. Results demonstrated MHP.

ABD Record Review

HSAG reviewed a random sample of 15 M/S and 15 MH/SUD ABD records to determine evidence of parity between M/S and MH/SUD authorization denial processes. Table A-4 presents the results of the record review.

Table A-4—ABD Record Review Results

ABD Evaluation Element	Percent of Compliant* M/S Records	Percent of Compliant* MH/SUD Records	MHP
1. Determination followed documented policies and procedures	100% (15/15)	100% (15/15)	Yes
2. Notice sent within required time frame	86.67% (13/15)	86.67% (13/15)	Yes
3. If denied for lack of information, requesting provider was contacted/consulted for additional information	100% (4/4)	100% (5/5)	Yes
4. Peer review policy/process followed as applicable	N/A	N/A	Yes
5. Determination based on established authorization criteria	100% (15/15)	100% (15/15)	Yes
6. The health plan used the HFS template to provide notice	100% (15/15)	100% (15/15)	Yes
7. Notice of denial met readability protocol (sixth-grade reading level)	66.67% (10/15)	46.67% (7/15)	Yes
Overall Compliance	**91.14 (72/79)**	**87.50% (70/80)**	**Yes**

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

Aetna's data indicated that the health plan had an opportunity for improvement related to readability testing, as 66.67 percent of M/S and 46.67 percent of MH/SUD denial letters met a sixth-grade reading level. HSAG noted that compliance scores for readability did not demonstrate a statistically significant difference, based on Chi-square testing. Aetna's data indicated that the health plan also had an opportunity for improvement related to timeliness of notifications of ABD.

Overall, results of the review demonstrated 91.14 percent compliance for M/S records and 87.50 percent compliance for MH/SUD records. HSAG completed a Chi-square analysis to determine statistically significant differences between the overall results of the M/S and MH/SUD record reviews, and no difference was identified. The results of the ABD record review demonstrated MHP.

Findings and Recommendations

Finding #1	The health plan had an opportunity for improvement related to the readability of M/S and MH/SUD ABDs. During the webinar review, the health plan reported that a dedicated team of clinical and nonclinical staff members complete the ABD notices for M/S and MH/SUD denials, and a pharmacy technician completes the notices for pharmacy denials.
Recommendation #1	Aetna should review the systems and processes responsible for letter creation and ensure that all relevant information is written in easily understandable language. HSAG noted that HFS provided all HealthChoice health plans with a readability protocol in February 2022, which provided guidance to achieve compliance with a sixth-grade reading level. HSAG's recommended action for Aetna may be achieved through revisions the health plan has made to processes subsequent to receipt of the HFS readability protocol.
Finding #2	The health plan had an opportunity for improvement related to timeliness of notices of ABD for M/S and MH/SUD decisions.
Recommendation #2	Aetna should ensure and demonstrate that its decisions and communications are processed in a timely manner, including decisions made by delegates.

Blue Cross Community Health Plans (BCBSIL)

MHP Attestation Review

HSAG reviewed the health plan's attestation form submission. Table A-5 provides the results of the review.

Table A-5—MHP Attestation Review Results

MHP Attestation Form Review	Change(s) Noted	Change(s) Compliant With Parity Standards
Have there been any changes to the health plan's responses in the July 2021 submission to HFS of the Phase I Mental Health Parity NQTL Form?	No	N/A

BCBSIL's attestation form confirmed that the health plan had made no changes to MHP policies and procedures since its submission to HFS in July 2021.

During the webinar review, the health plan confirmed its UM processes for review and decisions of M/S and MH/SUD authorization requests. The health plan reported using two delegates to process authorization requests. The health plan described its organization's enterprise MHP Operations Team and the organization's creation and maintenance of a benefits library, which provides a crosswalk of M/S and MH/SUD benefits, useful to both internal and external customers. The health plan reported that it had conducted MHP assessments and had not identified any parity issues or opportunities for improvement.

HSAG had no concerns regarding the attestation submitted or the health plan's UM processes.

PA and CPG Information Review

HSAG assessed each health plan's enrollee- and provider-facing websites to assess the availability of information related to M/S and MH/SUD CPGs and requirements for PAs for M/S and MH/SUD services. Table A-6 presents the results of the assessment.

Table A-6—PA and CPG Assessment

PA and CPG Assessment	Assessment Result
Does the health plan include CPGs for medical/surgical conditions?	Yes
Does the health plan include CPGs for mental health/substance abuse disorders?	Yes
Does the health plan include information about how often the CPGs are reviewed/updated?	Yes

PA and CPG Assessment	Assessment Result
Does the health plan include information on whom to contact if providers have questions/comments about the CPGs?	Yes
Does the health plan include information for providers regarding PAs?	Yes
Does the health plan have links/information about CPGs available for members/enrollees?	Yes
Does the health plan include information for members regarding PAs?	Yes

The review of BCBSIL's PA and CPG websites revealed that the CPGs and PA information for M/S and MH/SUD services were accessible on the health plan's website.

HSAG did not identify any MHP concerns related to availability of CPG and PA information for enrollees and providers.

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 2021

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	47,314	336,966	14%
PA (Behavioral Health Only)	63	22,266	0.3%

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. The health plan denied M/S authorization requests at a statistically significantly higher rate than MH/SUD requests. Results demonstrated MHP.

ABD Record Review

HSAG reviewed a random sample of 15 M/S and 15 MH/SUD ABD records to determine evidence of parity between M/S and MH/SUD authorization denial processes. Table A-8 presents the results of the record review.

Table A-8—ABD Record Review Results

ABD Evaluation Element	Percentage of Compliant* M/S Records	Percentage of Compliant* MH/SUD Records	MHP
1. Determination followed documented policies and procedures	100% (15/15)	100% (15/15)	Yes
2. Notice sent within required time frame	73.33% (11/15)	100% (15/15)	Yes
3. If denied for lack of information, requesting provider was contacted/consulted for additional information	100% (5/5)	100% (5/5)	Yes
4. Peer review policy/process followed as applicable	100% (7/7)	100% (5/5)	Yes
5. Determination based on established authorization criteria	100% (15/15)	100% (15/15)	Yes
6. The health plan used the HFS template to provide notice	100% (15/15)	100% (15/15)	Yes
7. Notice of denial met readability protocol (sixth-grade reading level)	33.33% (5/15)	53.33% (8/15)	Yes
Overall Compliance	**83.90% (73/87)**	**91.76% (78/85)**	**Yes**

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

BCBSIL's data indicated that the health plan had an opportunity for improvement related to readability testing, as 33.33 percent of M/S and 53.33 percent of MH/SUD denial letters met a sixth-grade reading level. HSAG noted that compliance scores for readability did not demonstrate a statistically significant difference, based on Chi-square testing. BCBSIL's data indicated that the health plan also had an opportunity for improvement related to timeliness of notifications of ABD for M/S cases.

Overall, results of the review demonstrated 83.90 percent compliance for M/S records and 91.76 percent compliance for MH/SUD records. HSAG completed a Chi-square analysis to determine statistically significant differences between the overall results of the M/S and MH/SUD record reviews, and no difference was identified. The results of the ABD record review demonstrated MHP.

Findings and Recommendations

Finding #1	The health plan had an opportunity for improvement related to the readability of M/S and MH/SUD ABDs. During the webinar review, the health plan reported that a dedicated administrative support team completes the ABD notices for M/S and MH/SUD denials. The team has access to and is supported by UM clinicians. The health plan reported that, after receipt of HFS' readability protocol, it updated its standard operating procedures for readability.
Recommendation #1	BCBSIL should review the systems and processes responsible for letter creation and ensure that all relevant information is fully printed and written in easily understandable language. HSAG noted that HFS provided all HealthChoice health plans with a readability protocol in February 2022, which provided guidance to achieve compliance with a sixth-grade reading level. HSAG's recommended action for BCBSIL may be achieved through revisions the health plan has made to processes subsequent to receipt of the HFS readability protocol.
Finding #2	The health plan had an opportunity for improvement related to timeliness of notices of ABD for M/S and MH/SUD decisions.
Recommendation #2	BCBSIL should ensure and demonstrate that its decisions and communications are processed in a timely manner, including decisions made by delegates.

CountyCare

MHP Attestation Review

HSAG reviewed the health plan's attestation form submission. Table A-9 provides the results of the review.

Table A-9—MHP Attestation Review Results

MHP Attestation Form Review	Change(s) Noted	Change(s) Compliant With Parity Standards
Have there been any changes to the health plan's responses in the July 2021 submission to HFS of the Phase I Mental Health Parity NQTL Form?	Yes	Yes

CountyCare's attestation form confirmed that the health plan made changes to MHP policies and procedures since its submission to HFS in July 2021:

- Added policy effective 1/1/2022: Chiropractic Services (Current Procedural Terminology [CPT] codes 98940 and 98941) for members older than 20 years of age.
- Removed policy effective 1/1/2022: Site of Service for Arthroplasty of Hips and Knees in the outpatient setting (CPT codes 27130, 27134, 27447, 27486, and 27487).
- Removed policy effective 1/1/2022: Abortion (CPT codes 59850, 59851, 59852, 59855, 59856, 59857, and 59840).
- Temporary waiver of PA requirements for services outlined through 10/31/2021: Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST); DME Equipment; Home Health Care Services; Inpatient Acute Care Admissions, Skilled Nursing Facility (SNF), and Long-Term Acute Care (LTAC) Hospitals.

HSAG reviewed the rationale for addition and removal of the policies described by the health plan, and noted appropriateness for monitoring fraud, waste, and abuse; alignment with evidence-based practices; and elimination of unnecessary delays of care.

During the webinar review, the health plan confirmed its UM processes for review and decisions of M/S and MH/SUD authorization requests. The health plan reported using one delegate and its subsidiary to process requests. The health plan reported that its oversight of delegates will include annual MHP review.

HSAG had no concerns regarding the attestation submitted or the health plan's UM processes.

PA and CPG Information Review

HSAG assessed each health plan's enrollee- and provider-facing websites to assess the availability of information related to M/S and MH/SUD CPGs and requirements for PAs for M/S and MH/SUD services. Table A-10 presents the results of the assessment.

Table A-10—PA and CPG Assessment

PA and CPG Assessment	Assessment Result
Does the health plan include CPGs for medical/surgical conditions?	Yes
Does the health plan include CPGs for mental health/substance abuse disorders?	Yes
Does the health plan include information about how often the CPGs are reviewed/updated?	No
Does the health plan include information on whom to contact if providers have questions/comments about the CPGs?	No
Does the health plan include information for providers regarding PAs?	Yes
Does the health plan have links/information about CPGs available for members/enrollees?	Yes
Does the health plan include information for members regarding PAs?	Yes

The review of CountyCare's PA and CPG websites revealed that the CPGs and PA information for M/S and MH/SUD were accessible on the health plan's website. CountyCare's website did not include information on whom to contact if providers have questions/comments about CPGs or how often CPGs are updated.

HSAG did not identify any MHP concerns related to availability of CPG and PA information for enrollees and providers.

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-11 presents the results of the assessment.

Table A-11—QBR Data Assessment: Total Requests Denied—CY 2021

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	3,550	72,828	5%
PA (Behavioral Health Only)	141	1,478	10%

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 MH/SUD authorization requests at a statistically significantly higher rate than M/S requests. Results did not demonstrate MHP.

During the webinar review, HSAG provided the health plan with the results of the Chi-square analysis. The health plan reported that as part of its ongoing MHP assessment, it conducted an internal review of MH/SUD denials to assess and document stringency and comparability, and noted a high volume of overturned cases (i.e., cases for which the initial denial is reversed in favor of the provider after additional information is received), which likely explains the statistically significant difference identified by HSAG. The health plan has targeted providers with the largest volume of overturns and noted that the targeted providers have an opportunity for improvement related to submission of required clinical documentation, which is not usually

received until initiation of the appeal process. The health plan's root cause analysis identified provider barriers such as batch submissions without supporting documentation, inconsistent documentation during the COVID-19 pandemic, and lack of electronic health records. The health plan reported that it continues to meet and educate providers in an effort to mitigate denials and appeals.

The health plan also provided information regarding its annual process to examine high approval rates, high volume, and consistent provider compliance to authorization requirements to determine whether PAs are required for all MH services. The health plan reported that analytics will continue to be an active process to determine potential changes to reduce burden and denials.

ABD Record Review

HSAG reviewed a random sample of 15 M/S and 15 MH/SUD ABD records to determine evidence of parity between M/S and MH/SUD authorization denial processes. Table A-12 presents the results of the record review.

Table A-12—ABD Record Review Results

ABD Evaluation Element	Percentage of Compliant* M/S Records	Percentage of Compliant* MH/SUD Records	MHP
1. Determination followed documented policies and procedures	100% (15/15)	100% (15/15)	Yes
2. Notice sent within required time frame	93.33% (14/15)	93.33% (14/15)	Yes
3. If denied for lack of information, requesting provider was contacted/consulted for additional information**	N/A	N/A	Yes
4. Peer review policy/process followed as applicable	100% (1/1)	100% (1/1)	Yes
5. Determination based on established authorization criteria	100% (15/15)	100% (15/15)	Yes
6. The health plan used the HFS template to provide notice	100% (15/15)	100% (15/15)	Yes
7. Notice of denial met readability protocol (sixth-grade reading level)	73.33% (11/15)	60.00% (9/15)	Yes
Overall Compliance	**93.42% (71/76)**	**90.79% (69/76)**	**Yes**

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

*** The health plan does not utilize a "lack of information" category for denials. The health plan makes decisions based on the information submitted by the provider; if documentation submitted does not provide enough evidence to warrant an authorization, a "lack of medical necessity" determination is used.*

CountyCare's data indicated that the health plan had an opportunity for improvement related to readability testing, as 73.33 percent of M/S and 60.00 percent of MH/SUD denial letters met a sixth-grade reading level. HSAG noted that compliance scores for readability did not demonstrate a statistically significant difference, based on Chi-square testing.

Overall, results of the review demonstrated 93.42 percent compliance for M/S records and 90.79 percent compliance for MH/SUD records. HSAG completed a Chi-square analysis to determine statistically significant differences between the overall results of the M/S and MH/SUD record reviews, and no difference was identified. The results of the ABD record review demonstrated MHP.

Findings and Recommendations

Finding #1	Analysis of the health plan's self-reported QBR denial data did not demonstrate MHP.
Recommendation #1	CountyCare should continue its efforts with high-volume MH/SUD providers to reduce overturns and identify strategies to address provider barriers to submission of clinical documentation during the PA process.
Finding #2	The health plan had an opportunity for improvement related to the readability of M/S and MH/SUD ABDs. During the webinar review, the health plan reported that a dedicated clinical team completes the ABD notices for M/S and MH/SUD denials, and a separate pharmacy team completes the notices for pharmacy denials.
Recommendation #2	CountyCare should review the systems and processes responsible for letter creation and ensure that all relevant information is written in easily understandable language. HSAG noted that HFS provided all HealthChoice health plans with a readability protocol in February 2022, which provided guidance to achieve compliance with a sixth-grade reading level. HSAG's recommended action for CountyCare may be achieved through revisions the health plan has made to processes subsequent to receipt of the HFS readability protocol.

MeridianHealth (Meridian)

MHP Attestation Review

HSAG reviewed the health plan's attestation form submission. Table A-13 provides the results of the review.

Table A-13—MHP Attestation Review Results

MHP Attestation Form Review	Change(s) Noted	Change(s) Compliant With Parity Standards
Have there been any changes to the health plan's responses in the July 2021 submission to HFS of the Phase I Mental Health Parity NQTL Form?	Yes	Yes

Meridian's attestation form confirmed that the health plan made changes to MHP policies and procedures since its submission to HFS in July 2021:

- Updated its UM Program Description and Policy 6.23: Timeliness of Decision Making and Notification to include the YouthCare line of business.

During the webinar review, the health plan confirmed its UM processes for review and decisions of M/S and MH/SUD authorization requests. The health plan reported using two delegates to process M/S and pharmacy requests. The health plan described its organization's corporate efforts related to MHP, including developing a standard package of NQTL analyses and parity training, both of which are projected to be implemented in 2022. The health plan reported that it had conducted MHP assessments and had not identified any parity issues or opportunities for improvement.

HSAG had no concerns regarding the attestation submitted or the health plan's UM processes.

PA and CPG Information Review

HSAG assessed each health plan's enrollee- and provider-facing websites to assess the availability of information related to M/S and MH/SUD CPGs and requirements for PAs for M/S and MH/SUD services. Table A-14 presents the results of the assessment.

Table A-14—PA and CPG Assessment

PA and CPG Assessment	Assessment Result
Does the health plan include CPGs for medical/surgical conditions?	Yes
Does the health plan include CPGs for mental health/substance abuse disorders?	Yes

PA and CPG Assessment	Assessment Result
Does the health plan include information about how often the CPGs are reviewed/updated?	Yes
Does the health plan include information on whom to contact if providers have questions/comments about the CPGs?	Yes
Does the health plan include information for providers regarding PAs?	Yes
Does the health plan have links/information about CPGs available for members/enrollees?	No
Does the health plan include information for members regarding PAs?	Yes

The review of Meridian's PA and CPG websites revealed that the CPGs and PA information for M/S and MH/SUD services were accessible on the health plan's website. Although the health plan's website did not include links/information about CPGs for members/enrollees, the search function allowed enrollees to locate the CPGs on the provider webpage.

HSAG did not identify any MHP concerns related to availability of CPG and PA information for enrollees and providers.

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-15 presents the results of the assessment.

Table A-15—QBR Data Assessment: Total Requests Denied—CY 2021

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	40,438	222,492	18%
PA (Behavioral Health Only)	3	1,343	0.2%

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. Results demonstrated MHP.

ABD Record Review

HSAG reviewed a random sample of 15 M/S and 15 MH/SUD ABD records to determine evidence of parity between M/S and MH/SUD authorization denial processes. Table A-16 presents the results of the record review.

Table A-16—ABD Record Review Results

ABD Evaluation Element	Percentage of Compliant* M/S Records	Percentage of Compliant* MH/SUD Records	MHP
1. Determination followed documented policies and procedures	100% (15/15)	100% (15/15)	Yes
2. Notice sent within required time frame	93.33% (14/15)	93.33% (14/15)	Yes
3. If denied for lack of information, requesting provider was contacted/consulted for additional information	100% (4/4)	100% (2/2)	Yes
4. Peer review policy/process followed as applicable	N/A	100% (1/1)	Yes
5. Determination based on established authorization criteria	100% (15/15)	100% (15/15)	Yes
6. The health plan used the HFS template to provide notice	100% (15/15)	100% (15/15)	Yes
7. Notice of denial met readability protocol (sixth-grade reading level)	46.67% (7/15)	0.00% (0/15)	No
Overall Compliance	**88.61% (70/79)**	**79.49% (62/78)**	**Yes**

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

Meridian's data indicated that the health plan had an opportunity for improvement related to readability testing, as 46.67 percent of M/S and 0.00 percent of MH/SUD denial letters met a sixth-grade reading level. HSAG noted that compliance scores for readability demonstrated a statistically significant difference, based on Chi-square testing.

Overall, results of the review demonstrated 88.61 percent compliance for M/S records and 79.49 percent compliance for MH/SUD records. HSAG completed a Chi-square analysis to determine statistically significant differences between the overall results of the M/S and MH/SUD record reviews, and no difference was identified. The results of the ABD record review demonstrated MHP.

Findings and Recommendations

Finding #1	The health plan had an opportunity for improvement related to the readability of M/S and MH/SUD ABDs. HSAG noted that the rate at which MH/SUD ABDs failed to meet a sixth-grade level was statistically significantly lower than the rate at which M/S ABDs failed to meet this level. During the webinar review, the health plan reported that a dedicated team completes the ABD notices for M/S and MH/SUD denials, and a pharmacy technician completes the notices for pharmacy denials.
Recommendation #1	Meridian should review the systems and processes responsible for letter creation and ensure that all relevant information is written in easily understandable language. HSAG noted that HFS provided all HealthChoice health plans with a readability protocol in February 2022, which provided guidance to achieve compliance with sixth-grade reading levels. HSAG's recommended action for Meridian may be achieved if the health plan revises processes identified in the HFS readability protocol.

Molina Healthcare of Illinois, Inc. (Molina)

MHP Attestation Review

HSAG reviewed the health plan's attestation form submission. Table A-17 provides the results of the review.

Table A-17—MHP Attestation Review Results

MHP Attestation Form Review	Change(s) Noted	Change(s) Compliant With Parity Standards
Have there been any changes to the health plan's responses in the July 2021 submission to HFS of the Phase I Mental Health Parity NQTL Form?	No	N/A

Molina's attestation form confirmed that the health plan made no changes to MHP policies and procedures since its submission to HFS in July 2021.

During the webinar review, the health plan confirmed its UM processes for review and decisions of M/S and MH/SUD authorization requests. The health plan reported using one delegate for UM during the review lookback period; however, the delegation was terminated in October 2021. The health plan described its organization's process to have subject matter experts complete parity analyses; the health plan had not identified any parity issues or opportunities for improvement.

HSAG had no concerns regarding the attestation submitted or the health plan's UM processes.

PA and CPG Information Review

HSAG assessed each health plan's enrollee- and provider-facing websites to assess the availability of information related to M/S and MH/SUD CPGs and requirements for PAs for M/S and MH/SUD services. Table A-18 presents the results of the assessment.

Table A-18—PA and CPG Assessment

PA and CPG Assessment	Assessment Result
Does the health plan include CPGs for medical/surgical conditions?	Yes
Does the health plan include CPGs for mental health/substance abuse disorders?	Yes
Does the health plan include information about how often the CPGs are reviewed/updated?	Yes
Does the health plan include information on whom to contact if providers have questions/comments about the CPGs?	No
Does the health plan include information for providers regarding PAs?	Yes

PA and CPG Assessment	Assessment Result
Does the health plan have links/information about CPGs available for members/enrollees?	Yes
Does the health plan include information for members regarding PAs?	Yes

The review of Molina's PA and CPG websites revealed that the CPGs and PA information for M/S and MH/SUD were accessible on the health plan's website. The health plan's website did not include information on whom to contact if the providers have questions/comments about the CPGs.

HSAG did not identify any MHP concerns related to availability of CPG and PA information for enrollees and providers.

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-19 presents the results of the assessment.

Table A-19—QBR Data Assessment: Total Requests Denied—CY 2021

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	10,904	68,717	16%
PA (Behavioral Health Only)	44	2,165	2%

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. Results demonstrated MHP.

ABD Record Review

HSAG reviewed a random sample of 15 M/S and 15 MH/SUD ABD records to determine evidence of parity between M/S and MH/SUD authorization denial processes. Table A-20 presents the results of the record review.

Table A-20—ABD Record Review Results

ABD Evaluation Element	Percentage of Compliant* M/S Records	Percentage of Compliant* MH/SUD Records	MHP
1. Determination followed documented policies and procedures	100% (15/15)	100% (14/14)	Yes
2. Notice sent within required time frame	80% (12/15)	100% (15/15)	Yes
3. If denied for lack of information, requesting provider was contacted/consulted for additional information	100% (2/2)	75% (3/4)	Yes
4. Peer review policy/process followed as applicable	100% (1/1)	N/A	Yes
5. Determination based on established authorization criteria	100% (15/15)	100% (15/15)	Yes
6. The health plan used the HFS template to provide notice	100% (15/15)	100% (15/15)	Yes
7. Notice of denial met readability protocol (sixth-grade reading level)	26.67% (4/15)	26.67% (4/15)	Yes
Overall Compliance	**82.05% (64/78)**	**84.62% (66/78)**	**Yes**

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

Molina's data indicated that the health plan had an opportunity for improvement related to readability testing, as 26.67 percent of M/S and 26.67 percent of MH/SUD denial letters met a sixth-grade reading level. HSAG noted that compliance scores for readability did not demonstrate a statistically significant difference, based on Chi-square testing. Molina's data indicated that the health plan also had an opportunity for improvement related to timeliness of notifications of ABD for M/S records.

Overall, results of the review demonstrated 82.05 percent compliance for M/S records and 84.62 percent compliance for MH/SUD records. HSAG completed a Chi-square analysis to determine statistically significant differences between the overall results of the M/S and MH/SUD record reviews, and no difference was identified. The results of the ABD record review demonstrated MHP.

Findings and Recommendations

Finding #1	The health plan had an opportunity for improvement related to the readability of M/S and MH/SUD ABDs. During the webinar review, the health plan reported that a dedicated team completes the ABD notices.
Recommendation #1	Molina should review the systems and processes responsible for letter creation and ensure that all relevant information is written in easily understandable language. HSAG noted that HFS provided all HealthChoice health plans with a readability protocol in February 2022, which provided guidance to achieve compliance with a sixth-grade reading level. HSAG's recommended action for Molina may be achieved through revisions the health plan has made to processes subsequent to receipt of the HFS readability protocol.
Finding #2	The health plan had an opportunity for improvement related to timeliness of notices of ABD for M/S decisions.
Recommendation #2	Molina should ensure and demonstrate that its decisions and communications are processed in a timely manner.

YouthCare Specialty Plan (YouthCare)

MHP Attestation Review

YouthCare was not included as part of the MHP submission to HFS in July 2021; however, YouthCare was required to complete an attestation to determine if its MHP policies and procedures were congruent with Meridian's policies and procedures. HSAG reviewed the health plan's attestation form submission. Table A-21 provides the results of the review.

Table A-21—MHP Attestation Review Results

MHP Attestation Form Review	Change(s) Noted	Change(s) Compliant With Parity Standards
Have there been any changes to the health plan's responses in the July 2021 submission to HFS of the Phase I Mental Health Parity NQTL Form?	Yes	Yes

YouthCare's attestation form confirmed that its MHP policies and procedures were congruent with Meridian's policies and procedures. Meridian's attestation form confirmed that the health plan made changes to MHP policies and procedures since its submission to HFS in July 2021:

- Updated its UM Program Description and Policy 6.23: Timeliness of Decision Making and Notification to include the YouthCare line of business.

During the webinar review, the health plan confirmed its UM processes for review and decisions of M/S and MH/SUD authorization requests, including its receipt of decisions from the Department of Children & Family Services' (DCFS) vendor, University of Illinois Chicago (UIC), to comply with Rule 325[A-1] for authorization of psychotropic medications for the Youth in Care (YiC) population.

The health plan described its organization's corporate efforts related to MHP, including developing a standard package of NQTL analyses and parity training, both of which are projected to be implemented in 2022. The health plan reported that it had conducted MHP assessments and had not identified any parity issues or opportunities for improvement.

HSAG had no concerns regarding the attestation submitted or the health plan's UM processes.

[A-1] Joint Committee on Administrative Rules. Administrative Code Part 325. Available at: https://www.ilga.gov/commission/jcar/admincode/089/08900325sections.html. Accessed on: June 15, 2022.

PA and CPG Information Review

HSAG assessed each health plan's enrollee- and provider-facing websites to assess the availability of information related to M/S and MH/SUD CPGs and requirements for PAs for M/S and MH/SUD services. Table A-22 presents the results of the assessment.

Table A-22—PA and CPG Assessment

PA and CPG Assessment	Assessment Result
Does the health plan include CPGs for medical/surgical conditions?	No
Does the health plan include CPGs for mental health/substance abuse disorders?	Yes
Does the health plan include information about how often the CPGs are reviewed/updated?	No
Does the health plan include information on whom to contact if providers have questions/comments about the CPGs?	Yes
Does the health plan include information for providers regarding PAs?	Yes
Does the health plan have links/information about CPGs available for members/enrollees?	No
Does the health plan include information for members regarding PAs?	Yes

The review of YouthCare's PA and CPG websites revealed that the CPGs and PA information for M/S and MH/SUD services were accessible on the health plan's website. Although the health plan's website included CPGs, they were limited to those set by the American Psychiatric Association and labeled as "Practice Guidelines: Adults." In addition, the webpage contained a notice indicating that one guideline is more than five years old and should not be assumed to be current (the notation does not identify which guideline this references). In addition, although the health plan's website did not include links/information about CPGs for members/enrollees, the search function allowed enrollees to locate the CPGs on the provider webpage.

HSAG noted that the health plan has an opportunity to provide additional CPG resources to providers and enrollees for M/S conditions. HSAG did not identify any MHP concerns related to availability of CPG and PA information for enrollees and providers.

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. YouthCare reports data for the YiC and Former Youth in Care (FYiC) populations. Table A-23 presents the results of the assessment.

Table A-23—QBR Data Assessment: Total Requests Denied—CY 2021

QBR Data Assessment: Total Denied	Numerator	Denominator	Percent
YiC			
PA requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging, and Pain Management	77	1,467	5%
PA (Behavioral Health Only)	0	577	0%

QBR Data Assessment: Total Denied	Numerator	Denominator	Percent
FYiC			
PA requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging, and Pain Management	71	638	11%
PA (Behavioral Health Only)	2	301	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. The health plan denied M/S authorization requests at a statistically significantly higher rate than MH/SUD requests for both YiC and FYiC populations. Results demonstrated MHP.

ABD Record Review

HSAG reviewed a random sample of 15 M/S and 15 MH/SUD ABD records to determine evidence of parity between M/S and MH/SUD authorization denial processes. Table A-24 presents the results of the record review.

Table A-24—ABD Record Review Results

ABD Evaluation Element	Percentage of Compliant* M/S Records	Percentage of Compliant* MH/SUD Records	MHP
1. Determination followed documented policies and procedures	100% (15/15)	100% (15/15)	Yes
2. Notice sent within required time frame	60.00% (9/15)	80.00% (12/15)	Yes
3. If denied for lack of information, requesting provider was contacted/consulted for additional information	100% (2/2)	N/A	Yes
4. Peer review policy/process followed as applicable	100% (1/1)	N/A	Yes
5. Determination based on established authorization criteria	100% (15/15)	100% (15/15)	Yes
6. The health plan used the HFS template to provide notice	86.67% (13/15)	100% (15/15)	Yes
7. Notice of denial met readability protocol (sixth-grade reading level)	6.67% (1/15)	13.33% (2/15)	Yes
Overall Compliance	**71.79% (56/78)**	**78.67% (59/75)**	**Yes**

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

YouthCare's data indicated that the health plan had an opportunity for improvement related to readability testing, as 6.67 percent of M/S and 13.33 percent of MH/SUD denial letters met a sixth-grade reading level. HSAG noted that compliance scores for readability did not demonstrate a statistically significant difference, based on Chi-square testing. YouthCare's data indicated that the health plan also had an opportunity for improvement related to timeliness of notifications of ABD.

Overall, results of the review demonstrated 71.79 percent compliance for M/S records and 78.67 percent compliance for MH/SUD records. HSAG completed a Chi-square analysis to determine statistically significant differences between the overall results of the M/S and MH/SUD record reviews, and no difference was identified. The results of the ABD record review demonstrated MHP.

Findings and Recommendations

Finding #1	The health plan had an opportunity for improvement related to the readability of M/S and MH/SUD ABDs. During the webinar review, the health plan reported that a dedicated team completes the ABD notices for M/S and MH/SUD denials, and a pharmacy technician completes the notices for pharmacy denials.
Recommendation #1	YouthCare should review the systems and processes responsible for letter creation and ensure that all relevant information is written in easily understandable language. HSAG noted that HFS provided all HealthChoice health plans with a readability protocol in February 2022, which provided guidance to achieve compliance with a sixth-grade reading level. HSAG's recommended action for YouthCare may be achieved through revisions the health plan has made to processes subsequent to receipt of the HFS readability protocol.
Finding #2	The health plan had an opportunity for improvement related to timeliness of notices of ABD for M/S and MH/SUD decisions.
Recommendation #2	YouthCare should ensure and demonstrate that its decisions and communications are processed in a timely manner.

Appendix B. Definitions

Department of Labor (DOL) MHPAEA Definitions[B-1]

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.

[B-1] 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: June 14, 2022.

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[B-2]

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

[B-2] 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."