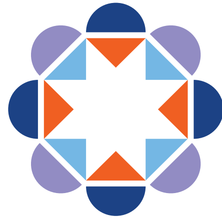

HFS

Illinois Department of
Healthcare and Family Services

2022 Mental Health Parity Analysis Summary Report

December 2023

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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 2022-2023 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*

[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.

Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs.[2]

The MHP analysis consisted of:

- Review of the health plans' MHP Parity Analysis Template and comparative analyses, which were submitted to HFS on June 30, 2022, and addressed HFS' Phase II parity reporting for:
  - Concurrent Review.
  - Retrospective Review.
  - Outlier Management.
  - Failure to Complete.
  - Blanket Exclusions of Services.
  - Exclusions for Court-Ordered Treatment or Involuntary Holds.
  - Provider Type Exclusions.
  - Out-Of-Network Coverage Standards.
  - Geographic Restrictions.
- Review of the health plans' utilization management (UM) documents and information.
- Analysis of M/S and MH/SUD PA denial data, which are self-reported to HFS.
- File review of prior authorization (PA) requests and health plans' decisions, encompassing both M/S and MH/SUD requests.

Table 1-1 lists the health plans included in the 2022-2023 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

[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.

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, as demonstrated in Table 1-2.

Table 1-2—Overall MHP Assessment Rating

Health Plan	Percentage of Denials Deviation Rating	Percentage Agreement with PA Request Decisions	Compliance Rating	MHP Compliance
Aetna	Substantial	100%	Compliant	Yes
BCBSIL	Substantial	100%	Compliant	Yes
CountyCare	None	100%	Compliant	Yes
Meridian	Substantial	100%	Compliant	Yes
Molina	Substantial	100%	Compliant	Yes
YouthCare (Youth in Care)	None	100%	Compliant	Yes
YouthCare (Former Youth in Care)	None	100%	Compliant	Yes

The health plans that received a rating of *substantial* did not demonstrate differences between M/S and MH/SUD denial rates; the differences were driven by a lower denial rate for MH/SUD services compared to M/S services, suggesting no concerns with parity.

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.

- HSAG noted that, although all health plans had processes to monitor and analyze MHP, ongoing review to determine enhancements to data stratification may inform areas of focus or opportunities for improvement.
- HFS should monitor CMS Final Rules to determine if changes to focus or assessment areas are applicable to the Medicaid population.
- 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.

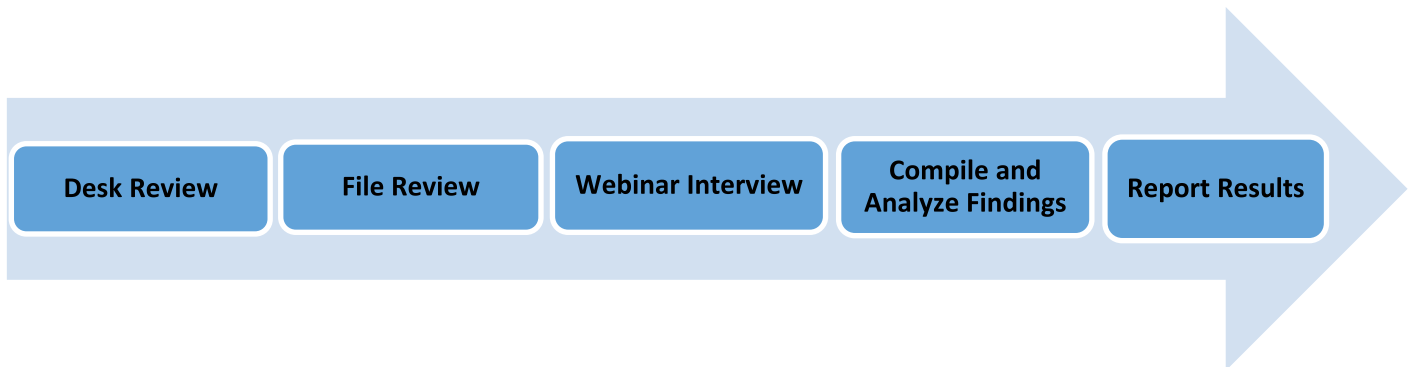
2. Methodology

The 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.

Process

The 2022-2023 MHP Analysis activities are illustrated in Figure 2-1 and described below.

Figure 2-1—2022-2023 MHP Analysis Activities



Activity 1: Desk Review

HFS provided HSAG with each health plan's response to HFS' Phase II template for parity reporting. 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, including policies and procedures related to authorizations for opioid medication-assisted treatment.

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:	Notify health plans of review.

For this step,	HSAG will…
	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.
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.

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. 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 *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 requested that each health plan submit a complete list of inpatient and outpatient PA requests made between January through September 2022. Using a random sampling technique, HSAG selected 50 PA requests for each health plan (25 M/S and 25 MH/SUD). The health plans submitted records and pertinent documentation related to each PA request record 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.
Step 2:	**Identify the number and types of reviewers needed.**
	HSAG assigns registered nurse review team members who have extensive experience and proven competency conducting utilization reviews. To ensure interrater reliability, HSAG reviewers are trained on the review methodology and tool used to determine agreement with the health plans' PA request decisions.
Step 3:	**Conduct file reviews for all sample cases.**
	HSAG reviewers use the file review tool to review records and to document findings regarding agreement with each health plan's decisions. A physician review will be conducted for any case for which the registered nurse does not agree with the health plan's decision. Interrater reliability will be conducted on 10 percent of cases.

PA Request Record Review Elements

M/S and MH/SUD PA request records were assessed against the following evaluation elements:

- Agreement with the criteria used for decision making.
- Agreement with the health plan decision (approval or denial).

During the file review, the HSAG review team reviewed documentation for the selected PA request cases.

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.**

For this step,	HSAG will…
	HSAG provides the health plans with the webinar dates for 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.

HSAG used the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant*, as defined in Table 2-5, 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.[1]

Table 2-5—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*.

[1] 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: Oct 21, 2023.

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 2022-2023 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 June 30, 2022.
- Review of the health plans' UM documents and information.
- Analysis of M/S and MH/SUD PA denial data, which are self-reported to HFS.
- File review of PA request records encompassing both M/S and MH/SUD requests.
- Webinar review with each health plan.

Results Summary

Review of MHP Procedures

All six health plans demonstrated ongoing processes and procedures to analyze MHP. The health plans had 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.

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 3-1 displays the results of the assessment.

Table 3-1—QBR Data Assessment: Total Requests Denied—CY 2022

Health Plan	PA Requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME,* Home Health, Imaging, and Pain Management	PA Requests (Behavioral Health Only)	Deviation Rating	MHP Compliance
Aetna	19%	6%	Substantial	Yes
BCBSIL	13%	0.3%	Substantial	Yes
CountyCare	5%	6%	None	Yes
Meridian	15%	0.2%	Substantial	Yes
Molina	14%	3%	Substantial	Yes

Health Plan	PA Requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME,* Home Health, Imaging, and Pain Management	PA Requests (Behavioral Health Only)	Deviation Rating	MHP Compliance
YouthCare (Youth in Care)	5%	5%	None	Yes
YouthCare (Former Youth in Care)	8%	5%	None	Yes

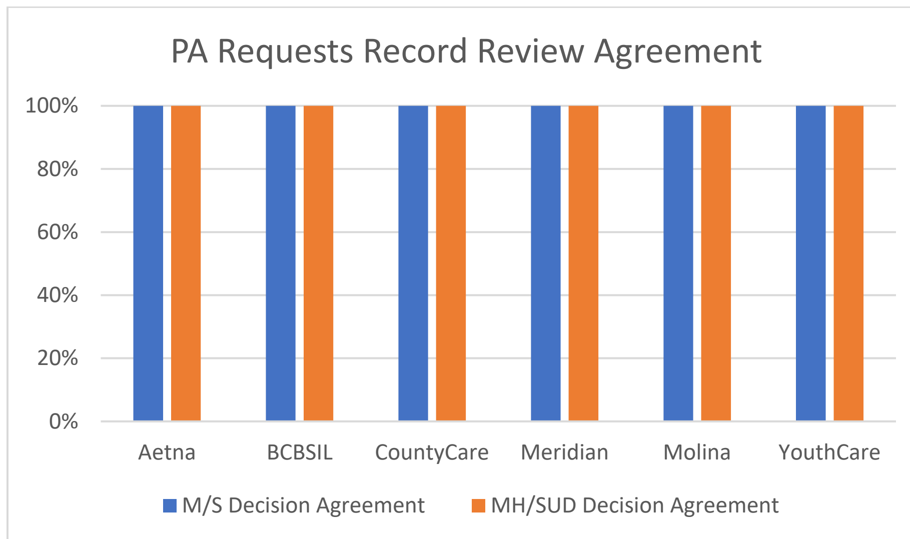
*DME = durable medical equipment

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. 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. Four of the six health plans demonstrated *substantial* differences; however, the differences were driven by a lower denial rate for MH/SUD services compared to M/S services, suggesting no concerns with parity.

PA Request Record Review

HSAG evaluated each health plan based on whether the health plan followed selected regulations for making authorization determinations, as well as whether the health plan followed its own policies and procedures related to these regulations and which services require prior authorization. HSAG reviewed a random sample of 25 M/S and 25 MH/SUD PA request records for each health plan to determine evidence of parity between M/S and MH/SUD PA decision processes. Results demonstrated 100 percent concordance between independent UM decisions and the health plans' decisions, as displayed in Figure 3-1. Individual health plan results are presented in Appendix A.

Figure 3-1—Overall PA Requests Record Review Agreement Percentage Results



HSAG reviewed the PA request documentation submitted by the health plans, including provider medical records and clinical criteria used to make decisions. HSAG's review resulted in 100 percent agreement with the clinical criteria used in the decision. UM review of the 50 sampled cases resulted in 100 percent agreement with the health plans' decisions.

HSAG's review did not suggest any parity concerns.

Conclusions

Based on a review of the HFS Phase II response documents, QBR data, and UM review of PA request decisions, 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.
- All health plans' policies and procedures described an appropriate level of expertise required for UM staff members making PA request decisions, and record reviews demonstrated that all health plans followed decision-making guidelines. The documentation within the files demonstrated that in all cases, the individual who made the determination possessed the required credentials and expertise to do so.
- All health plans followed their policies and procedures regarding interrater reliability testing to ensure the consistency and quality of UM decisions.
- The health plans demonstrated ongoing review of M/S and MH/SUD data and information to inform MHP.

Appendix A. Health Plan-Specific Findings

This appendix provides detailed findings from the QBR Data Assessment and PA Request Record Review, and general observations for each health plan.

Aetna Better Health of Illinois (Aetna)

Review of 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 had been established to conduct additional review. M/S, MH/SUD, and Pharmacy are involved in analyses of data and information, which is reported to quality management and UM committees. Aetna reported that the Chief Medical Officer, medical directors, and UM leaders are responsible for acting on any MHP differences or opportunities for improvement.

Aetna confirmed that processes are the same for executing M/S and MH/SUD 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 (e.g., the health plan reviews all codes that are approved 95 percent of the time to determine if those codes should be reconsidered for PA). During the Phase II reporting period, no changes were made for MH/SUD unless there was an HFS requirement, and M/S changes related only to extending public health emergency flexibilities.

Pharmacy representatives reported that up to 80 percent of PA requests were submitted via the electronic system. Providers reported satisfaction with this system, as they are able to see PA criteria online as they are submitting. Pharmacy completes required quarterly PA reporting to HFS and confirmed that the only changes to PA requirements were made due to HFS requirements.

Aetna demonstrated that interrater reliability testing was conducted for M/S, MH/SUD, and Pharmacy. No opportunities for improvement were identified.

Review of Aetna's Phase II documentation identified an opportunity for greater separation of reporting of M/S and MH/SUD concurrent and retrospective reviews, as MH/SUD data was identical to the M/S data reported. The health plan confirmed that MH/SUD appeals are stratified and categorized, with the top three drivers reviewed on a regular basis to determine if additional analysis is needed. Results are reporting through the health plan's Grievance and Appeals Committee and Service Improvement Committee.

For both M/S and MH/SUD, the health plan confirmed that raw data is reviewed to look at overall numbers of denials and appeals, decisions upheld, and decisions overturned, as well as to review providers who may be submitting a higher number of portal complaints related to their service authorization request denials. This process allows the health plan to focus education for providers. The health plan reviews out of network requests as opportunities to contract with providers; however, they did not focus on denial rates for those providers. The health plan also discussed the process to provide their Special Investigations Unit (SIU) with information if any outlier trends are identified.

HSAG reviewed recommendations from the 2021 MHP Analysis with the health plan. The health plan demonstrated compliance with timeliness of decisions. The health plan reported that the HFS

Readability Protocol was shared with all business units providing enrollee materials and has reeducated staff members to ensure application of the protocol.

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 that it had not identified any parity issues or opportunities for improvement.

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 2022

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	19,383	103,306	19%
PA (Behavioral Health Only)	813	14,353	6%

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.

HSAG noted that QBR data for calendar year 2023 showed a decreasing trend in denial rates for both M/S and MH/SUD when compared to 2022. The health plan reported that the decreases were a result of education and retraining of medical director staff for consistency of application of guidelines.

PA Decisions Record Review

HSAG reviewed a random sample of 25 M/S and 25 MH/SUD PA request records to determine independent agreement of the health plan's M/S and MH/SUD authorization decisions. Table A-2 presents the results of the record review.

Table A-2—PA Decisions Record Review Results

Type of Record	Number of Records with Agreement	Number of Records with Disagreement	Total Reviewed	Percent Agreement
Overall Agreement	**50**	**0**	**50**	**100%**

Type of Record	Number of Records with Agreement	Number of Records with Disagreement	Total Reviewed	Percent Agreement
M/S	25	0	25	100%
Inpatient	*16*	*0*	*16*	*100%*
Outpatient	*9*	*0*	*9*	*100%*
MH/SUD	25	0	25	100%
Inpatient	*18*	*0*	*18*	*100%*
Outpatient	*7*	*0*	*7*	*100%*

HSAG reviewed the PA request documentation submitted by the health plan, including provider medical records and clinical criteria used to make decisions. HSAG's review resulted in 100 percent agreement with the clinical criteria used in the decision. UM review of the 50 sampled cases resulted in 100 percent agreement with the health plan's decisions.

HSAG's review did not suggest any parity concerns.

Findings and Recommendations

Finding #1 The health plan had an opportunity for improvement related to consistent reporting of MH/SUD data in the HFS NQTL Phase II documents.

Recommendation #1 Aetna should review its submissions to HFS to ensure that M/S and MH/SUD data are distinct and clearly reported.

HSAG HEALTH SERVICES ADVISORY GROUP

Blue Cross Community Health Plans (BCBSIL)

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

The health plan prioritizes review of NQTLs based on regulator request and by looking for data variances that might suggest a difference for MH/SUD benefits. The health plan discussed its 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 also conducts an annual review of its PA grid, with ad hoc review as needed if codes change. If utilization patterns change after codes are taken off or added, the health plan conducts a focused review.

BCBSIL 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, and in network and out of network providers. Timeliness is reviewed, and interrater reliability is conducted. Policies and procedures are reviewed annually to determine if any changes are needed. UM data is reported monthly through the UM Committee and submitted to the Quality Improvement Committee quarterly.

The health plan had processes in place to review low-volume data to identify opportunities for improvement. For retrospective reviews, the health plan analyzes the detail to determine the driver and were able to identify that acute MH hospitalizations drove retrospective review requests. The health plan also addressed out of network providers by educating about registering as an Illinois Medicaid provider or attempting to obtain network contracts.

The health plan's Pharmacy has access to its pharmacy benefits manager (PBM) database. Review is conducted on a monthly basis and the Pharmacy team is able to address any changes needed to the preferred drug list (PDL) and conduct outlier management. The health plan completes biweekly clinical calls with its PBM to review cases and criteria.

HSAG reviewed recommendations from the 2021 MHP Analysis with the health plan. The health plan demonstrated compliance with timeliness of decisions. The health plan reported that the HFS Readability Protocol was shared with all business units providing enrollee materials and has reeducated staff members to ensure application of the protocol.

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 that it had not identified any parity issues or opportunities for improvement.

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 2022

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	45,788	354,114	13%
PA (Behavioral Health Only)	75	22,935	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. 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.

PA Decisions Record Review

HSAG reviewed a random sample of 25 M/S and 25 MH/SUD PA request records to determine independent agreement of the health plan's M/S and MH/SUD authorization decisions. Table A-4 presents the results of the record review.

Table A-4— PA Decisions Record Review Results

Type of Record	Number of Records with Agreement	Number of Records with Disagreement	Total Reviewed	Percent Agreement
Overall Agreement	**50**	**0**	**50**	**100%**
M/S	25	0	25	100%
Inpatient	*2*	*0*	*2*	*100%*
Outpatient	*23*	*0*	*23*	*100%*
MH/SUD	25	0	25	100%
Inpatient	*18*	*0*	*18*	*100%*
Outpatient	*7*	*0*	*7*	*100%*

HSAG reviewed the PA request documentation submitted by the health plan, including provider medical records and clinical criteria used to make decisions. HSAG's review resulted in 100 percent agreement with the clinical criteria used in the decision. UM review of the 50 sampled cases resulted in 100 percent agreement with the health plan's decisions.

HSAG's review did not suggest any parity concerns.

Findings and Recommendations

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

CountyCare

Review of 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 MHP team included health plan team members and delegate representatives (and delegate parity workgroups), including PBM. M/S, MH/SUD, and Pharmacy are involved in analyses of data and information. A QTL analysis was conducted in 2023 and the health plan reported that a Phase II NQTL analysis was in progress. In addition, a pharmaceutical NQTL analysis is conducted annually; the most recent analysis demonstrated that MH/SUD denials were lower than M/S. The health plan reported that it had not identified any parity issues or opportunities for improvement.

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 PBM, MedImpact, was responsible for guidelines, management, and application of guidelines, including review for MHP. The PBM utilized FDA standards and peer-reviewed medical literature; guidelines were approved by both MedImpact's Pharmacy & Therapeutics (P&T) Committee and CountyCare's P&T Committee.

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 is conducted. The health plan adopted a PA Factors Grid to evaluate benefits and services and to assist with decision-making for removals of PA.

The health plan had processes in place to review outlier data to identify opportunities for improvement. From a pharmacy perspective, outlier management analysis demonstrated higher stringency for HIV medications but no other differences.

HSAG reviewed recommendations from the 2021 MHP Analysis with the health plan. The health plan demonstrated compliance with timeliness of decisions. The health plan reported that the HFS Readability Protocol was shared with all business units providing enrollee materials and has reeducated staff members to ensure application of the protocol.

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 that it had not identified any parity issues or opportunities for improvement

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-5 presents the results of the assessment.

Table A-5—QBR Data Assessment: Total Requests Denied—CY 2022

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	3,972	75,339	5%
PA (Behavioral Health Only)	90	1,465	6%

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.

Results of the QBR data assessment demonstrated improvement from 2021 rates. The health plan reported that education of providers and use of auto-authorizations have led to the improvement in rates.

PA Decisions Record Review

HSAG reviewed a random sample of 25 M/S and 25 MH/SUD PA request records to determine independent agreement of the health plan's M/S and MH/SUD authorization decisions. Table A-6 presents the results of the record review.

Table A-6— PA Decisions Record Review Results

Type of Record	Number of Records with Agreement	Number of Records with Disagreement	Total Reviewed	Percent Agreement
Overall Agreement	**50**	**0**	**50**	**100%**
M/S	25	0	25	100%
Inpatient	*13*	*0*	*13*	*100%*
Outpatient	*12*	*0*	*12*	*100%*
MH/SUD	25	0	25	100%
Inpatient	*18*	*0*	*18*	*100%*
Outpatient	*7*	*0*	*7*	*100%*

HSAG reviewed the PA request documentation submitted by the health plan, including provider medical records and clinical criteria used to make decisions. HSAG's review resulted in 100 percent agreement with the clinical criteria used in the decision. UM review of the 50 sampled cases resulted in 100 percent agreement with the health plan's decisions.

HSAG's review did not suggest any parity concerns.

Findings and Recommendations

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

Meridian

Review of MHP Procedures

Meridian utilized a collaborative approach to review and maintain MHP, including partnership with outside counsel for evaluation of MHP analyses. Annual MHP analysis included identification of local and enterprise subject matter experts and teams, which described relevant policies and procedures and processes. Quantitative processes and measures were identified, and analyses developed. The most recent analysis showed comparability; the health plan reported that it had not identified any parity issues or opportunities for improvement.

The health plan conducts analyses based on the HFS cycle; therefore, Pharmacy was not included in 2022. Annual instructions and forms from HFS are used to inform and analyze results. If there are changes to benefits or factors to apply NQTL, then the analyses are refreshed. Underlying strategies to monitor MHP occur on an ongoing basis through routine monitoring. Staff are educated to escalate any MHP concerns; annual training on escalation procedures was implemented in May 2022.

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. The health plan's ongoing monitoring processes included review of codes that were largely approved, to determine whether there was a need to continue PAs for those codes. MH/SUD authorizations are also reviewed to determine trends related to out of network providers. UM data is reported quarterly through the UM Committee.

When determining processes or key issues for focus in reviewing processes or policies that may indicate potential parity compliance issues, the health plan reported that their outside legal counsel assists the health plan in determining if they have processes in place to effectively evaluate and analyze information to identify potential MHP issues. Legal counsel has not identified any need for changes based on MHP standards.

HSAG reviewed recommendations from the 2021 MHP Analysis with the health plan. The health plan demonstrated compliance with timeliness of decisions. The health plan reported that the HFS Readability Protocol was shared with all teams creating member materials. After recent compliance reviews were conducted, the health plan implemented an additional compliance team overview process to review for sixth grade reading level, with feedback provided to team members.

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 2022

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	32,318	217,276	15%
PA (Behavioral Health Only)	1	367	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. 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.

PA Decisions Record Review

HSAG reviewed a random sample of 25 M/S and 25 MH/SUD PA request records to determine independent agreement of the health plan's M/S and MH/SUD authorization decisions. Table A-16 presents the results of the record review.

Table A-8—PA Decisions Record Review Results

Type of Record	Number of Records with Agreement	Number of Records with Disagreement	Total Reviewed	Percent Agreement
Overall Agreement	**50**	**0**	**50**	**100%**
M/S	25	0	25	100%
Inpatient	*7*	*0*	*7*	*100%*
Outpatient	*18*	*0*	*18*	*100%*
MH/SUD	25	0	25	100%
Inpatient	*25*	*0*	*25*	*100%*
Outpatient	*0*	*0*	*0*	*Not Applicable*

HSAG reviewed the PA request documentation submitted by the health plan, including provider medical records and clinical criteria used to make decisions. HSAG's review resulted in 100 percent agreement

with the clinical criteria used in the decision. UM review of the 50 sampled cases resulted in 100 percent agreement with the health plan's decisions.

HSAG's review did not suggest any parity concerns.

Findings and Recommendations

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

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Molina Healthcare of Illinois, Inc. (Molina)

Review of 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. For NQTLs, the enterprise team predetermined which UM leaders at the health plan were responsible for answering the questions in the analysis. Their pharmacy partner reviewed PBM in conjunction with internal processes.

The most recent MHP analysis was focused on NQTLs for PA, concurrent review, case management, network, and credentialing. Results are shared with the enterprise quality improvement committee, and the health plan is responsible for their own deep dive into the results. The analysis did not identify any specific issues for Molina in Illinois. The enterprise team identified an opportunity to enhance current reporting to meet commercial MHP standards that will be in place in 2024 and 2025 and intend to apply those same requirements to Medicaid.

Molina's health plan representatives confirmed that they participate in the enterprise level analysis and conduct independent analyses to determine if any issues need to be escalated to the enterprise team. MHP is considered when changing standard operating procedures or policies, and the local health plan reviews UM rates across several areas.

The health plan's pharmacy representative confirmed that parity analysis is conducted annually. Results demonstrated parity among drugs. The health plan uses Molina PA criteria, which goes through national P&T to ensure review by outside members not affiliated with Molina, and that they are no more restrictive.

Molina reviews UM data monthly as part of its ongoing oversight and monitoring. Interrater reliability was conducted quarterly. On an annual basis, trends, PA volumes, and approvals and denials are reviewed, and UM trends are reviewed at the health plan's Healthcare Services Committee biannually. Molina's UM representatives confirmed that denials are reviewed to ensure consistent decisions. In addition, the health plan reviews trends around more frequently denied diagnoses. Provider training has been established to assist with documentation. The health plan also reviewed PA codes with high rates of approvals and reported that over 200 codes were removed at the beginning of 2023 from their PA code list because they were approving at a 100 percent rate.

The health plan has an inpatient dashboard that allows for review of rates and captures both M/S and MH/SUD. Although PA decisions are not included in the dashboard, authorization volumes are presented. Outpatient reporting is not available on the dashboard. The health plan did not review in network and out of network data to determine if there were any opportunities for improvement; the health plan reported that this stratification may be included in future reporting enhancements.

HSAG reviewed recommendations from the 2021 MHP Analysis with the health plan. The health plan demonstrated compliance with timeliness of decisions. The health plan reported that the HFS Readability Protocol was shared with all teams creating member materials.

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-9 presents the results of the assessment.

Table A-9—QBR Data Assessment: Total Requests Denied—CY 2022

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	7,659	53,366	14%
PA (Behavioral Health Only)	63	1,819	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. 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.

PA Decisions Record Review

HSAG reviewed a random sample of 25 M/S and 25 MH/SUD PA request records to determine independent agreement of the health plan's M/S and MH/SUD authorization decisions. Table A-10 presents the results of the record review.

Table A-10—PA Decisions Record Review Results

Type of Record	Number of Records with Agreement	Number of Records with Disagreement	Total Reviewed	Percent Agreement
Overall Agreement	**50**	**0**	**50**	**100%**
M/S	25	0	25	100%
Inpatient	*6*	*0*	*6*	*100%*
Outpatient	*19*	*0*	*19*	*100%*
MH/SUD	25	0	25	100%
Inpatient	*1*	*0*	*1*	*100%*
Outpatient	*24*	*0*	*24*	*100%*

HSAG reviewed the PA request documentation submitted by the health plan, including provider medical records and clinical criteria used to make decisions. HSAG's review resulted in 100 percent agreement

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with the clinical criteria used in the decision. UM review of the 50 sampled cases resulted in 100 percent agreement with the health plan's decisions.

HSAG's review did not suggest any parity concerns.

Findings and Recommendations

Finding #1	Although the health plan has an integrated dashboard to monitor UM metrics, it is limited to inpatient data.
Recommendation #1	Molina should consider system enhancements or reporting options to ensure review of outpatient data, in network and out of network provider data, and outlier management.

YouthCare Specialty Plan (YouthCare)

Review of MHP Procedures

YouthCare utilized a collaborative approach to review and maintain MHP, including partnership with outside counsel for evaluation of MHP analyses. Annual MHP analysis included identification of local and enterprise subject matter experts and teams, which described relevant policies and procedures and processes. Quantitative processes and measures were identified, and analyses developed. The most recent analysis showed comparability; the health plan reported that it had not identified any parity issues or opportunities for improvement.

The health plan conducts analyses based on the HFS cycle; therefore, Pharmacy was not included in 2022. Annual instructions and forms from HFS are used to inform and analyze results. If there are changes to benefits or factors to apply NQTL, then the analyses are refreshed. Underlying strategies to monitor MHP occur on an ongoing basis through routine monitoring. Staff are educated to escalate any MHP concerns; annual training on escalation procedures was implemented in May 2022.

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. The health plan's ongoing monitoring processes included review of codes that were largely approved, to determine whether there was a need to continue PAs for those codes; YouthCare completed this review monthly. MH/SUD authorizations are also reviewed to determine trends related to out of network providers. YouthCare also reviews all denials and appeals on a monthly basis. If issues are identified, UM leadership is notified. UM data is reported quarterly through the UM Committee.

When determining processes or key issues for focus in reviewing processes or policies that may indicate potential parity compliance issues, the health plan reported that their outside legal counsel assists the health plan in determining if they have processes in place to effectively evaluate and analyze information to identify potential MHP issues. Legal counsel has not identified any need for changes based on MHP standards.

HSAG reviewed recommendations from the 2021 MHP Analysis with the health plan. The health plan demonstrated compliance with timeliness of decisions. The health plan reported that the HFS Readability Protocol was shared with all teams creating member materials. After recent compliance reviews were conducted, the health plan implemented an additional compliance team overview process to review for sixth grade reading level, with feedback provided to team members.

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-11 presents the results of the assessment.

Table A-11—QBR Data Assessment: Total Requests Denied—CY 2022

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	88	1,939	5%
PA (Behavioral Health Only)	3	60	5%
FYiC			
PA requests for Medical (Non-Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging, and Pain Management	87	1,032	8%
PA (Behavioral Health Only)	2	36	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. 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.

PA Decisions Record Review

HSAG reviewed a random sample of 25 M/S and 25 MH/SUD PA request records to determine independent agreement of the health plan's M/S and MH/SUD authorization decisions. Table A-12 presents the results of the record review.

Table A-12—PA Decisions Record Review Results

Type of Record	Number of Records with Agreement	Number of Records with Disagreement	Total Reviewed	Percent Agreement
Overall Agreement	**50**	**0**	**50**	**100%**
M/S	25	0	25	100%
Inpatient	*4*	*0*	*4*	*100%*
Outpatient	*21*	*0*	*21*	*100%*
MH/SUD	25	0	25	100%
Inpatient	*25*	*0*	*25*	*100%*
Outpatient	*0*	*0*	*0*	*Not Applicable*

HSAG reviewed the PA request documentation submitted by the health plan, including provider medical records and clinical criteria used to make decisions. HSAG's review resulted in 100 percent agreement with the clinical criteria used in the decision. UM review of the 50 sampled cases resulted in 100 percent agreement with the health plan's decisions.

HSAG's review did not suggest any parity concerns.

Findings and Recommendations

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

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.

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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.”