HFS

Illinois Department of
Healthcare and Family Services

2023–2024 Mental Health Parity Analysis Summary Report

December 2024

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[2]). 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 determined 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 2023–2024 MHP Analysis across all health plans.

Methodology

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

[1] Illinois General Assembly. Illinois Compiled Statutes, 215 ILCS 5/370c.1. Available at: https://www.ilga.gov/legislation/ilcs/ilcs5.asp?ActID=1249&ChapterID=22. Accessed on: Oct 30, 2024.

[2] The terms "health plans" and managed care organizations (MCOs) are used interchangeably in this report.

Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs.[3]

The MHP analysis consisted of:

- Review of the health plans' NQTL Submission Form and comparative analyses, which were submitted to HFS and addressed parity reporting for provider reimbursement.
- An Administrative Data Profile review of claims.[4]
- An attestation of continued compliance with MHP requirements and documentation of any related policy or procedural changes associated with the designated review period (calendar year 2023).

Table 1-1 lists the health plans included in the 2023–2024 MHP Analysis and the associated health plan abbreviations.

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

Health Plan Name	Health Plan Abbreviation
HealthChoice Health Plans	
Aetna Better Health of Illinois	Aetna, AET
Blue Cross Community Health Plans	BCBSIL
CountyCare	CountyCare, CC
Meridian	Meridian, MER
Molina Healthcare of Illinois	Molina, MOL
Specialty Foster Care Plan	
YouthCare Specialty Plan	YouthCare, YC

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

[3] 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: Oct 16, 2024.

[4] Claims data excluded non-emergency medical transportation (NEMT) and pharmacy (Rx) claims.

Conclusions

The overall findings from the 2023–2024 MHP Evaluation are presented below.

MHP Attestation and NQTL Submission Form Review

For its review of the attestation and NQTL Submission Form, HSAG assessed each health plan's responses across two evaluation domains:

- The comparability of the processes, strategies, evidentiary standards, and other factors (in writing and in operation) used in applying treatment limitations to MH/SUD benefits and M/S benefits.
- The stringency with which the processes, strategies, evidentiary standards, and other factors (in writing and operation) were applied to MH/SUD benefits and M/S benefits.

Based on the information submitted by the health plans for desk review and during webinar review, all health plans received a rating of *Compliant*.

Administrative Data Profile/Claims

For the Administrative Data Profile, parity between MH/SUD and M/S benefit administration was evaluated across three domains:

- Overall paid and denied ratios for in-network (INN) and out-of-network (OON) claims.
- Differences of INN versus OON paid ratios at the header and detail level.
- The difference of header-level versus detail-level paid ratios for MH/SUD and M/S services for both the INN and OON.

The analyses included stratification by inpatient (IP), outpatient (OP), and emergency service (ER).

Overall, MCO aggregate results across each domain showed minimal variation between MH/SUD and M/S, and considerable variation in MCO performance within each of the measures. However, the review of administrative data from the MCOs is not indicative of an impact on parity across benefit types, differences in claims, paid and denied patterns at the header and detail level, and INN and OON.

Header Level

Table 1-2 presents a statewide summary of the results from the analysis of header-level paid claims by service and benefit type.

Table 1-2—State Total Number and Percentage of Header-Level Claims by Benefit Type

Service Type	Benefit Type	Total In-Network Claims	Paid Claims[1]		Total Out-of-Network Claims	Out-of-Network Paid Claims	
		Number	Number	Percent	Number	Number	Percent
IP	MH/SUD	127,984	119,168	93.1%	12,369	10,864	87.8%
	M/S	427,594	385,984	90.3%	39,971	33,636	84.2%
OP	MH/SUD	4,296,025	4,060,938	94.5%	182,967	149,708	81.8%
	M/S	23,155,044	21,600,043	93.3%	2,496,873	2,103,045	84.2%
ER	MH/SUD	124,679	119,608	95.9%	21,491	19,305	89.8%
	M/S	1,911,432	1,837,258	96.1%	367,311	333,794	90.9%
Total	**MH/SUD**	**4,548,688**	**4,299,714**	**94.5%**	**216,827**	**179,877**	**83.0%**
	M/S	**25,494,070**	**23,823,285**	**93.4%**	**2,904,155**	**2,470,475**	**85.1%**

Overall, the analysis showed a minimal difference in the percentage of header-level paid claims between MH/SUD and M/S claims for INN (94.5 percent and 93.4 percent), with MH/SUD claims being paid at a higher rate than M/S claims. For overall OON claims, the analysis also showed a minimal difference in the percentage of header-level paid claims between MH/SUD and M/S (83.0 percent and 85.1 percent, respectively) claims; however, M/S claims are being paid at a higher rate than MH/SUD claims. For OON OP and all ER claims, the M/S header-level claims are being paid at a higher rate than MH/SUD header-level claims. For INN IP, INN OP, and OON IP claims, the MH/SUD claims are being paid at a higher rate than M/S claims across the entire State of Illinois.

Overall, the difference in the percentage of header-level paid MH/SUD and M/S claims in total for all MCOs across all categories of service (i.e., IP, OP, ER) was minimal, with a less than 5 percentage point difference. Total INN header-level MH/SUD claims had a higher paid rate at 94.5 percent, compared to M/S claims at 93.4 percent; however, total OON header-level MH/SUD claims had a lower paid rate than M/S claims (83.0 percent and 85.1 percent, respectively).

All individual MCOs exhibited a minimal difference in the percentage of header-level paid MH/SUD claims and header-level paid M/S claims for INN in aggregate across all categories of service. However, Aetna and CountyCare MH/SUD claims were paid at a lower rate than M/S claims. For header-level paid differences between MH/SUD claims and M/S claims for OON in aggregate across all categories of service, Aetna and CountyCare exhibited moderate differences (5.0 percentage points and 5.8 percentage points, respectively), while YouthCare and Molina exhibited substantial differences (11.6 percentage points and 28.8 percentage points, respectively).

For OON header-level claims in aggregate across all categories of service, Meridian, YouthCare, and Molina demonstrated MH/SUD claims paid at a lower rate than M/S claims. Individual MCO differences that were moderate or substantial for header-level paid IP claims were due to a higher percentage of header-level paid MH/SUD claims compared to M/S claims. Molina OON IP was the only MCO to pay M/S claims at a higher rate than MH/SUD. Individual MCO differences that were moderate

or substantial for header-level paid OP claims were due to a higher percentage of header-level paid M/S claims compared to MH/SUD claims, exhibited by Molina OON OP and YouthCare OON OP claims.

All individual MCO differences were minimal for header-level paid ER claims.

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

Detail Level

Table 1-3 presents a statewide summary of the results from the analysis of detail-level paid claims by service and benefit type.

Table 1-3—State Total Number and Percentage of Detail-Level Claims by Benefit Type

Service Type	Benefit Type	Total In-Network Claims	Paid Claims[1]		Total Out-of-Network Claims	Out-of-Network Paid Claims	
		Number	Number	Percent	Number	Number	Percent
IP	MH/SUD	329,436	283,105	85.9%	28,893	21,426	74.2%
	M/S	2,563,351	2,129,216	83.1%	255,586	188,156	73.6%
OP	MH/SUD	6,380,986	5,847,465	91.6%	330,316	256,945	77.8%
	M/S	59,932,486	52,924,740	88.3%	5,612,484	4,490,540	80.0%
ER	MH/SUD	619,682	568,265	91.7%	86,640	74,655	86.2%
	M/S	9,068,936	8,327,489	91.8%	1,262,850	1,070,543	84.8%
Total	**MH/SUD**	**7,330,104**	**6,698,835**	**91.4%**	**445,849**	**353,026**	**79.2%**
	M/S	**71,564,773**	**63,381,445**	**88.6%**	**7,130,920**	**5,749,239**	**80.6%**

Overall, the analysis showed a minimal difference in the percentage of detail-level paid claims between MH/SUD and M/S claims for INN (91.4 percent and 88.6 percent), with MH/SUD claims being paid at a higher rate than M/S claims. For overall OON claims, the analysis also showed a minimal difference in the percentage of detail-level paid claims between MH/SUD and M/S (79.2 percent and 80.6 percent, respectively) claims; however, M/S claims are being paid at a higher rate than MH/SUD claims. For OON OP and INN ER, the M/S detail-level claims are being paid at a higher rate than MH/SUD detail-level claims. For all IP, INN OP, and OON ER claims, the MH/SUD claims are being paid at a higher rate than M/S claims across the entire State of Illinois.

Overall, the difference in the percentage of detail-level paid MH/SUD and M/S claims in aggregate for all MCOs across all categories of service (i.e., IP, OP, ER) was minimal, with less than a 5-percentage-point difference. Total INN detail-level MH/SUD claims had a higher paid rate of 91.4 percent, compared to M/S claims at 88.6 percent; however, total OON detail-level MH/SUD claims had a lower paid rate than M/S claims (79.2 percent and 80.6 percent, respectively). All individual MCOs exhibited a minimal difference in the percentage of detail-level paid MH/SUD claims and detail-level paid M/S claims for INN in aggregate across all categories of service except for YouthCare, which exhibited a moderate difference. Aetna was the only MCO where aggregate INN MH/SUD claims were paid at a

lower rate than M/S claims at a detail level. Most individual MCOs exhibited a minimal difference in the percentage of detail-level paid MH/SUD claims and detail-level paid M/S claims for OON in aggregate across all categories of service, with Aetna exhibiting a moderate difference and Molina exhibiting a substantial difference. Half of the individual MCOs paid the aggregate OON detail-level MH/SUD claims at a lower rate than M/S claims, including Meridian, YouthCare, and Molina.

Although differences in the percentage of paid OON claims may be legitimate, they may also indicate procedural or network differences that highlight potential barriers to members' access to MH/SUD services. The MCOs should review OON claim denials to understand factors affecting the lower percentage of paid MH/SUD claims compared to M/S claims and assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside the MCO's network (e.g., appointment availability).

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

Recommendations

As the landscape of mental health care continues to evolve, HSAG recommends the following to further HFS's commitment to comprehensive and inclusive MHP analysis. The following recommendations are proposed to enhance the accuracy and applicability of future reports. These proposed updates are designed to strengthen the analytic framework and provide a more nuanced understanding of mental health service utilization and outcomes among different demographic groups. Although all MCOs were found *Compliant* based on comparability and stringency of the information assessed, additional analysis of data would allow for greater examination of the MCOs' administration of MH/SUD and M/S benefits to determine whether opportunities for improvement exist.

First, it is recommended that MCOs be required to submit member-level enrollment, demographic, eligibility, and claims data. This foundational step will enable the validation of aggregate data, ensuring that the findings presented in the analysis are both reliable and reflective of actual utilization patterns. By validation, HSAG is referring to the ability to compare the aggregated MCO data in the claims summary templates used in the MHP review to the encounter-level data HFS receives from the MCOs. This would ensure that the appropriate methodology was used in the data aggregation by the MCOs when populating the submitted templates. Additionally, this detailed data submission will facilitate the stratification of results by demographic indicators, allowing the analysis to identify patterns and disparities between diverse populations. Analyses can then be expanded to incorporate health equity stratification, thereby enabling stakeholders to assess how various demographic factors intersect with mental health service utilization and outcomes.

To provide a more comprehensive picture, data collection should span across multiple years. Longitudinal data would not only allow for trend analysis but also capture changes over time in service usage and access. Additionally, it would enable reviewers to identify patterns that may emerge in the levels of claims paid and denied. This temporal dimension is vital for understanding progression or regression in MHP and will provide insights into systemic issues that may be impacting specific groups.

Furthermore, incorporating claims-cost data into the HFS annual analysis is essential. This recommendation extends beyond utilization metrics, allowing for a more thorough measurement of the impact of cost variations in total care. Understanding the cost of care for different service areas and demographic populations would highlight where there may be economic barriers for marginalized populations. By highlighting the relevance of claims based on financial metrics—not solely on utilization—valuable insight can be gained, highlighting how differences in costs correlate with disparities in service access and quality.

In addition, to allow sufficient time to review documents and conduct key informant interviews with relevant health plan staff members, the review of NQTLs (i.e., Medical Management, Provider Network, and Pharmacy Management) should be conducted as part of a three-year cycle, beginning in 2026, wherein each NQTL domain is reviewed separately. In addition to allowing a greater dive into the nuanced implementation of these processes, HFS would also be able to provide additional technical assistance regarding the documentation necessary to demonstrate compliance allowing for a comprehensive analysis.

In summary, these recommendations aim to elevate the HFS annual MHP analysis by fostering a more robust data collection framework that prioritizes member-level insights, longitudinal trends, and cost analyses. By implementing these changes, HFS can not only enhance the quality of its reports, but also facilitate informed decision-making that promotes equitable mental health outcomes across the community. This strategic approach will ultimately contribute to a more effective and just mental health care system, aligned with equity principles essential in today's healthcare policy landscape.

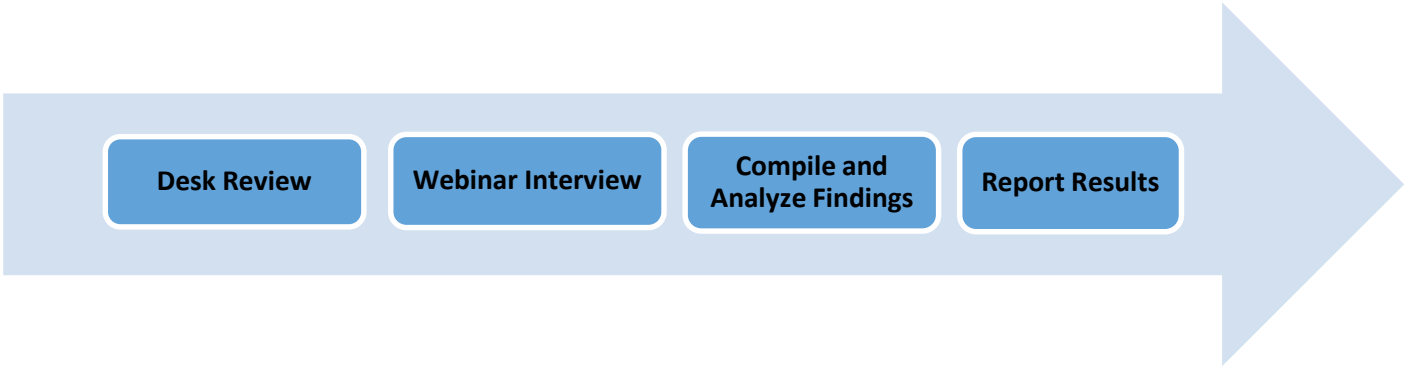
2. Methodology

The 2023–2024 MHP Analysis identified and addressed differences between the policies and standards governing limitations applied to MH/SUD services compared to M/S services. Differences in how limits were applied to MH/SUD services as compared to M/S services were evaluated for continued compliance with MHP regulations to ensure evidence-based, quality MH/SUD care.

Process

The 2023–2024 MHP Analysis activities are illustrated in Figure 2-1 and described below.

Figure 2-1—2023–2024 MHP Analysis Activities



Activity 1: Desk Review

HFS provided HSAG with each health plan's response to HFS's NQTL Submission Form for parity reporting. HSAG requested MHP documents from each health plan to inform HSAG's review team of each health plan's processes for claims management. The health plans also completed and submitted an attestation form, to attest to the absence of changes to existing organizational structures, policies, or procedures that were previously confirmed to support parity of MH/SUD and M/S benefits or provide information on changes to its operations that may impact parity (e.g., contracting changes, system changes, or changes to utilization management policies and procedures). In addition, the form allowed the MCOs to document procedural and system changes implemented to enhance the quality MH/SUD services and administration of MH/SUD benefits.

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.**
	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.

Claims Data Assessment

The health plans were required to submit 2023 claims data. HSAG analyzed the health plans' data to determine parity in claim-count relativities between M/S and MH/SUD. HSAG used deviation ratings of *Minimal*, *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
Minimal	Difference between MH/SUD and M/S profile metric is **less than** 5 percentage points.
Moderate	Difference between MH/SUD and M/S profile metric is: • **greater than or equal** to 5 percentage points, and • **less than** 10 percentage points.
Substantial	Difference between MH/SUD and M/S profile metric is **greater than or equal to** 10 percentage points.

Activity 2: 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 data 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 2-3 below.

Table 2-3—Activity 2: Conduct Webinar Review

For this step,	HSAG will…
Step 1:	**Provide the health plans with webinar date options.**
	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 3: Compile and Analyze Findings

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

HSAG used the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant*, as defined in Table 2-3, 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.[5]

Table 2-4—Rating Definitions of Compliance to MHP

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

[5] 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 4: Report Results

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

Technical Methods of Data Collection

2023 MHP Data Submission Template

HSAG provided the MCOs with a Microsoft Excel-based template to report data on IP, OP, and ER claim counts. Claim counts were further stratified by INN, OON, MH/SUD, M/S, paid, partial paid, and denied. Claim counts were submitted at the header (total claim), and detail (each service within the claim) level.

How Data Were Aggregated and Analyzed

Administrative Data Profile

To further understand the impact of MCO policies and procedures on the management of MH/SUD and M/S benefits, HSAG analyzed MCO data collected between January 1, 2023, and December 31, 2023. The data included aggregate counts for claims/encounters for MH/SUD and M/S services. HSAG reviewed all submitted data for consistency and conducted a comparative analysis to identify trends between MH/SUD and M/S services, between MCOs, and statewide. Data collected to support the Administrative Data Profiles included services covered through the HealthChoice Illinois and YouthCare programs.

Although descriptive, the Administrative Data Profile was used to observe key patterns and outcomes associated with the administration of MH/SUD and M/S covered benefits. To further assess parity, HSAG evaluated the extent to which key claims/encounters differed between MH/SUD and M/S services. HSAG used deviation ratings of *Minimal*, *Moderate*, and *Substantial*, as defined in Table 3-1, to indicate the degree to which each MCO's reported profile metrics differed across MH/SUD and M/S services.

Table 3-1—Deviation Rating Definitions for Administrative Data Profile

Deviation Rating	Definition
Minimal	Difference between MH/SUD and M/S profile metric is **less than** 5 percentage points.
Moderate	Difference between MH/SUD and M/S profile metric is: • **greater than or equal** to 5 percentage points, and • **less than** 10 percentage points.
Substantial	Difference between MH/SUD and M/S profile metric is **greater than or equal to** 10 percentage points.

Administrative Data Profiles

The following Administrative Data Profile identified key patterns and outcomes associated with the administration of MH/SUD and M/S covered benefits across multiple levels for the header- and line-level claim-counts data for each of the categories of service: IP, OP, and ER:

- Comparison of overall paid and denied ratios for INN and OON.
- Difference of INN versus OON paid ratios for MH/SUD and M/S services, analyzed at both the header and detail level.
- Difference of header-level versus detail-level paid ratios for MH/SUD and M/S services, analyzed at both the INN and OON level.

Each of the following subsections examines the extent to which results in claim-count relativities differed for MH/SUD and M/S services in order to identify potential areas of parity concerns. To facilitate the presentation of results, the differences noted between MH/SUD and M/S performance metrics are displayed as an absolute value or difference.[6] As such, the larger the number in the figure, the greater the difference between the MH/SUD and M/S performance metrics. Detailed results and findings for individual MCOs are available in Appendix A.

Claims

To conduct the claims analysis, the MCOs submitted claims counts that encompassed all covered services (except NEMT and Rx) by claim type (i.e., IP, OP, and ER) and provider network status (i.e., INN and OON) at the header and detail claim level. Since claims are paid at the detail (service) line level, aggregate header counts were categorized as paid, partially paid, and denied. Claims were defined as *partially paid* if at least one detail claim line was denied; claims that included all paid detail lines or all denied detail lines should be classified as paid claims and denied claims, respectively. The total number of IP, OP, and ER claims were evaluated at the header level and reported as the total number paid (i.e., paid and partially paid claims) and denied overall, and by network status. The aggregate counts from the MCOs were then used to generate the percentage of claims paid by benefit type; the difference between the percentage of paid claims for MH/SUD versus M/S services was then evaluated as the core metric for evaluating parity. The absolute difference was used to classify the deviation in the rates of claims paid between MH/SUD and M/S services to determine if the difference was minimal (less than 5 percentage points), moderate (greater than or equal to 5 percentage points, but less than 10 percentage points), or substantial (greater than or equal to 10 percentage points).

Data were not available to determine specific procedure type codes that were paid versus denied. HSAG was able to evaluate detail-level versus header-level claims; moderate and substantial differences in the rate of paid and denied claim counts identify areas where operational policies and procedures (i.e.,

[6] The *absolute value* is the actual magnitude of a numerical value or measurement. As such, the *absolute difference* represents the difference, taken without regard to sign, between the values of two variables.

claims submission requirements, authorization determinations, claims processing, provider billing, etc.) highlight instances where MH/SUD and M/S outcomes were different and warrant further review, especially when the differences were outliers compared to other MCOs and the MCO aggregate. In addition to assessing the absolute difference in the percentage of paid claims, the analysis indicated whether the difference reflected greater rates of payment for MH/SUD services over M/S services.

Overall, in aggregate across all MCOs and all claim types (i.e., IP, OP, ER, INN and OON), the difference in the percentage of paid MH/SUD and M/S claim counts was minimal. Additionally, there was considerable variation in paid claim counts across individual MCOs. However, when MCO differences were moderate or substantial for paid IP claims, the deviation was generally due to a higher percentage of paid MH/SUD claims versus paid M/S claims. Paid OP claims did not show the same pattern; when differences were moderate or substantial for paid OP claims, the deviation was generally due to a higher percentage of paid M/S claims versus paid MH/SUD claims. When the payment of claims was stratified by INN and OON claims, at least half of the MCOs exhibited moderate to substantial differences in the percentages of OON paid IP and OP claims. The deviation was due to a higher percentage of paid M/S claims versus paid MH/SUD claims. The following figures display the results of the comparisons in the percentage of paid and denied MH/SUD and M/S claims for all MCOs, deviation between paid percentages by network, and deviations between header- and line-level claims. The larger the number, the greater the difference between the percentage of paid claims between MH/SUD and paid M/S. Green bars indicate a deviation rating of *Minimal*, while the orange and red bars indicate a rating of *Moderate* and *Substantial*, respectively. Solid bars, along with the absolute percentage-point difference, indicate that a lower percentage of MH/SUD claims were paid compared to M/S claims.

Inpatient Claims

Figure 3-1, Figure 3-2, and Table 3-2 through Table 3-7 display detailed results of the IP claim review for all MCOs. Results presented include comparison of overall paid and denied ratios for each MCO for INN and OON as well as header and detail level between MH/SUD and M/S, the deviation in paid claims between INN and OON, and the deviation between paid header- and detail-level claims.

Table 3-2—Inpatient Header-Level In-Network Paid Claim-Count Distribution

MCO	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
MH/SUD	6.4%	5.7%	2.0%	6.2%	2.7%	0.5%
M/S	17.4%	16.3%	8.1%	24.4%	9.9%	0.3%
State Total	**23.9%**	**22.0%**	**10.1%**	**30.7%**	**12.6%**	**0.8%**

Table 3-2 represents the significance of each MCO's impact on the overall claim-count distribution—specifically, displaying the percentage of total paid claim counts for IP header-level INN for each MCO relative to the State total paid claim count for IP header-level INN stratified by MH/SUD and M/S. MH/SUD represented 23.6 percent of the State total IP header-level INN paid claim counts, while M/S represented 76.4 percent. Review of claim-count distributions for each MCO adds context to the overall state-level analysis. Distribution levels provide insight to the number of claim counts impacted, and by

extension beneficiaries impacted, especially when the differences between MH/SUD and M/S claim counts are moderate or substantial. For the IP header-level INN paid claim-count distribution, Meridian represents 30.7 percent of the State total, indicating it has the highest level of influence on the state-level IP header-level INN MHP results. On the contrary, YouthCare has the smallest level of influence.

Figure 3-1—Inpatient Header-Level In-Network Paid and Denied Claim Counts

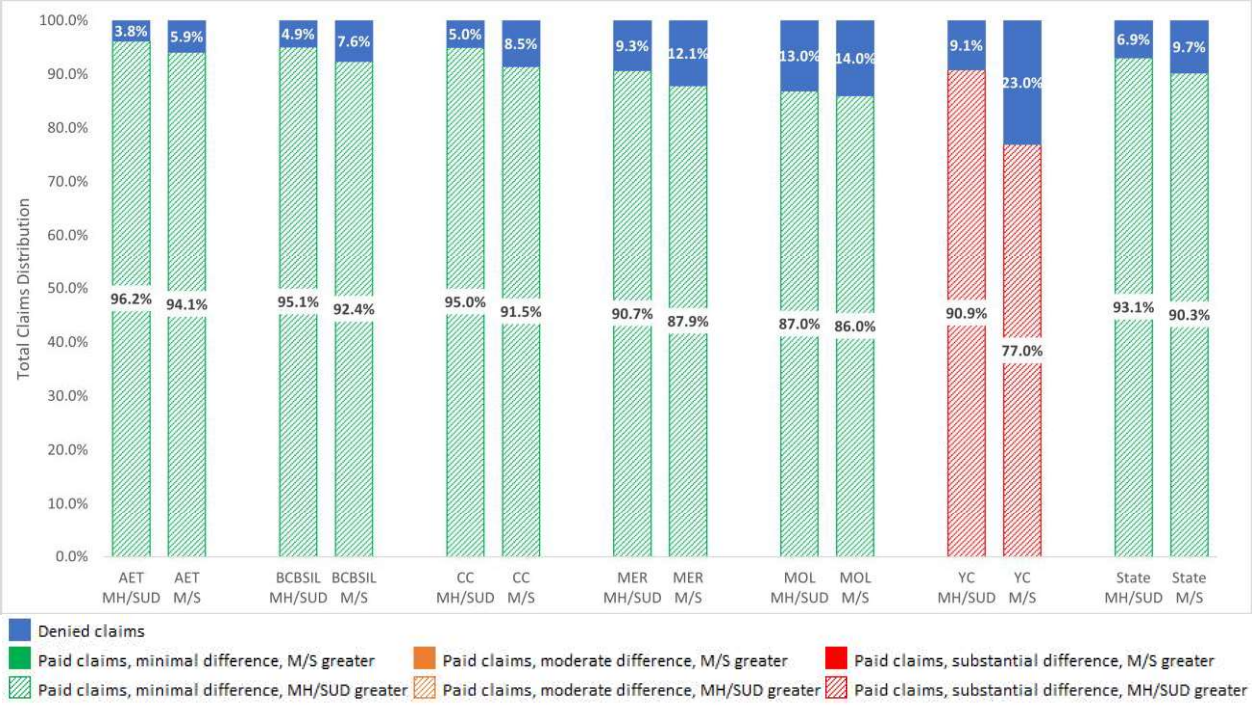


Figure 3-1 displays the IP header-level INN claim-count percentages for MH/SUD and M/S claim categories distributed between paid and denied claims for each MCO and the statewide total. Overall, the difference in the statewide MCO percentage of IP INN header-level paid claims for MH/SUD services (93.1 percent) and M/S services (90.3 percent) was minimal (2.8 percentage points), with individual MCO differences ranging from 0.9 percentage points (Molina with 12.6 percent of aggregate MCO IP INN header-level paid claims) to 13.9 percentage points (YouthCare with 0.8 percent of aggregate MCO IP INN header-level paid claims). Only one MCO, YouthCare, exhibited a substantial difference in the percentage of paid IP INN header-level claims; however, all MCOs' IP INN MH/SUD header-level claims had a higher paid rate than IP INN M/S header-level claims. The remaining five MCOs had less than a 5-percentage-point difference in IP INN header-level paid claims rates.

Table 3-3—Inpatient Header-Level Out-of-Network Paid Claim-Count Distribution

MCO	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
MH/SUD	2.8%	2.3%	1.1%	16.7%	1.2%	0.3%
M/S	15.0%	12.0%	3.5%	36.2%	8.2%	0.6%
State Total	**17.8%**	**14.3%**	**4.6%**	**52.9%**	**9.4%**	**1.0%**

Table 3-3 represents the significance of each MCO's impact on the overall claim-count distribution—specifically, displaying the percentage of total paid claim counts for IP header-level OON for each MCO relative to the state total paid claim count for IP header-level OON stratified by MH/SUD and M/S. MH/SUD represented 24.4 percent of the State total IP header-level OON paid claim counts, while M/S represented 75.6 percent. Review of claim-count distributions for each MCO adds context to the overall state-level analysis. Distribution levels provide insight to the number of claim counts impacted, and by extension beneficiaries impacted, especially when the differences between MH/SUD and M/S claim counts are moderate or substantial. For the IP header-level OON paid claim count distribution, Meridian represents 52.9 percent of the State total, indicating it has the highest level of influence on the state-level IP header-level OON MHP results. On the contrary, YouthCare has the smallest level of influence.

Figure 3-2—Inpatient Header-Level Out-of-Network Paid and Denied Claim Counts

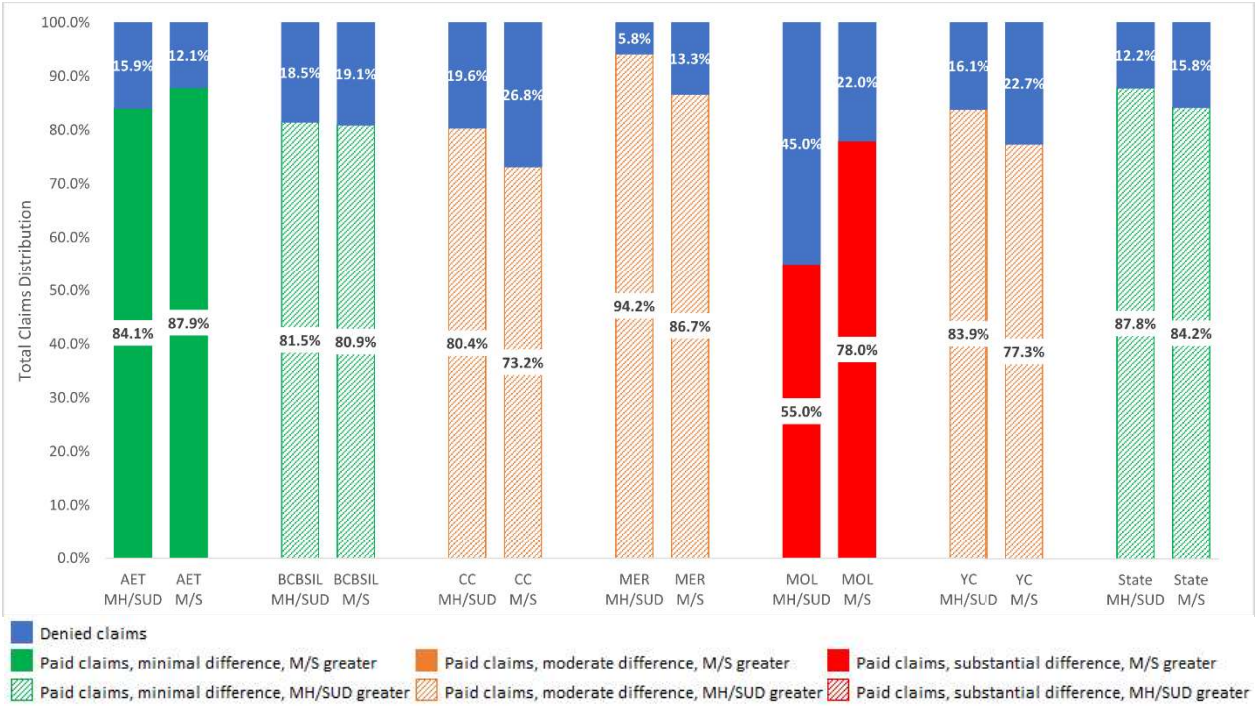


Figure 3-2 displays the IP header-level OON claim-count percentages for MH/SUD and M/S claim categories distributed between paid and denied claims for each MCO and the statewide total. Overall, the difference in the statewide MCO percentage of IP OON header-level paid claims for MH/SUD services (87.8 percent) and M/S services (84.2 percent) was minimal (3.7 percentage points), with individual MCO differences ranging from -22.9 percentage points (Molina with 9.4 percent of aggregate

MCO IP OON header-level paid claims) to 7.5 percentage points (Meridian with 52.9 percent of aggregate MCO IP OON header-level paid claims). Only one MCO, Molina, exhibited a substantial difference in the percentage of paid IP OON header-level claims with lower paid MH/SUD claims than M/S claims. Of the remaining MCOs, three (Meridian, YouthCare, and CountyCare) demonstrated a moderate difference; however, the MH/SUD claims were paid at a higher rate than the M/S claims. The remaining two MCOs, BCBSIL and Aetna, had less than a 5-percentage-point difference in IP OON header-level paid claims rates.

Table 3-4—Inpatient Detail-Level In-Network Paid Claim-Counts Distribution

MCO	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
MH/SUD	2.2%	4.2%	2.4%	1.4%	1.3%	0.1%
M/S	16.3%	31.2%	21.7%	7.6%	11.4%	0.1%
State Total	**18.5%**	**35.4%**	**24.2%**	**9.0%**	**12.7%**	**0.2%**

Table 3-4 represents the significance of each MCO's impact on the overall claim-count distribution—specifically, displaying the percentage of total paid claim counts for IP detail-level INN for each MCO relative to the State total paid claim count for IP detail-level INN stratified by MH/SUD and M/S. MH/SUD represented 11.7 percent of the State total IP detail-level INN paid claim counts, while M/S represented 88.3 percent. Review of claim-count distributions for each MCO adds context to the overall state-level analysis. Distribution levels provide insight to the number of claim counts impacted, and by extension beneficiaries impacted, especially when the differences between MH/SUD and M/S claim counts are moderate or substantial. For the IP detail-level INN paid claim-count distribution, Blue Cross Blue Shield of Illinois represents 35.4 percent of the State total, indicating it has the highest level of influence on the state-level IP detail-level INN MHP results. On the contrary, YouthCare has the smallest level of influence.

Figure 3-3—Inpatient Detail-Level In-Network Paid and Denied Claim Counts

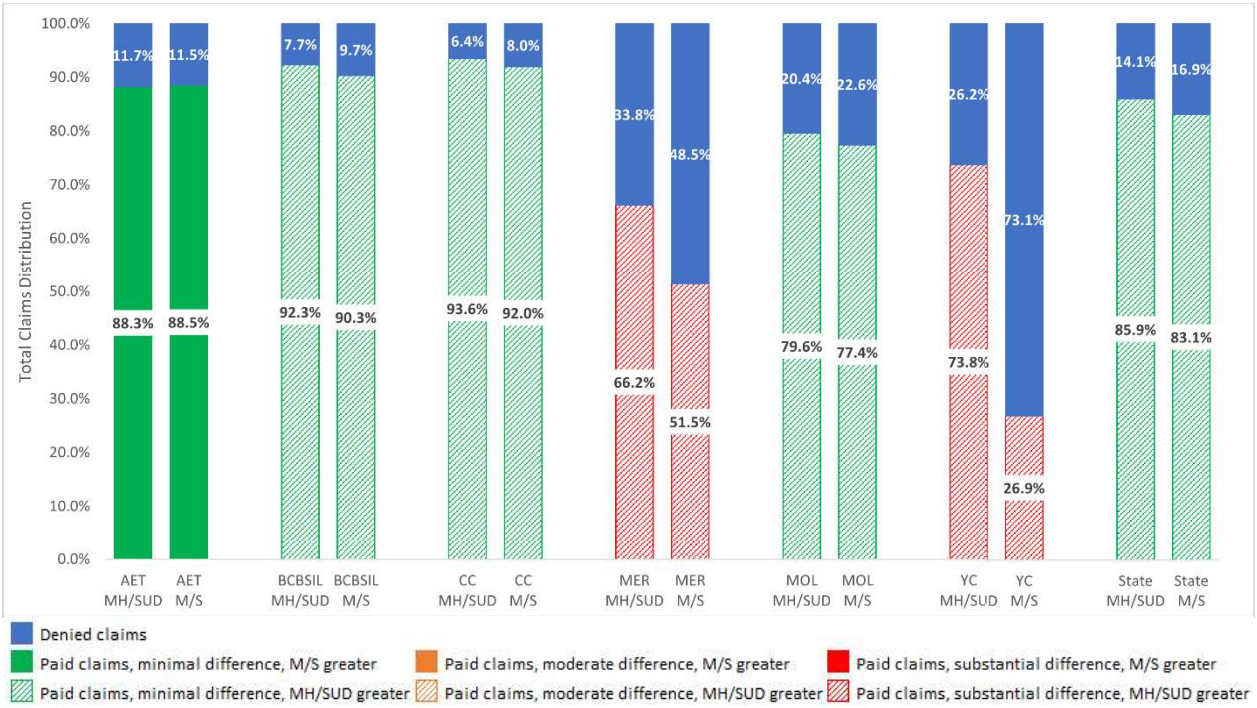


Figure 3-3 displays the IP detail-level INN claim-count percentages for MH/SUD and M/S claim categories distributed between paid and denied claims for each MCO and the statewide total. Overall, the difference in the statewide MCO percentage of IP INN detail level paid claims for MH/SUD services (85.9 percent) and M/S services (83.1 percent) was minimal (2.9 percentage points), with individual MCO differences ranging from -0.3 percentage points (Aetna with 18.5 percent of aggregate MCO IP INN detail-level paid claims) to 46.9 percentage points (YouthCare with 0.2 percent of aggregate MCO IP INN detail-level paid claims). Both Meridian and YouthCare exhibited substantial differences in the percentage of paid IP INN detail-level claims; the remaining four MCOs had less than a 5-percentage-point difference in IP INN detail-level paid claims rates. All but one MCO's IP INN detail-level MH/SUD claims had a higher paid rate than IP INN detail-level M/S claims, with Aetna showing a marginally higher paid ratio for M/S IP INN detail-level claims.

Table 3-5—Inpatient Detail-Level Out-of-Network Paid Claim-Count Distribution

MCO	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
MH/SUD	2.3%	1.5%	1.4%	3.9%	1.1%	0.1%
M/S	26.9%	25.4%	9.7%	9.5%	18.1%	0.1%
State Total	**29.1%**	**26.9%**	**11.1%**	**13.4%**	**19.2%**	**0.2%**

Table 3-5 represents the significance of each MCO's impact on the overall claim-count distribution—specifically, displaying the percentage of total paid claim counts for IP detail-level OON for each MCO relative to the State total paid claim count for IP detail-level OON stratified by MH/SUD and M/S. MH/SUD represented 10.2 percent of the State total IP detail-level OON paid claim counts, while M/S represented 89.8 percent. Review of claim-count distributions for each MCO adds context to the overall state-level analysis. Distribution levels provide insight to the number of claim counts impacted, and by extension beneficiaries impacted, especially when the differences between MH/SUD and M/S claim counts are moderate or substantial. For the IP detail-level OON paid claim-count distribution, Aetna represents 29.1 percent of the State total, indicating it has the highest level of influence on the state-level IP detail-level OON MHP results. On the contrary, YouthCare has the smallest level of influence.

Figure 3-4—Inpatient Detail-Level Out-of-Network Paid and Denied Claim Counts

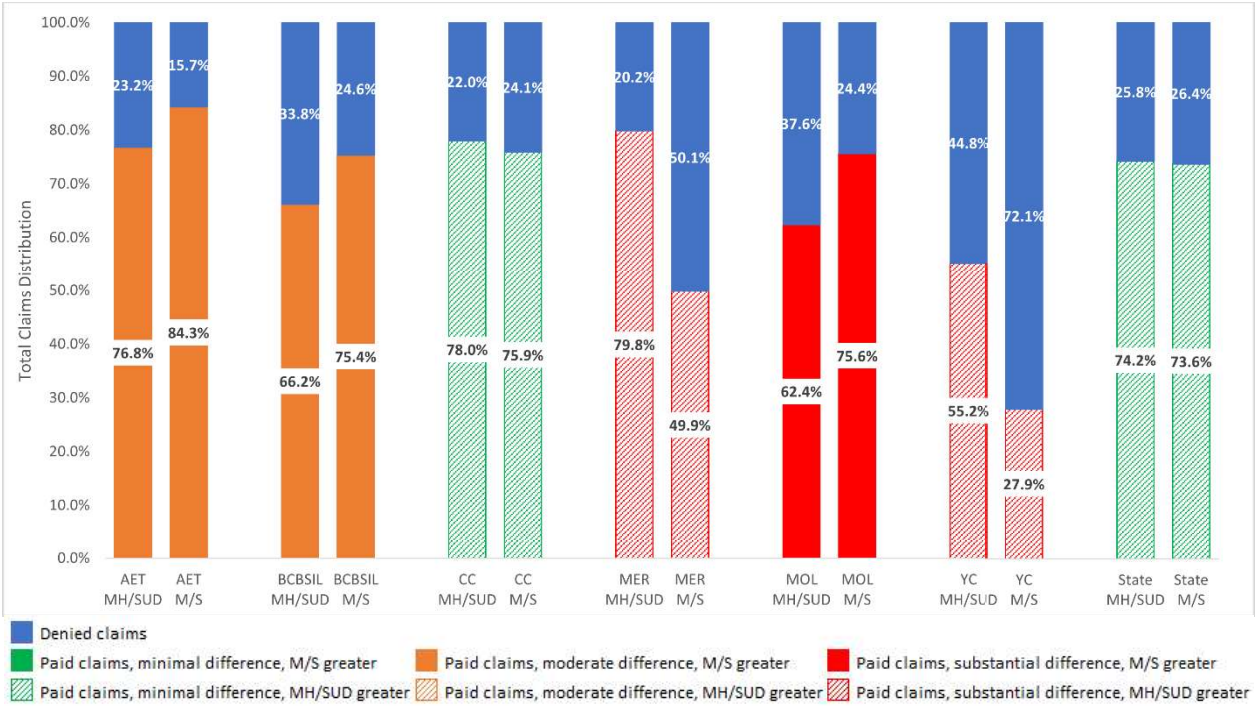


Figure 3-4 displays the IP detail-level OON claim-count percentages for MH/SUD and M/S claim categories distributed between paid and denied claims for each MCO and the statewide total. Overall, the difference in the statewide MCO percentage of IP OON detail-level paid claims for MH/SUD services (74.2 percent) and M/S services (73.6 percent) was minimal (0.5 percentage points), with individual MCO differences ranging from -13.2 percentage points (Molina with 19.2 percent of

aggregate MCO IP OON detail-level paid claims) to 29.9 percentage points (Meridian with 13.4 percent of aggregate MCO IP OON detail-level paid claims). Only one MCO, CountyCare, exhibited a minimal difference in the percentage of paid IP OON detail-level claims with higher paid MH/SUD claims than M/S. Of the remaining MCOs, both Aetna and BCBSIL demonstrated a moderate difference as the MH/SUD detail-level claims were paid at a lower rate than the M/S claims. Both Meridian and YouthCare demonstrated substantial differences between IP OON detail-level paid claims with higher paid MH/SUD than M/S.

Table 3-6—Summary of Inpatient Paid Claim Differences between In-Network and Out-of-Network

	Header Claims			Detail Claims		
	MH/SUD INN-OON	M/S INN-OON	Difference	MH/SUD INN-OON	M/S INN-OON	Difference
	a	b	c=a-b	d	e	f=d-e
Aetna	12.1%	6.3%	5.9%	11.5%	4.2%	7.2%
BCBSIL	13.6%	11.4%	2.2%	26.1%	14.9%	11.2%
CountyCare	14.7%	18.3%	-3.6%	15.5%	16.1%	-0.5%
Meridian	-3.5%	1.2%	-4.7%	-13.6%	1.6%	-15.2%
Molina	31.9%	8.1%	23.8%	17.2%	1.8%	15.4%
YouthCare	7.0%	-0.4%	7.3%	18.6%	-1.0%	19.6%
State Total	**5.3%**	**6.1%**	**-0.8%**	**11.8%**	**9.4%**	**2.3%**

Overall, the difference in the statewide MH/SUD and M/S for INN compared to OON IP header- and detail-level paid claims was minimal (-0.8 and 2.3 percentage points, respectively). At the header level the differential between INN and OON IP paid claims was lower for MH/SUD, however at the detail claim level MH/SUD showed a larger differential than M/S. Discussions with the MCOs revealed that these variations and the lower paid percentages for IP OON claims was driven by authorization and network limitations. The MCOs stated routine review and provider outreach is performed for limiting OON claims and denials.

Table 3-7—Summary of Inpatient Paid Claim Differences between Header- and Detail-Level Paid Claims

	INN			OON		
	MH/SUD Header-Detail	M/S Header-Detail	Difference	MH/SUD Header-Detail	M/S Header-Detail	Difference
	a	b	c=a-b	d	e	f=d-e
Aetna	8.0%	5.6%	2.4%	7.3%	3.6%	3.7%
BCBSIL	2.8%	2.1%	0.7%	15.3%	5.6%	9.7%
CountyCare	1.5%	-0.5%	2.0%	2.4%	-2.7%	5.1%
Meridian	24.5%	36.4%	-12.0%	14.4%	36.8%	-22.4%
Molina	7.3%	8.7%	-1.3%	-7.4%	2.4%	-9.8%

	INN			OON		
	MH/SUD Header-Detail	M/S Header-Detail	Difference	MH/SUD Header-Detail	M/S Header-Detail	Difference
	a	b	c=a-b	d	e	f=d-e
YouthCare	17.1%	50.1%	-33.0%	28.7%	49.4%	-20.8%
State Total	**7.2%**	**7.2%**	**0.0%**	**13.7%**	**10.5%**	**3.1%**

Overall, the difference in the statewide MH/SUD and M/S for IP header- and detail-level paid claims at the INN and OON level was minimal (0.0 and 3.1 percentage points, respectively). At the OON detail claim level MH/SUD showed a larger differential than M/S.

Outpatient Claims

Figure 3-5 through Figure 3-8 and Table 3-8 through Table 3-13 outline detailed results of the outpatient claim review for all MCOs. Results presented include comparison of overall paid and denied ratios for each MCO for INN and OON as well as header and detail level between MH/SUD and M/S, the deviation in paid claims between INN and OON and the deviation between paid header- and detail-level claims.

Table 3-8—Outpatient Header-Level In-Network Paid Claim-Count Distribution

MCO	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
MH/SUD	0.2%	6.0%	0.2%	6.5%	1.5%	1.4%
M/S	2.4%	32.9%	2.3%	33.9%	11.4%	1.2%
State Total	**2.6%**	**38.9%**	**2.5%**	**40.4%**	**13.0%**	**2.6%**

Table 3-8 represents the significance of each MCO's impact on the overall claim-count distribution—specifically, displaying the percentage of total paid claim counts for OP header-level INN for each MCO relative to the State total paid claim count for OP header-level INN stratified by MH/SUD and M/S. MH/SUD represented 15.8 percent of the state total OP header-level INN paid claim counts, while M/S represented 84.2 percent. Review of claim-count distributions for each MCO adds context to the overall state-level analysis. Distribution levels provide insight to the number of claim counts impacted, and by extension beneficiaries impacted, especially when the differences between MH/SUD and M/S claim counts are moderate or substantial. For the OP header-level INN paid claim-count distribution, Meridian represents 40.4 percent of the State total, indicating it has the highest level of influence on the state-level OP header-level INN MHP results. On the contrary, CountyCare has the smallest level of influence.

Figure 3-5—Outpatient Header-Level In-Network Paid and Denied Claim Counts

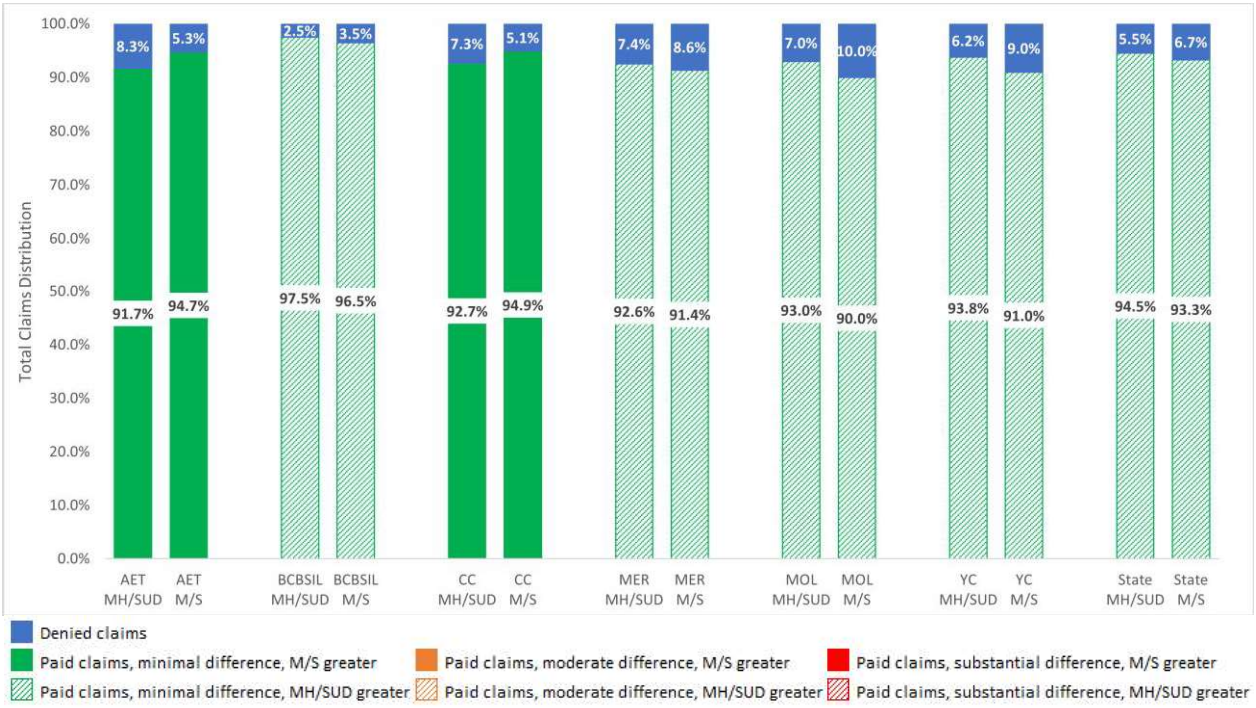


Figure 3-5 displays the OP header-level INN claim-count percentages for MH/SUD and M/S claim categories distributed between paid and denied claims for each MCO and the statewide total. Overall, the difference in the statewide MCO percentage of OP INN header-level paid claims for MH/SUD services (94.5 percent) and M/S services (93.3 percent) was minimal (1.2 percentage points), with individual MCO differences ranging from -3.0 percentage points (Aetna with 2.6 percent of aggregate MCO OP INN header-level paid claims) to 3.0 percentage points (Molina with 13.0 percent of aggregate MCO IP INN header-level paid claims). Only two MCOs, CountyCare and Aetna, exhibited a higher OP INN M/S paid header claims rate than OP INN MH/SUD paid header claims. All MCOs had less than a 5-percentage-point difference in OP INN paid header claims.

Table 3-9—Outpatient Header-Level Out-of-Network Paid Claim-Count Distribution

MCO	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
MH/SUD	0.0%	2.9%	0.0%	2.8%	0.3%	0.6%
M/S	0.4%	38.8%	0.0%	32.9%	20.0%	1.1%
State Total	**0.5%**	**41.8%**	**0.1%**	**35.7%**	**20.3%**	**1.7%**

Table 3-9 represents the significance of each MCO's impact on the overall claim-count distribution—specifically, displaying the percentage of total paid claim counts for OP header-level OON for each MCO relative to the State total paid claim count for OP header-level OON stratified by MH/SUD and M/S. MH/SUD represented 6.6 percent of the State total OP header-level OON paid claim counts, while M/S represented 93.4 percent. Review of claim-count distributions for each MCO adds context to the overall state-level analysis. Distribution levels provide insight to the number of claim counts impacted,

and by extension beneficiaries impacted, especially when the differences between MH/SUD and M/S claim counts are moderate or substantial. For the OP header-level OON paid claim-count distribution, Blue Cross Blue Shield of Illinois represents 41.8 percent of the State total, indicating it has the highest level of influence on the state-level OP header-level OON MHP results. On the contrary, CountyCare has the smallest level of influence.

Figure 3-6—Outpatient Header-Level Out-of-Network Paid and Denied Claim Counts

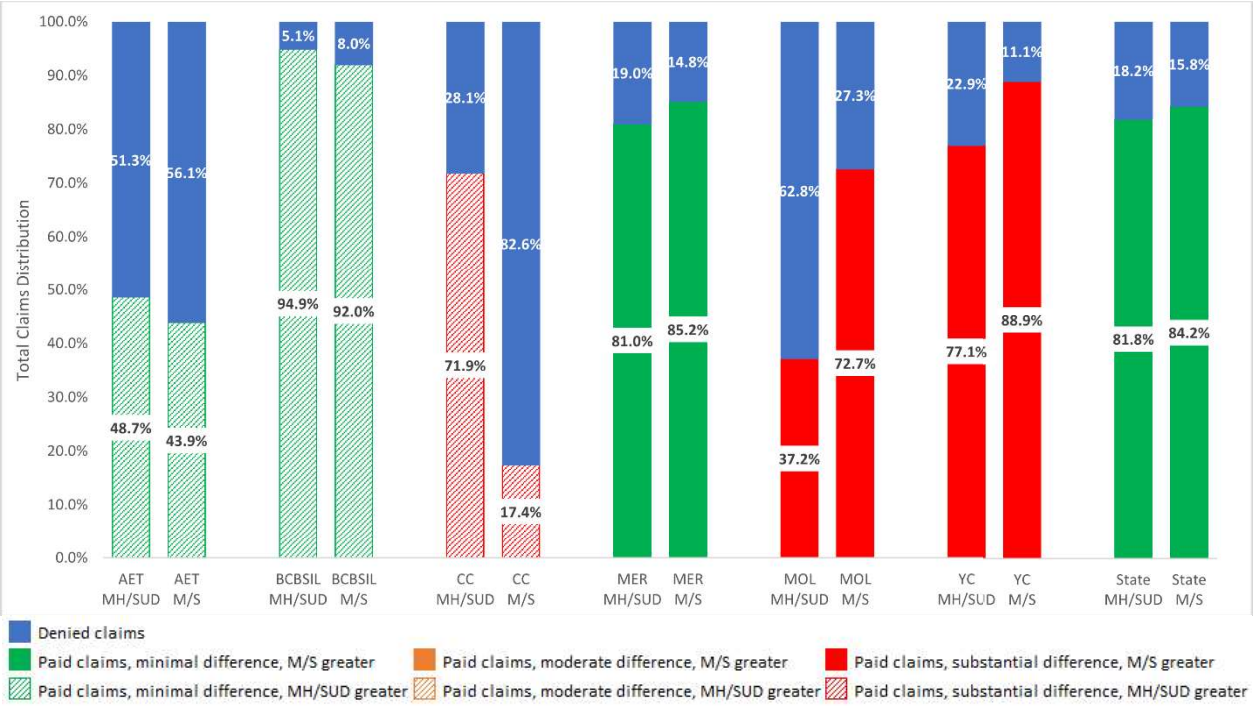


Figure 3-6 displays the OP header-level OON claim-count percentages for MH/SUD and M/S claim categories distributed between paid and denied claims for each MCO and the statewide total. Overall, the difference in the statewide MCO percentage of OP OON header-level paid claims for MH/SUD services (81.8 percent) and M/S services (84.2 percent) was minimal (-2.4 percentage points), with M/S claims being paid at a higher rate than the MH/SUD claims. Individual MCO differences ranged from -35.5 percentage points (Molina with 20.3 percent of aggregate MCO OP OON header-level paid claims) to 54.5 percentage points (CountyCare with 0.1 percent of aggregate MCO OP OON header-level paid claims). Three MCOs, YouthCare, Molina, and CountyCare, exhibited substantial differences in the percentage of paid OP OON claims. Both YouthCare and Molina paid M/S claims at a higher rate than MH/SUD claims. The remaining three MCOs had less than a 5-percentage-point difference in OP OON paid claims rates.

Table 3-10—Outpatient Detail-Level In-Network Paid Claim-Count Distribution

MCO	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
MH/SUD	0.1%	4.1%	0.2%	3.9%	1.0%	0.7%
M/S	3.8%	37.1%	3.8%	31.8%	12.5%	1.1%
State Total	**4.0%**	**41.3%**	**3.9%**	**35.7%**	**13.4%**	**1.8%**

Table 3-10 represents the significance of each MCO's impact on the overall claim-count distribution—specifically, displaying the percentage of total paid claim counts for OP detail-level INN for each MCO relative to the State total paid claim count for OP detail-level INN stratified by MH/SUD and M/S. MH/SUD represented 9.9 percent of the State total OP detail-level INN paid claim counts, while M/S represented 90.1 percent. Review of claim-count distributions for each MCO adds context to the overall state-level analysis. Distribution levels provide insight to the number of claim counts impacted, and by extension beneficiaries impacted, especially when the differences between MH/SUD and M/S claim counts are moderate or substantial. For the OP detail-level INN paid claim-count distribution, Blue Cross Blue Shield of Illinois represents 41.3 percent of the State total, indicating it has the highest level of influence on the state-level OP detail-level INN MHP results. On the contrary, YouthCare has the smallest level of influence.

Figure 3-7—Outpatient Detail-Level In-Network Paid and Denied Claim Counts

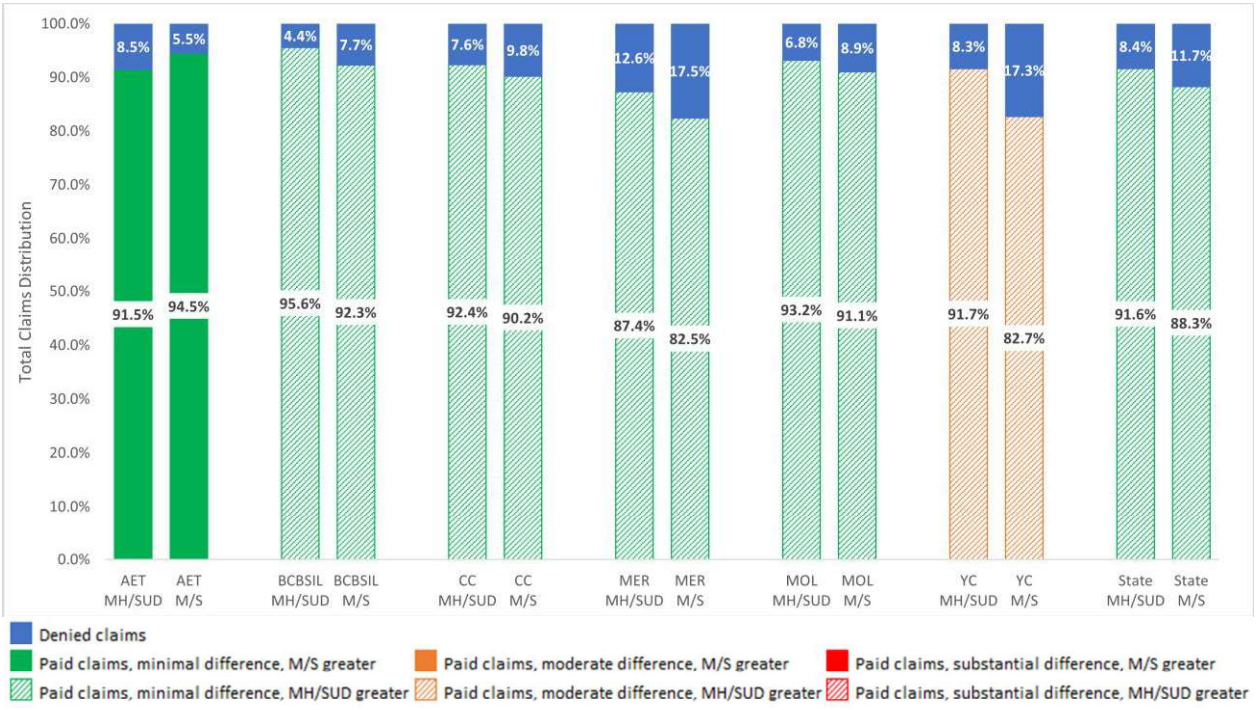


Figure 3-7 displays the OP detail-level INN claim-count percentages for MH/SUD and M/S claim categories distributed between paid and denied claims for each MCO and the statewide total. Overall, the difference in the statewide MCO percentage of OP INN detail-level paid claims for MH/SUD services (91.6 percent) and M/S services (88.3 percent) was minimal (3.3 percentage points), with

individual MCO differences ranging from -3.0 percentage points (Aetna with 4.0 percent of aggregate MCO OP INN detail-level paid claims) to 8.9 percentage points (YouthCare with 1.8 percent of aggregate MCO OP INN detail-level paid claims). One MCO, YouthCare, showed a moderate difference in the percentage of paid OP INN detail-level claims with a higher paid MH/SUD claims than M/S claims. The remaining four MCOs had less than a 5-percentage-point difference in OP INN detail-level claims. All but one MCO's OP INN detail-level MH/SUD claims had a higher paid rate than OP INN detail-level M/S claims, with Aetna showing a marginally higher paid ratio for M/S OP INN detail-level claims.

Table 3-11—Outpatient Detail-Level Out-of-Network Paid Claim-Count Distribution

MCO	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
MH/SUD	0.0%	2.4%	0.0%	2.3%	0.2%	0.5%
M/S	0.9%	36.2%	0.1%	35.4%	20.9%	1.2%
State Total	**0.9%**	**38.6%**	**0.1%**	**37.7%**	**21.0%**	**1.7%**

Table 3-11 represents the significance of each MCO's impact on the overall claim-count distribution—specifically, displaying the percentage of total paid claim counts for OP detail-level OON for each MCO relative to the State total paid claim count for OP detail-level OON stratified by MH/SUD and M/S. MH/SUD represented 5.4 percent of the State total OP detail-level OON paid claim counts, while M/S represented 94.6 percent. Review of claim-count distributions for each MCO adds context to the overall state-level analysis. Distribution levels provide insight to the number of claim counts impacted, and by extension beneficiaries impacted, especially when the differences between MH/SUD and M/S claim counts are moderate or substantial. For the OP detail-level OON paid claim-count distribution, Blue Cross Blue Shield of Illinois represents 38.6 percent of the State total, indicating it has the highest level of influence on the state-level OP detail-level OON MHP results. On the contrary, CountyCare has the smallest level of influence.

Figure 3-8—Outpatient Detail-Level Out-of-Network Paid and Denied Claim Counts

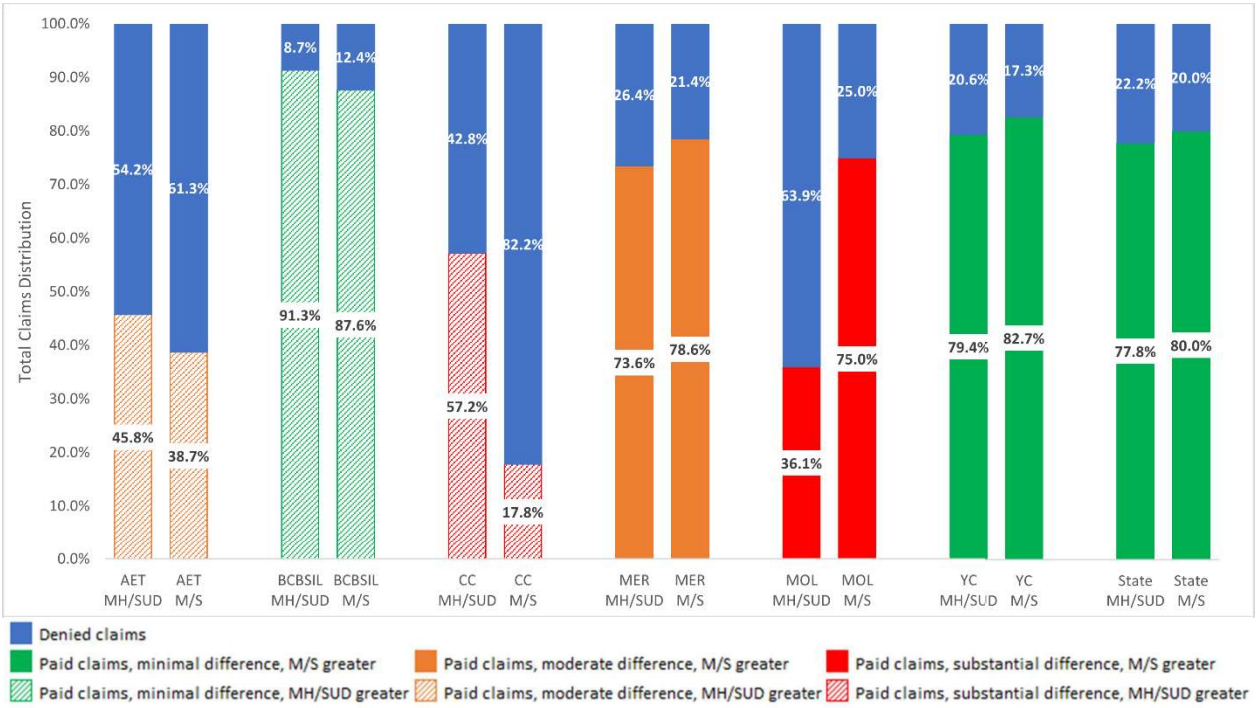


Figure 3-8 displays the OP detail-level OON claim-count percentages for MH/SUD and M/S claim categories distributed between paid and denied claims for each MCO and the statewide total. Overall, the difference in the statewide MCO percentage of OP OON detail-level paid claims for MH/SUD services (77.8 percent) and M/S services (73.6 percent) was minimal (-2.2 percentage points), with M/S claims being paid at a higher rate than the MH/SUD claims. Individual MCO differences ranged from -38.9 percentage points (Molina with 21.0 percent of aggregate MCO OP OON detail-level paid claims) to 39.4 percentage points (CountyCare with 0.1 percent of aggregate MCO OP OON detail-level paid claims). Both YouthCare and BCBSIL exhibited a minimal difference in the percentage of paid OP OON detail-level claims. Meridian and Aetna exhibited a moderate difference while Molina and CountyCare exhibited a substantial difference. Three MCOs (YouthCare, Meridian, and Molina) paid M/S claims at a higher rate than MH/SUD claims.

Table 3-12—Summary of Outpatient Paid Claim Differences between In-Network and Out-of-Network

	Header Claims			Detail Claims		
	MH/SUD INN-OON	M/S INN-OON	Difference	MH/SUD INN-OON	M/S INN-OON	Difference
	a	b	c=a-b	d	e	f=d-e
Aetna	43.1%	50.8%	-7.7%	45.7%	55.8%	-10.0%
BCBSIL	2.6%	4.4%	-1.8%	4.3%	4.7%	-0.4%
CountyCare	20.8%	77.5%	-56.7%	35.2%	72.4%	-37.3%
Meridian	11.6%	6.2%	5.4%	13.8%	3.9%	9.9%
Molina	55.8%	17.3%	38.5%	57.2%	16.1%	41.1%
YouthCare	16.7%	2.0%	14.7%	12.3%	0.1%	12.2%
State Total	**12.7%**	**9.1%**	**3.6%**	**13.9%**	**8.3%**	**5.6%**

Overall, the difference in the statewide MH/SUD and M/S claims for INN compared to OON OP header paid claims was minimal at 3.6 percentage points, while the difference in the statewide MH/SUD and M/S claims for INN compared to OON OP detail paid claims was moderate at 5.6 percentage points. At both the header and detail level the differential between INN and OON OP paid claims was higher for MH/SUD at 12.7 percentage points and 13.9 percentage points, respectively. Discussions with the MCOs revealed that variations and the lower paid percentages for individual MCO's OP OON claims were driven by authorization and network limitations. The MCOs stated routine review and provider outreach is performed for limiting OON claims and denials.

Table 3-13—Summary of Outpatient Paid Claim Differences between Header- and Detail-Level Paid Claims

	INN			OON		
	MH/SUD Header-Detail	M/S Header-Detail	Difference	MH/SUD Header-Detail	M/S Header-Detail	Difference
	a	b	c=a-b	d	e	f=d-e
Aetna	0.2%	0.2%	0.0%	2.9%	5.2%	-2.3%
BCBSIL	1.9%	4.2%	-2.2%	3.6%	4.4%	-0.8%
CountyCare	0.3%	4.7%	-4.4%	14.6%	-0.4%	15.0%
Meridian	5.2%	8.9%	-3.7%	7.4%	6.6%	0.8%
Molina	-0.2%	-1.1%	0.9%	1.1%	-2.3%	3.5%
YouthCare	2.1%	8.2%	-6.1%	-2.3%	6.2%	-8.6%
State Total	**2.9%**	**5.0%**	**-2.1%**	**4.0%**	**4.2%**	**-0.2%**

Overall, the difference in the statewide MH/SUD and M/S for OP header- and detail-level paid claims at the INN and OON level minimal (-2.1 and -0.2 percentage points, respectively). Looking at the INN level, M/S claims showed a larger differential between header- and detail-level paid claims than MH/SUD (5.0 and 2.9 percentage points, respectively).

Emergency Services

Figure 3-9 through Figure 3-12 and Table 3-14 through Table 3-19 outline detailed results of the emergency claim review for all MCOs. Results presented include comparison of overall paid and denied ratios for each MCO for INN and OON as well as header and detail level between MH/SUD and M/S, the deviation in paid claims between INN and OON and the deviation between paid header and detail level claims.

Table 3-14—Emergency Header-Level In-Network Paid Claim-Count Distribution

MCO	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
MH/SUD	0.9%	1.2%	0.9%	2.4%	0.6%	0.2%
M/S	11.6%	19.7%	12.7%	38.8%	9.4%	1.7%
State Total	**12.5%**	**20.9%**	**13.6%**	**41.1%**	**10.0%**	**1.9%**

Table 3-14 represents the significance of each MCO's impact on the overall claim-count distribution—specifically, displaying the percentage of total paid claim counts for ER header-level INN for each MCO relative to the State total paid claim count for ER header-level INN stratified by MH/SUD and M/S. MH/SUD represented 6.1 percent of the State total ER header-level INN paid claim counts, while M/S represented 93.9 percent. Review of claim-count distributions for each MCO adds context to the overall state-level analysis. Distribution levels provide insight to the number of claim counts impacted, and by extension beneficiaries impacted, especially when the differences between MH/SUD and M/S claim counts are moderate or substantial. For the ER header-level INN paid claim-count distribution, Meridian represents 41.1 percent of the State total, indicating it has the highest level of influence on the state-level ER header-level INN MHP results. On the contrary, YouthCare has the smallest level of influence.

Figure 3-9—Emergency Header-Level In-Network Paid and Denied Claim Counts

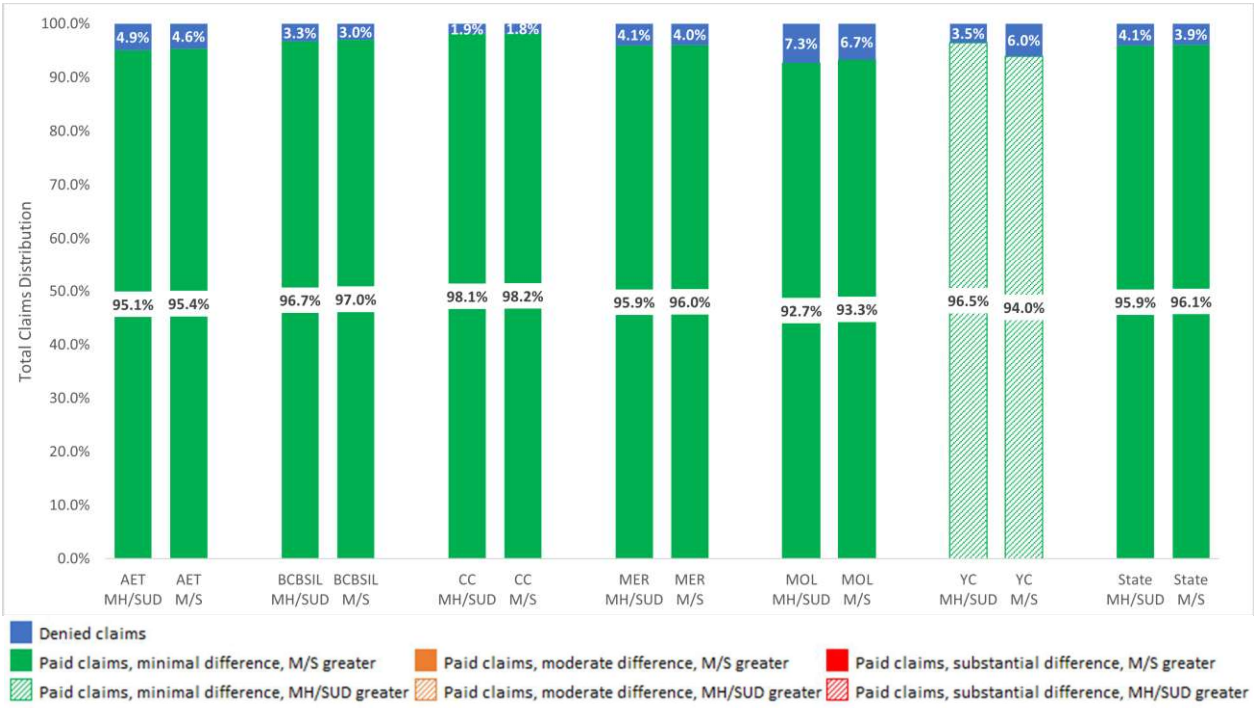


Figure 3-9 displays the ER header-level INN claim-count percentages for MH/SUD and M/S claim categories distributed between paid and denied claims for each MCO and the statewide total. Overall, the difference in the statewide MCO percentage of ER INN header-level paid claims for MH/SUD services (95.9 percent) and M/S services (96.1 percent) was minimal (-0.2 percentage points), with M/S claims being paid at a higher rate than the MH/SUD claims. Individual MCO differences ranged from -0.6 percentage points (Molina with 10.0 percent of aggregate MCO ER INN header-level paid claims) to 2.5 percentage points (YouthCare with 1.9 percent of aggregate MCO ER INN header-level paid claims). All six MCOs had less than a 5-percentage-point difference in ER INN header-level paid claims, with YouthCare being the only MCO to have MH/SUD claims being paid at a higher rate than M/S claims.

Table 3-15—Emergency Header-Level Out-of-Network Paid Claim-Count Distribution

MCO	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
MH/SUD	0.9%	0.4%	0.2%	3.1%	0.7%	0.2%
M/S	12.5%	8.5%	4.6%	58.1%	9.1%	1.7%
State Total	**13.5%**	**8.8%**	**4.8%**	**61.2%**	**9.8%**	**1.9%**

Table 3-15 represents the significance of each MCO's impact on the overall claim-count distribution—specifically, displaying the percentage of total paid claim counts for ER header-level OON for each MCO relative to the State total paid claim count for ER header-level OON stratified by MH/SUD and M/S. MH/SUD represented 5.5 percent of the State total ER header-level OON paid claim counts, while M/S represented 94.5 percent. Review of claim-count distributions for each MCO adds context to the

overall state-level analysis. Distribution levels provide insight to the number of claim counts impacted, and by extension beneficiaries impacted, especially when the differences between MH/SUD and M/S claim counts are moderate or substantial. For the ER header-level OON paid claim-count distribution, Meridian represents 61.2 percent of the State total, indicating it has the highest level of influence on the state-level ER header-level OON MHP results. On the contrary, YouthCare has the smallest level of influence.

Figure 3-10—Emergency Header-Level Out-of-Network Paid and Denied Claim Counts

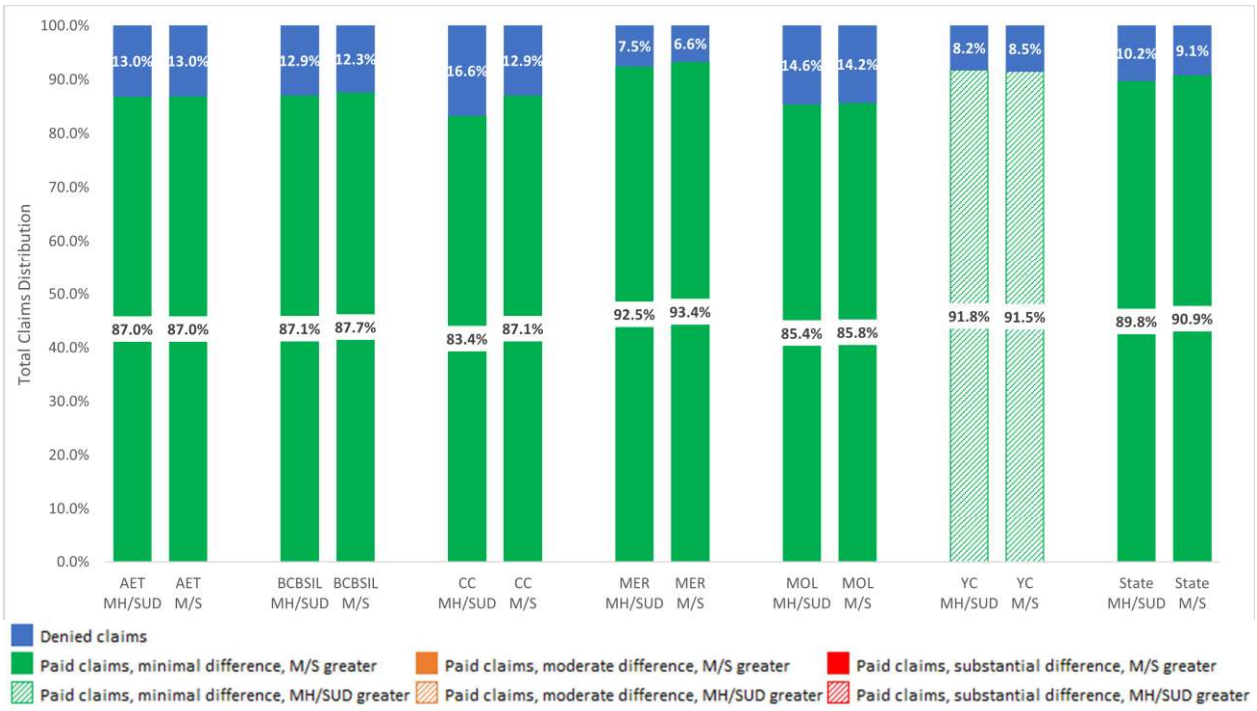


Figure 3-10 displays the ER header-level OON claim-count percentages for MH/SUD and M/S claim categories distributed between paid and denied claims for each MCO and the statewide total. Overall, the difference in the statewide MCO percentage of ER OON header-level paid claims for MH/SUD services (89.8 percent) and M/S services (90.9 percent) was minimal (-1.0 percentage points), with M/S claims being paid at a higher rate than the MH/SUD claims. Individual MCO differences ranged from -3.8 percentage points (CountyCare with 4.8 percent of aggregate MCO ER OON header-level paid claims) to 0.3 percentage points (YouthCare with 1.9 percent of aggregate MCO ER OON header-level paid claims). All six MCOs had less than a 5-percentage-point difference in ER INN header-level paid claims, with YouthCare being the only MCO to have MH/SUD claims being paid at a higher rate than M/S claims.

Table 3-16—Emergency Detail-Level In-Network Paid Claim-Count Distribution

MCO	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
MH/SUD	1.5%	2.3%	1.3%	1.1%	0.2%	0.1%
M/S	20.4%	33.9%	20.5%	15.4%	2.8%	0.6%
State Total	**21.9%**	**36.2%**	**21.7%**	**16.5%**	**2.9%**	**0.7%**

Table 3-16 represents the significance of each MCO's impact on the overall claim-count distribution—specifically, displaying the percentage of total paid claim counts for ER detail-level INN for each MCO relative to the State total paid claim count for ER detail-level INN stratified by MH/SUD and M/S. MH/SUD represented 6.4 percent of the State total ER detail-level INN paid claim counts, while M/S represented 93.6 percent. Review of claim-count distributions for each MCO adds context to the overall state-level analysis. Distribution levels provide insight to the number of claim counts impacted, and by extension beneficiaries impacted, especially when the differences between MH/SUD and M/S claim counts are moderate or substantial. For the ER detail-level INN paid claim-count distribution, Blue Cross Blue Shield of Illinois represents 36.2 percent of the State total, indicating it has the highest level of influence on the state-level ER detail-level INN MHP results. On the contrary, YouthCare has the smallest level of influence.

Figure 3-11—Emergency Detail-Level In-Network Paid and Denied Claim Counts

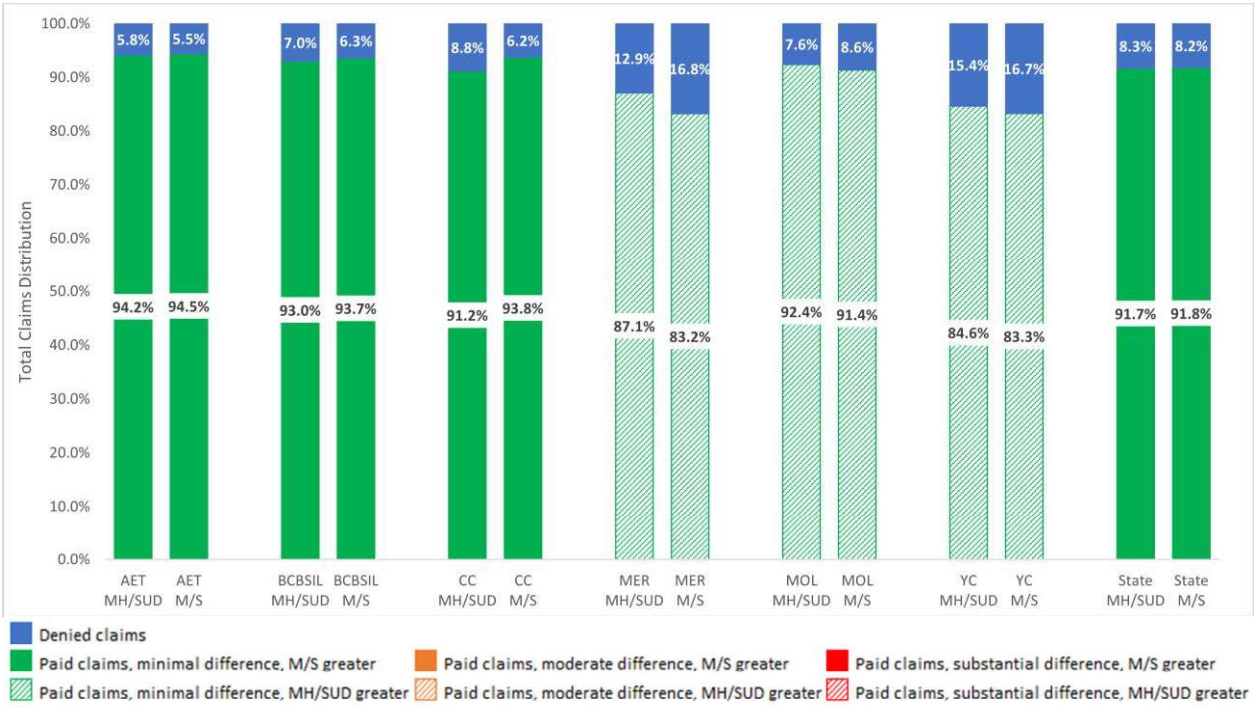


Figure 3-11 displays the ER detail-level INN claim-count percentages for MH/SUD and M/S claim categories distributed between paid and denied claims for each MCO and the statewide total. Overall, the difference in the statewide MCO percentage of ER INN detail-level paid claims for MH/SUD services (91.7 percent) and M/S services (91.8 percent) was minimal (-0.1 percentage points), with M/S

claims being paid at a higher rate than the MH/SUD claims. Individual MCO differences ranged from -2.6 percentage points (CountyCare with 21.7 percent of aggregate MCO ER INN detail-level paid claims) to 3.9 percentage points (Meridian with 16.5 percent of aggregate MCO ER INN detail-level paid claims). All six MCOs had less than a 5-percentage-point difference in ER INN detail-level paid claims. Three MCOs (Aetna, BCBSIL, and CountyCare) paid M/S ER INN detail-level claims at a higher rate than MH/SUD ER INN detail-level claims.

Table 3-17—Emergency Detail-Level Out-of-Network Paid Claim-Count Distribution

MCO	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
MH/SUD	3.2%	1.0%	0.6%	1.5%	0.2%	0.1%
M/S	32.1%	21.4%	10.0%	25.6%	3.7%	0.8%
State Total	**35.3%**	**22.4%**	**10.6%**	**27.1%**	**3.9%**	**0.9%**

Table 3-17 represents the significance of each MCO's impact on the overall claim-count distribution—specifically, displaying the percentage of total paid claim counts for ER detail-level OON for each MCO relative to the State total paid claim count for ER detail-level OON stratified by MH/SUD and M/S. MH/SUD represented 6.5 percent of the state total ER detail-level OON paid claim counts, while M/S represented 93.5 percent. Review of claim-count distributions for each MCO adds context to the overall state-level analysis. Distribution levels provide insight to the number of claim counts impacted, and by extension beneficiaries impacted, especially when the differences between MH/SUD and M/S claim counts are moderate or substantial. For the ER detail-level OON paid claim-count distribution, Aetna represents 35.3 percent of the State total, indicating it has the highest level of influence on the state-level ER detail-level OON MHP results. On the contrary, YouthCare has the smallest level of influence.

Figure 3-12—Emergency Detail-Level Out-of-Network Paid and Denied Claim Counts

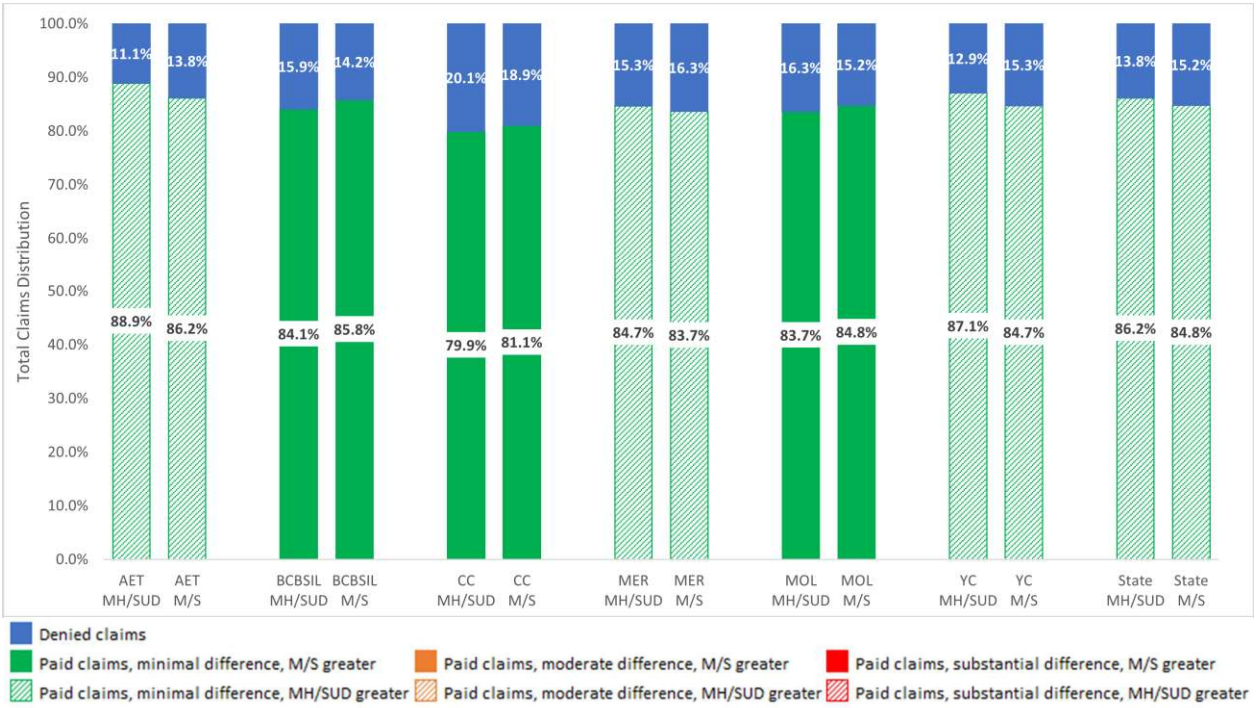


Figure 3-12 displays the ER detail-level OON claim-count percentages for MH/SUD and M/S claim categories distributed between paid and denied claims for each MCO and the statewide total. Overall, the difference in the statewide MCO percentage of ER OON detail-level paid claims for MH/SUD services (86.2 percent) and M/S services (84.8 percent) was minimal (1.4 percentage points), with individual MCO differences ranging from -1.7 percentage points (BCBSIL with 22.4 percent of aggregate MCO ER OON detail-level paid claims) to 2.7 percentage points (Aetna with 35.3 percent of aggregate MCO ER OON detail-level paid claims). All six MCOs had less than a 5-percentage-point difference in ER OON detail-level paid claims. Three MCOs (CountyCare, Molina, and BCBSIL), paid M/S ER OON detail-level claims at a higher rate than MH/SUD ER OON detail-level claims.

Table 3-18—Summary of Emergency Paid Claim Differences between In-Network and Out-of-Network

	Header Claims			Detail Claims		
	MH/SUD INN-OON	M/S INN-OON	Difference	MH/SUD INN-OON	M/S INN-OON	Difference
	a	b	c=a-b	d	e	f=d-e
Aetna	8.1%	8.3%	-0.2%	5.3%	8.3%	-3.0%
BCBSIL	9.5%	9.3%	0.3%	8.9%	7.8%	1.1%
CountyCare	14.7%	11.1%	3.6%	11.2%	12.7%	-1.5%
Meridian	3.4%	2.6%	0.8%	2.4%	-0.5%	2.9%
Molina	7.3%	7.5%	-0.2%	8.7%	6.6%	2.2%
YouthCare	4.7%	2.4%	2.3%	-2.4%	-1.4%	-1.0%
State Total	**6.1%**	**5.2%**	**0.9%**	**5.5%**	**7.1%**	**-1.5%**

Overall, the difference in the statewide MH/SUD and M/S for INN compared to OON ER header- and detail-level paid claims was minimal (0.9 and -1.5 percentage points, respectively). At the header level the differential between INN and OON ER paid claims was higher for MH/SUD at 6.1 percentage points, while at the detail level the differential between INN and OON ER paid claims was higher for M/S at 7.1 percentage points. Discussions with the MCOs revealed that variations and the lower paid percentages for individual MCO's ER OON claims was driven by authorization and network limitations. The MCOs stated routine review and provider outreach is performed for limiting OON claims and denials.

Table 3-19—Summary of Emergency Paid Claim Differences between Header- and Detail-Level Paid Claims

	INN			OON		
	MH/SUD Header-Detail	M/S Header-Detail	Difference	MH/SUD Header-Detail	M/S Header-Detail	Difference
	a	b	c=a-b	d	e	f=d-e
Aetna	0.9%	0.9%	0.0%	-2.0%	0.8%	-2.8%
BCBSIL	3.7%	3.3%	0.3%	3.0%	1.9%	1.1%
CountyCare	6.9%	4.4%	2.5%	3.4%	6.1%	-2.6%
Meridian	8.8%	12.8%	-4.0%	7.8%	9.8%	-1.9%
Molina	0.3%	1.9%	-1.6%	1.8%	1.0%	0.8%
YouthCare	11.9%	10.7%	1.2%	4.7%	6.8%	-2.1%
State Total	**4.2%**	**4.3%**	**-0.1%**	**3.7%**	**6.1%**	**-2.4%**

Overall, the difference in the statewide MH/SUD and M/S for ER header- and detail-level paid claims at the INN and OON level was minimal (-0.1 and -2.4 percentage points, respectively). Review of the OON level demonstrated that M/S claims showed a larger differential between header- and detail-level paid claims than MH/SUD (6.1 and 3.7 percentage points, respectively).

Appendix A. Health Plan-Specific Findings

This appendix provides detailed findings for each health plan.

Aetna Better Health of Illinois (Aetna)

MHP Attestation

HSAG reviewed the health plan's attestation form submission and noted the following changes:

- The health plan reported transitioning to the use of a new internal electronic document system used to record authorization requests, clinical reviews to apply medical necessity criteria, and notification of decisions. In addition, in 2023 the health plan implemented a "gold carding" program used to ease administrative burden for providers delivering services covered under both MH/SUD and M/S covered benefits.

During the webinar review, Aetna provided additional information regarding the changes. The system change was completed and created consistency with use by other Aetna enterprise business units. The implementation was completed with no impact to claims or utilization management. Aetna also described the gold carding program, which was implemented to provide automated authorization approvals for providers who demonstrate a 95 percent or greater prior authorization approval rate. The health plan noted that over 1,000 providers have been provided gold card status and reported successful use of the automated authorization program.

NQTL Submission Form Review

Aetna submitted its provider reimbursement NQTL comparative analysis. The health plan's submission was found to be thorough and complete. The health plan concluded that its reimbursement approach and methodology for provider reimbursement achieved parity between MH/SUD and M/S benefits. HSAG and HFS reviewed the information, including responses related to payment methodologies, reimbursement rates, contracting, pharmacy, and alternative payment models and had no concerns with the health plan's analysis.

Claims

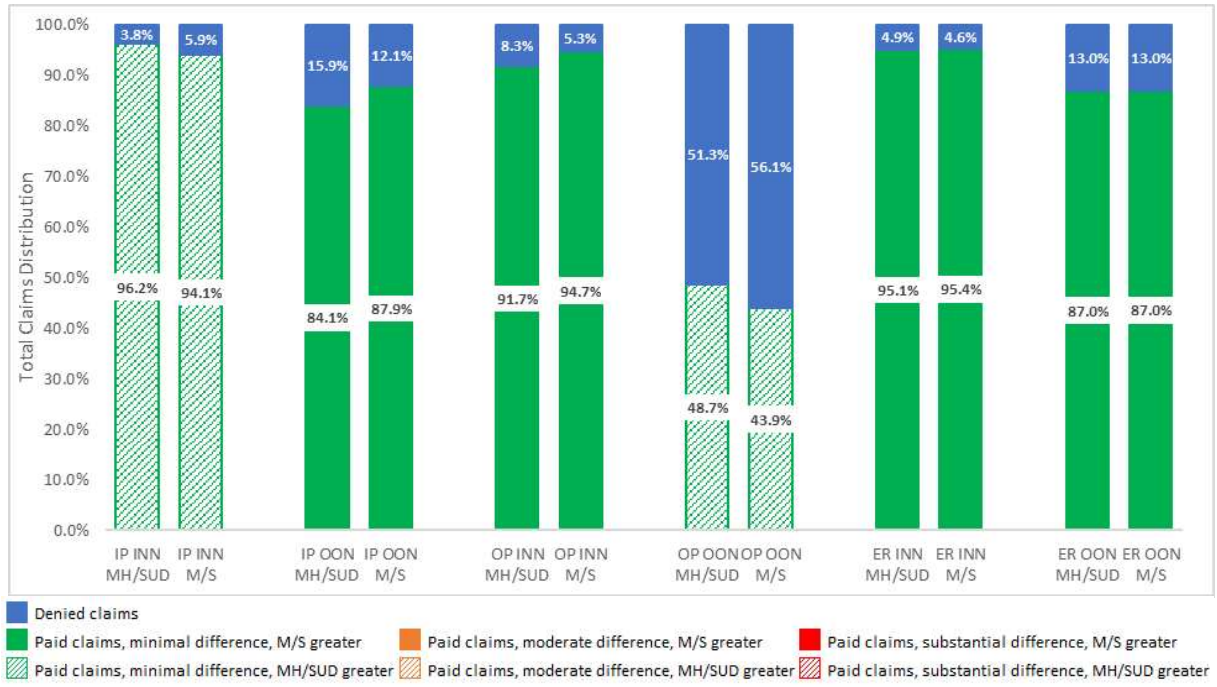
The health plan submitted its 2023 claims header and detail line-level data. HSAG assessed the health plan's data to determine evidence of parity between M/S and MH/SUD claims.

Table A-1 and Figure A-1 present a summary of the results from the analysis of header-level paid claims by service and benefit type for Aetna.

Table A-1—Aetna Number and Percentage of Header-Level Claims by Benefit Type

Service Type	Benefit Type	Total In-Network Claims	Paid Claims[1]		Total Out-of-Network Claims	Out-of-Network Paid Claims	
		Number	Number	Percent	Number	Number	Percent
IP	MH/SUD	33,733	32,460	96.2%	1,484	1,248	84.1%
	M/S	93,496	88,021	94.1%	7,614	6,691	87.9%
OP	MH/SUD	44,917	41,206	91.7%	1,009	491	48.7%
	M/S	662,640	627,796	94.7%	22,630	9,944	43.9%
ER	MH/SUD	17,962	17,077	95.1%	3,775	3,283	87.0%
	M/S	238,141	227,078	95.4%	50,888	44,275	87.0%
Total	**MH/SUD**	**96,612**	**90,743**	**93.9%**	**6,268**	**5,022**	**80.1%**
	M/S	**994,277**	**942,895**	**94.8%**	**81,132**	**60,910**	**75.1%**

Figure A-1—Aetna Paid and Denied Header-Level Claims Distributions



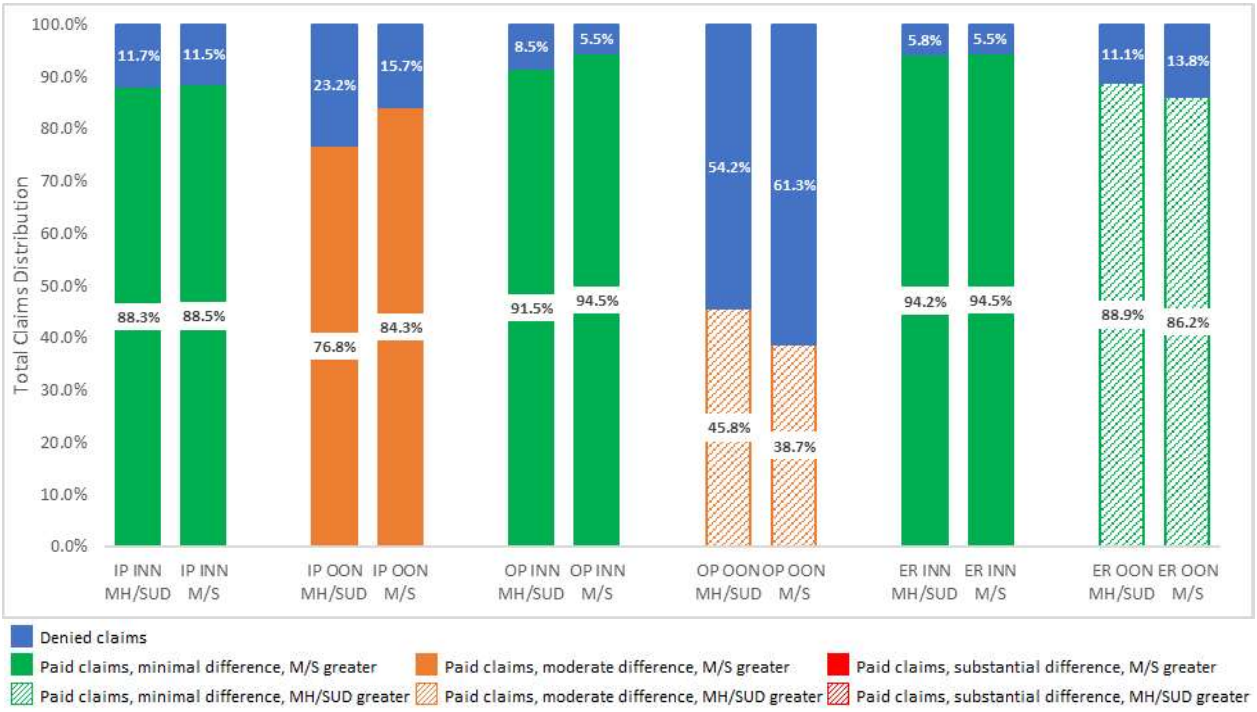
Overall, the analysis showed minimal differences in the percentage of header-level paid claims between MH/SUD and M/S claims for both INN and OON. INN claims showed a slightly higher percentage of header-level paid M/S claims at 94.8 percent compared to MH/SUD claims at 93.9 percent, while OON showed a higher percentage of paid MH/SUD claims at 80.1 percent compared to M/S claims at 75.1 percent. INN IP and OON OP both paid MH/SUD header-level claims at a higher rate compared to M/S claims, while INN OP, OON IP, and all ER claims paid M/S claims at a higher rate compared to MH/SUD claims.

Table A-2 and Figure A-2 present a summary of the results from the analysis of detail-level paid claims by service and benefit type for Aetna.

Table A-2—Aetna Number and Percentage of Detail-Level Claims by Benefit Type

Service Type	Benefit Type	Total In-Network Claims	Paid Claims		Total Out-of-Network Claims	Out-of-Network Paid Claims	
		Number	Number	Percent	Number	Number	Percent
IP	MH/SUD	60,511	53,405	88.3%	6,177	4,744	76.8%
	M/S	444,043	393,147	88.5%	66,773	56,286	84.3%
OP	MH/SUD	76,783	70,278	91.5%	3,305	1,513	45.8%
	M/S	2,392,616	2,261,538	94.5%	104,674	40,553	38.7%
ER	MH/SUD	141,101	132,892	94.2%	41,038	36,490	88.9%
	M/S	1,923,096	1,817,007	94.5%	426,368	367,409	86.2%
Total	**MH/SUD**	**278,395**	**256,575**	**92.2%**	**50,520**	**42,747**	**84.6%**
	M/S	**4,759,755**	**4,471,692**	**93.9%**	**597,815**	**464,248**	**77.7%**

Figure A-2—Aetna Paid and Denied Detail-Level Claims Distributions



Overall, the analysis showed a minimal difference in the percentage of detail-level paid claims between MH/SUD and M/S claims for INN (92.2 percent and 93.9 percent, respectively), with M/S claims being paid at a slightly higher rate than MH/SUD claims. However, for overall OON claims, the analysis showed a moderate difference in the percentage of detail-level paid claims between MH/SUD and M/S

(84.6 percent and 77.7 percent, respectively), with MH/SUD claims being paid at a higher rate than M/S claims. Both IP OON and OP OON exhibited moderate differences in the percentage of detail-level paid claims for MH/SUD and M/S services, while the remaining subcategories exhibited less than a 5-percentage-point difference. Only the OP OON and ER OON detail-level MH/SUD claims had a higher paid rate than M/S claims.

Overall, when comparing the header-level paid claims by service and benefit type to the detail-level paid claims by service and benefit type, both INN showed minimal differences, while both OON showed moderate differences. Additionally, IP OON and OP OON exhibited variances. The header-level paid claims analysis reflects minimal differences (3.8 percent and 4.7 percent, respectively) in the percentage of paid claims between MH/SUD and M/S compared to the moderate differences (7.5 percent and 7.0 percent, respectively) in the percentage of paid claims between MH/SUD and M/S reflected in the detail-level paid claims analysis.

During the webinar review, HSAG and Aetna discussed variances by paid and denied ratios by INN and OON, as well as category of service at both the header and detail levels. The health plan noted that the volume of OON OP claims was a very small percentage of overall spend. Aetna described the results of its analyses of drivers for denials, which included MH billing errors and State file provider status. Aetna dedicates provider representatives to MH/SUD providers to assist those providers with claims processes and submissions. HSAG acknowledged the health plan's efforts.

Overall MHP Compliance Rating

Based on the review of the MHP attestation form, NQTL submission form, and claims analysis, HSAG assigned an overall rating of *Compliant*.

Blue Cross Community Health Plans (BCBSIL)

MHP Attestation

HSAG reviewed the health plan's attestation form submission and noted the following changes:

- The health plan reported review and updates to prior authorization requirements, which were completed regularly to address new technologies, changes in benefits, and changes in requirements or updates to Healthcare Common Procedure Coding System (HCPCS) codes and services.
- The health plan reported continued use of ASAM[1] and Milliman Clinical Guidelines (MCG) criteria for medical necessity determinations.

HSAG had no concerns regarding the health plan's descriptions of updates completed during the evaluation period.

NQTL Submission Form Review

BCBSIL submitted its provider reimbursement NQTL comparative analysis. The health plan's submission was found to be thorough and complete. The health plan concluded that its reimbursement approach and methodology for provider reimbursement were applied no more stringently to MH/SUD than M/S. HSAG and HFS reviewed the information, including responses related to payment methodologies, reimbursement rates, contracting, pharmacy, and alternative payment models and had no concerns with the health plan's analysis.

Claims

The health plan submitted its 2023 claims header and detail line-level data. Table A-3 and Figure A-3 present a summary of the results from the analysis of header-level paid claims by service and benefit type for BCBSIL.

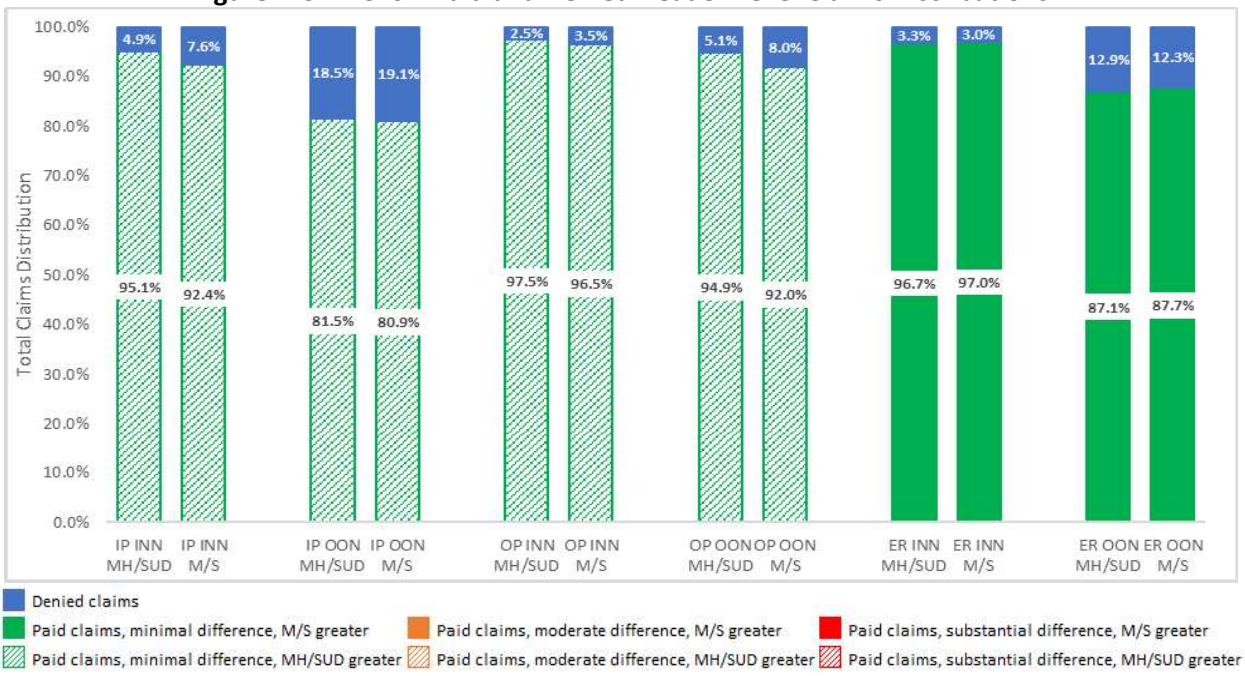
Table A-3—BCBSIL Number and Percentage of Header-Level Claims by Benefit Type

Service Type	Benefit Type	Total In-Network Claims	Paid Claims[1]		Total Out-of-Network Claims	Out-of-Network Paid Claims	
		Number	Number	Percent	Number	Number	Percent
IP	MH/SUD	30,409	28,923	95.1%	1,248	1,017	81.5%
	M/S	89,058	82,276	92.4%	6,582	5,328	80.9%
OP	MH/SUD	1,583,266	1,543,798	97.5%	69,667	66,128	94.9%
	M/S	8,749,208	8,438,783	96.5%	950,662	874,799	92.0%

[1] ASAM Criteria® is a registered product of the American Society of Addiction Medicine.

Service Type	Benefit Type	Total In-Network Claims	Paid Claims[1]		Total Out-of-Network Claims	Out-of-Network Paid Claims	
		Number	Number	Percent	Number	Number	Percent
ER	MH/SUD	24,843	24,018	96.7%	1,524	1,328	87.1%
	M/S	397,801	385,859	97.0%	34,064	29,883	87.7%
Total	**MH/SUD**	**1,638,518**	**1,596,739**	**97.5%**	**72,439**	**68,473**	**94.5%**
	M/S	**9,236,067**	**8,906,918**	**96.4%**	**991,308**	**910,010**	**91.8%**

Figure A-3—BCBSIL Paid and Denied Header-Level Claims Distributions



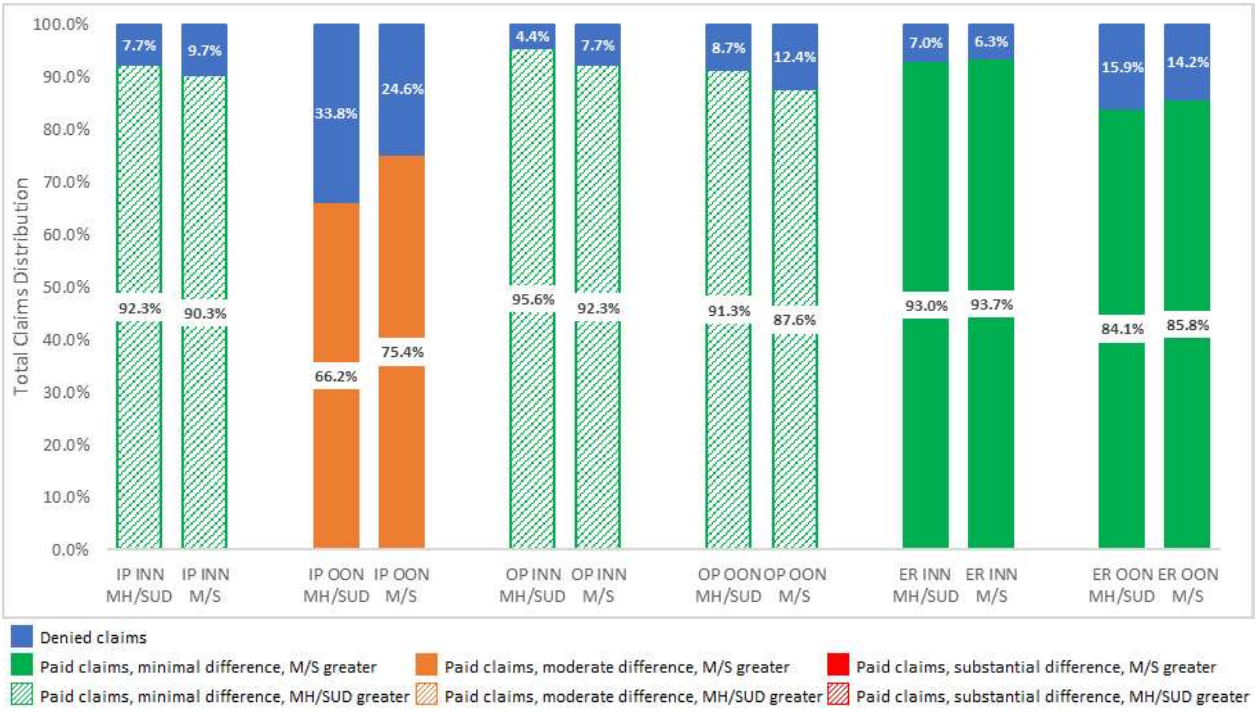
Overall, the analysis showed minimal differences in the percentage of header-level paid claims between MH/SUD and M/S claims for both INN (97.5 percent and 96.4 percent, respectively) and OON (94.5 percent and 91.8 percent, respectively). For both INN and OON, the percentage of header-level paid MH/SUD claims were paid at a higher rate than M/S claims for both IP and OP. For ER header-level paid claims, the percentage of M/S claims were paid at a slightly higher rate than MH/SUD claims, but still minimal for both INN and OON.

Table A-4 and Figure A-4 present a summary of the results from the analysis of detail-level paid claims by service and benefit type for BCBSIL.

Table A-4—BCBSIL Number and Percentage of Detail-Level Claims by Benefit Type

Service Type	Benefit Type	Total In-Network Claims	Paid Claims		Total Out-of-Network Claims	Out-of-Network Paid Claims	
		Number	Number	Percent	Number	Number	Percent
IP	MH/SUD	110,067	101,607	92.3%	4,811	3,184	66.2%
	M/S	833,448	752,753	90.3%	70,709	53,294	75.4%
OP	MH/SUD	2,534,343	2,422,817	95.6%	126,116	115,204	91.3%
	M/S	23,651,690	21,830,028	92.3%	1,958,962	1,716,478	87.6%
ER	MH/SUD	219,187	203,877	93.0%	13,355	11,235	84.1%
	M/S	3,223,916	3,019,628	93.7%	285,090	244,746	85.8%
Total	**MH/SUD**	**2,863,597**	**2,728,301**	**95.3%**	**144,282**	**129,623**	**89.8%**
	M/S	**27,709,054**	**25,602,409**	**92.4%**	**2,314,761**	**2,014,518**	**87.0%**

Figure A-4—BCBSIL Paid and Denied Detail-Level Claims Distributions



Overall, the analysis showed minimal differences in the percentage of detail-level paid claims between MH/SUD and M/S claims for both INN (95.3 percent and 92.4 percent, respectively) and OON (89.8 percent and 87.0 percent, respectively). Only one service type, IP OON, exhibited a moderate difference (9.2 percent) in the percentage of detail-level paid claims between MH/SUD and M/S claims. At the

detail level the percentage of M/S claims were paid at a higher rate than MH/SUD claims for IP OON. All ER detail-level paid claims had a higher percentage of M/S claims than MH/SUD claims as well, but still minimal for both INN and OON.

Overall, when comparing the header-level paid claims by service and benefit type to the detail-level paid claims by service and benefit type, both INN and OON showed minimal differences. Only one service type, IP OON, exhibited a variance. The header-level paid claims analysis reflects a minimal difference (0.05 percent) in the percentage of paid claims between MH/SUD and M/S, with the MH/SUD claims paid at a slightly higher rate than M/S claims. The detail-level paid claims analysis reflects a moderate difference (9.2 percent) in the percentage of paid claims between MH/SUD and M/S, with the M/S claims paid at a higher rate than MH/SUD claims.

During the webinar review, HSAG and BCBSIL discussed variances by paid and denied ratios by INN and OON, as well as category of service at both the header and detail levels. BCBSIL reported that denials were attributed to authorization issues and coordination of benefits/other primary insurance. The health plan described its process to communicate and educate providers on authorization processes, as well as their network team's role to continuously review OON data to determine any needs for provider contracting. HSAG acknowledged the health plan's efforts.

Overall MHP Compliance Rating

Based on the review of the MHP attestation form, NQTL submission form, and claims analysis, HSAG assigned an overall rating of *Compliant*.

CountyCare

MHP Attestation

HSAG reviewed the health plan's attestation form submission and noted that the health plan did not report any changes during the evaluation period. HSAG noted that the health plan described its process to use technology to auto-authorize services with historically high approval rates to ensure timely access to services without compromising patient safety or quality of care.

HSAG had no concerns regarding the health plan's descriptions of its processes used during the evaluation period.

NQTL Submission Form Review

CountyCare submitted its provider reimbursement NQTL comparative analysis. The health plan's submission was found to be thorough and complete. The health plan concluded that its reimbursement approach and methodology for provider reimbursement achieved parity between MH/SUD and M/S benefits. HSAG and HFS reviewed the information, including responses related to payment methodologies, reimbursement rates, contracting, pharmacy, and alternative payment models and had no concerns with the health plan's analysis.

Claims

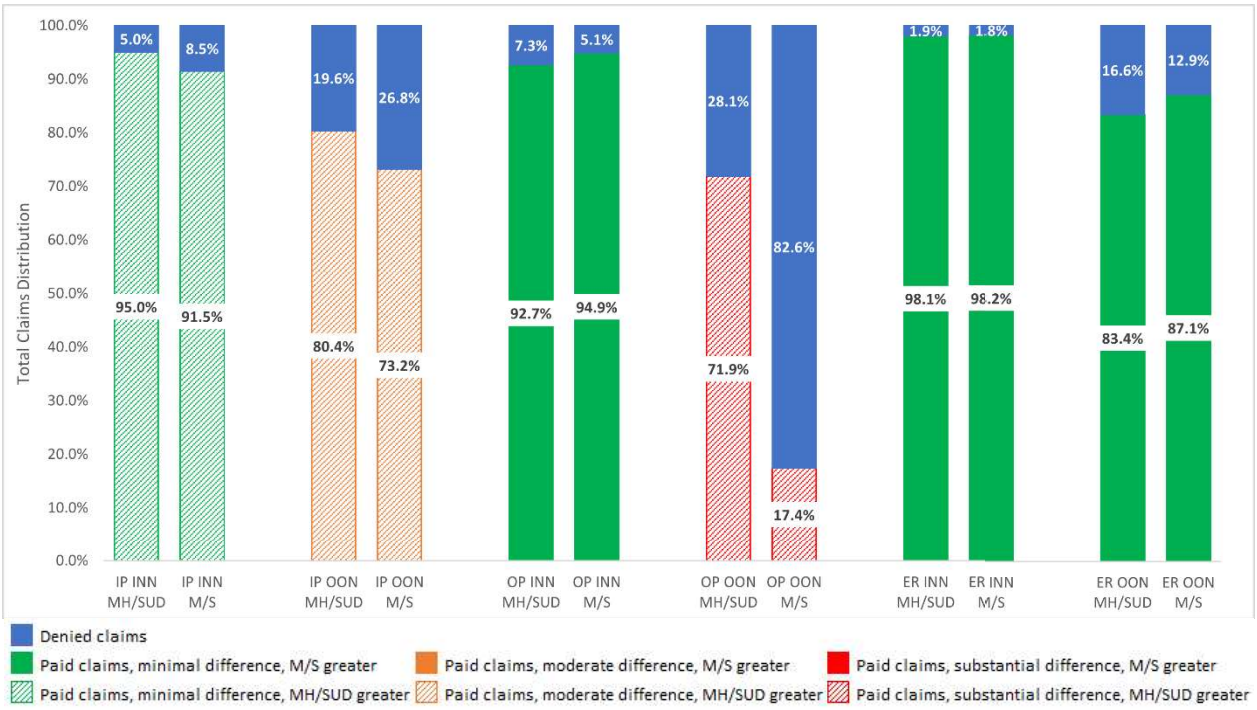
The health plan submitted its 2023 claims header and detail line-level data. Table A-5 and Figure A-5 present a summary of the results from the analysis of header-level paid claims by service and benefit type for CountyCare.

Table A-5—CountyCare Number and Percentage of Header-Level Claims by Benefit Type

Service Type	Benefit Type	Total In-Network Claims	Paid Claims[1]		Total Out-of-Network Claims	Out-of-Network Paid Claims[1]	
		Number	Number	Percent	Number	Number	Percent
IP	MH/SUD	10,599	10,074	95.0%	622	500	80.4%
	M/S	44,566	40,765	91.5%	2,126	1,556	73.2%
OP	MH/SUD	60,831	56,369	92.7%	786	565	71.9%
	M/S	623,723	592,144	94.9%	4,774	833	17.4%
ER	MH/SUD	17,030	16,705	98.1%	980	817	83.4%
	M/S	253,081	248,572	98.2%	18,699	16,295	87.1%
Total	**MH/SUD**	**88,460**	**83,148**	**94.0%**	**2,388**	**1,882**	**78.8%**
	M/S	**921,370**	**881,481**	**95.7%**	**25,599**	**18,684**	**73.0%**

[1] Differences of 10 percentage points or more where a greater percentage of M/S claims were paid compared to MH/SUD claims are presented in red text.

Figure A-5—CountyCare Paid and Denied Header-Level Claims Distributions



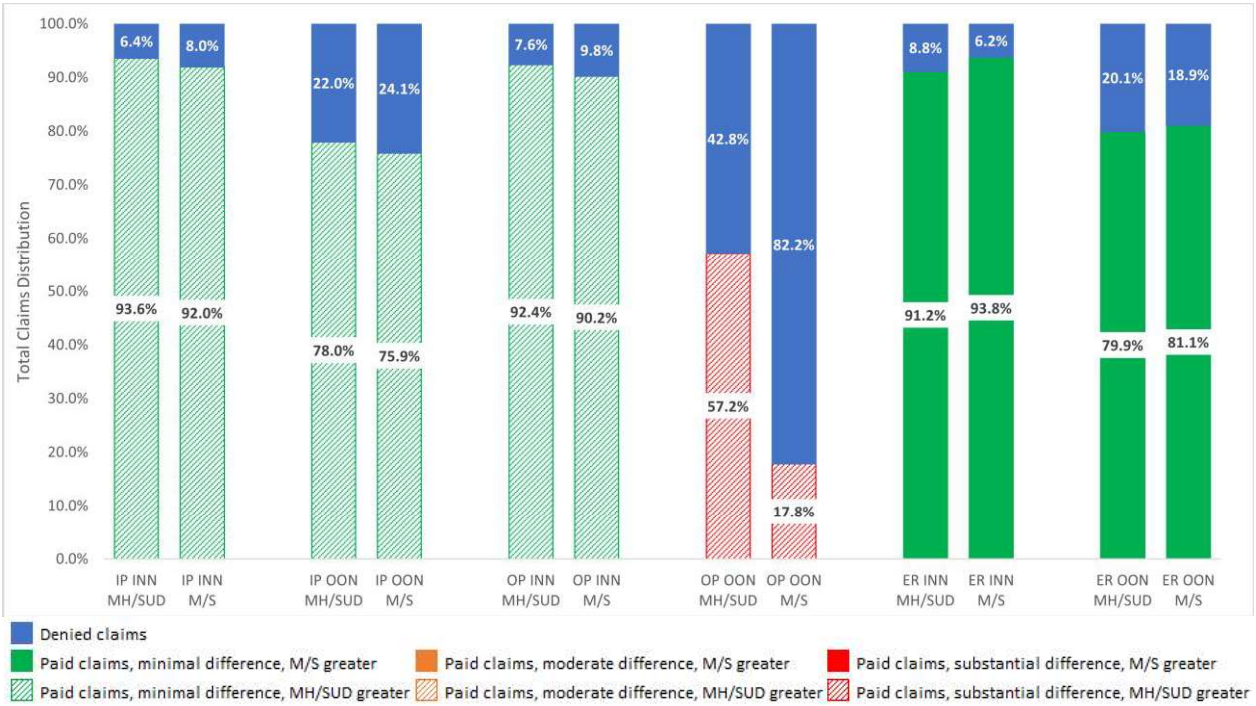
Overall, the analysis showed a minimal difference in the percentage of header-level paid claims between MH/SUD and M/S claims for INN (94.0 percent and 95.7 percent), with M/S claims being paid at a higher rate than MH/SUD claims. However, for overall OON claims, the analysis showed a moderate difference in the percentage of header-level paid claims between MH/SUD and M/S (78.8 percent and 73.0 percent, respectively) claims, with MH/SUD claims being paid at a higher rate than M/S claims. OON OP exhibited a substantial difference of 54.4 percentage points between MH/SUD (71.9 percent) header-level paid claims and M/S (17.4 percent) claims; additionally, the MH/SUD claims were being paid at the higher rate compared to M/S. OON IP exhibited a moderate difference of 7.2 percentage points between MH/SUD (80.4 percent) header-level paid claims and M/S (73.2 percent) claims; additionally, the MH/SUD claims were being paid at the higher rate compared to M/S. The remaining sub-categories exhibited less than a 5-percentage-point difference in the percentage of header-level paid claims between MH/SUD and M/S claims.

Table A-6 and Figure A-6 present a summary of the results from the analysis of detail-level paid claims by service and benefit type for CountyCare.

Table A-6—CountyCare Number and Percentage of Detail-Level Claims by Benefit Type

Service Type	Benefit Type	Total In-Network Claims	Paid Claims		Total Out-of-Network Claims	Out-of-Network Paid Claims	
		Number	Number	Percent	Number	Number	Percent
IP	MH/SUD	62,880	58,835	93.6%	3,658	2,854	78.0%
	M/S	570,053	524,389	92.0%	26,855	20,393	75.9%
OP	MH/SUD	95,849	88,566	92.4%	1,244	712	57.2%
	M/S	2,445,171	2,206,301	90.2%	17,917	3,191	17.8%
ER	MH/SUD	122,838	111,989	91.2%	7,924	6,335	79.9%
	M/S	1,942,408	1,821,502	93.8%	141,384	114,646	81.1%
Total	**MH/SUD**	**281,567**	**259,390**	**92.1%**	**12,826**	**9,901**	**77.2%**
	M/S	**4,957,632**	**4,552,192**	**91.8%**	**186,156**	**138,230**	**74.3%**

Figure A-6—CountyCare Paid and Denied Detail-Level Claims Distributions



Overall, the analysis showed a minimal difference in the percentage of detail-level paid claims between MH/SUD and M/S claims for both INN (92.1 percent and 91.8 percent, respectively) and OON (77.2 percent and 74.3 percent, respectively). Both INN and OON paid MH/SUD detail-level claims at a higher rate than M/S detail-level claims. The analysis showed minimal differences in the percentage of detail-level paid claims between MH/SUD and M/S claims for all benefit types except for OP OON. Only OP OON exhibited a substantial difference (39.4 percent) in the percentage of detail-level paid

claims for MH/SUD and M/S services, paying MH/SUD detail-level claims at a higher rate than M/S detail-level claims.

Overall, when comparing the header-level paid claims by service and benefit type to the detail-level paid claims by service and benefit type, both INN claims showed minimal differences. However, overall OON claims at the header level showed a moderate difference (5.8 percent) while the overall OON claims at the detail level showed a minimal difference (2.9 percent). Additionally, IP OON exhibited a moderate difference (7.2 percent) in the percentage of header-level paid claims between MH/SUD and M/S, while the IP OON detail-level paid claims exhibited a minimal difference (2.1 percent). Although there was a variance in the IP OON, both the header- and detail-level claims paid the MH/SUD claims at a higher rate than M/S claims.

During the webinar review, HSAG and CountyCare discussed variances by paid and denied ratios by INN and OON, as well as category of service at both the header and detail levels. CountyCare reported that most claims are for INN providers, and OON services require an authorization. The health plan described efforts to communicate and educate providers on authorization processes, including establishing documents to assist providers with documentation to reduce denials and rejection rates. The health plan also reported that its network team attempts to contract with OON providers. HSAG acknowledged the health plan's efforts.

Overall MHP Compliance Rating

Based on the review of the MHP attestation form, NQTL submission form, and claims analysis, HSAG assigned an overall rating of *Compliant*.

Meridian

MHP Attestation

HSAG reviewed the health plan's attestation form submission and noted that the health plan reports that no changes were made to the organization's delegation arrangements, utilization management processes, provider admission processes, or OON/Out-of-State (OOS) processes that impacted MHP during the evaluation period. HSAG had no concerns regarding the health plan's attestation.

NQTL Submission Form Review

Meridian submitted its provider reimbursement NQTL comparative analysis. The health plan's submission was found to be thorough and complete. The health plan concluded that its reimbursement approach and methodology for provider reimbursement were applied no more stringently to MH/SUD than M/S. HSAG and HFS reviewed the information, including responses related to payment methodologies, reimbursement rates, contracting, pharmacy, and alternative payment models and had no concerns with the health plan's analysis.

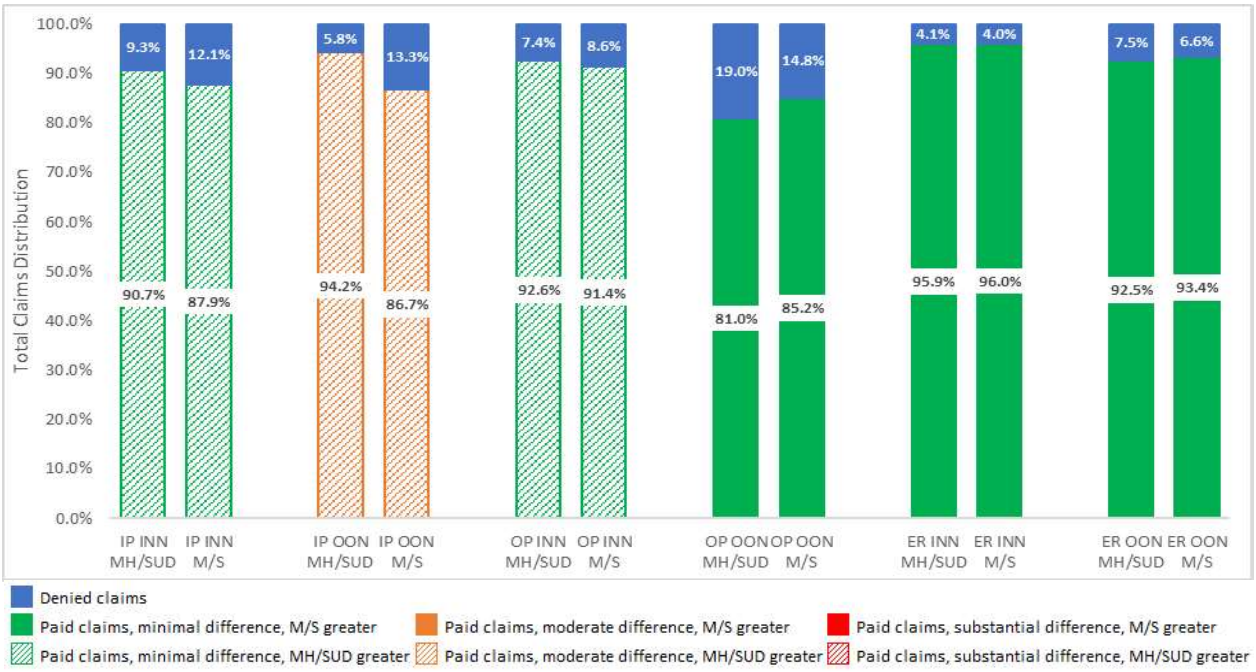
Claims

The health plan submitted its 2023 claims header and detail line-level data. Table A-7 and Figure A-7 present a summary of the results from the analysis of header-level paid claims by service and benefit type for Meridian.

Table A-7—Meridian Number and Percentage of Header-Level Claims by Benefit Type

Service Type	Benefit Type	Total In-Network Claims	Paid Claims[1]		Total Out-of-Network Claims	Out-of-Network Paid Claims	
		Number	Number	Percent	Number	Number	Percent
IP	MH/SUD	34,771	31,536	90.7%	7,878	7,423	94.2%
	M/S	140,470	123,456	87.9%	18,592	16,120	86.7%
OP	MH/SUD	1,804,126	1,669,895	92.6%	78,034	63,208	81.0%
	M/S	9,515,288	8,694,339	91.4%	869,678	741,063	85.2%
ER	MH/SUD	48,013	46,064	95.9%	11,854	10,967	92.5%
	M/S	790,370	759,091	96.0%	219,388	204,978	93.4%
Total	**MH/SUD**	**1,886,910**	**1,747,495**	**92.6%**	**97,766**	**81,598**	**83.5%**
	M/S	**10,446,128**	**9,576,886**	**91.7%**	**1,107,658**	**962,161**	**86.9%**

Figure A-7—Meridian Paid and Denied Header-Level Claims Distributions



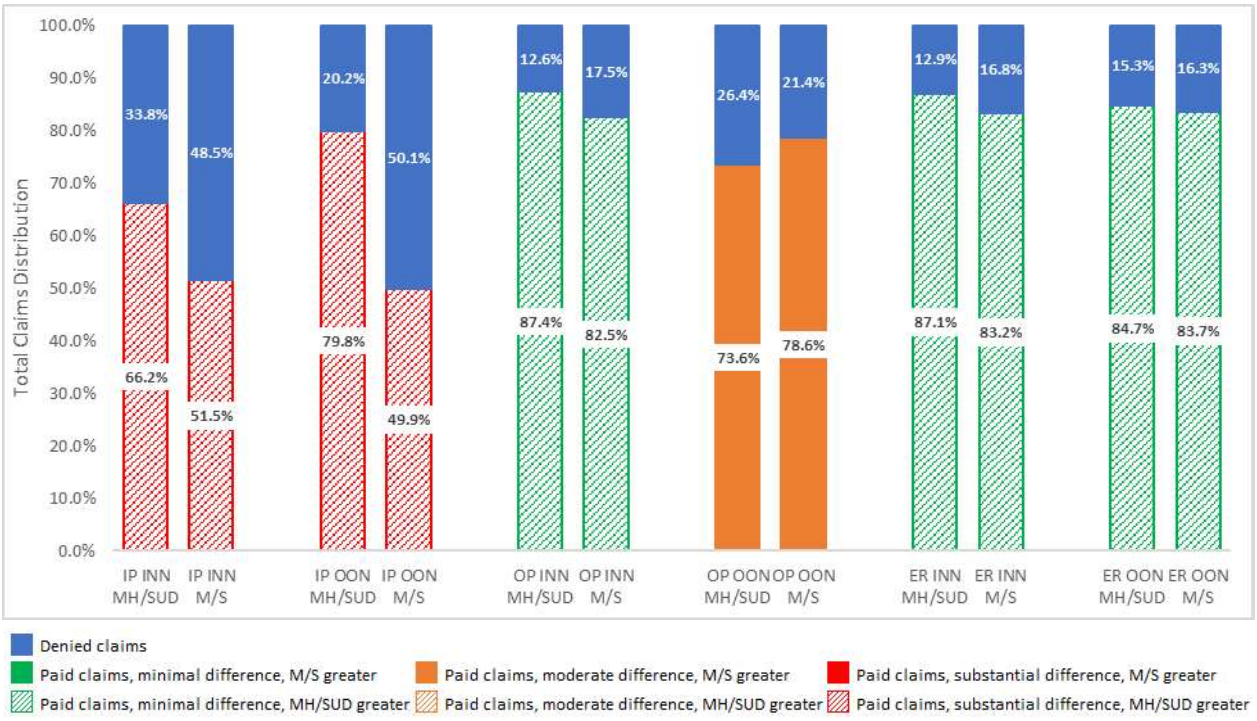
Overall, the analysis showed minimal differences in the percentage of header-level paid claims between MH/SUD and M/S claims for both INN (92.6 percent and 91.7 percent, respectively) and OON (83.5 percent and 86.9 percent, respectively). The overall OON header-level paid M/S claims rate was higher than MH/SUD claims. Only one sub-category, OON IP, showed a moderate difference of 7.5 percentage points between the header-level paid rate of MH/SUD claims to M/S claims, while the remaining sub-categories had less than a 5-percentage-point difference in header-level paid claims rates.

Table A-8 and Figure A-8 present a summary of the results from the analysis of detail-level paid claims by service and benefit type for Meridian.

Table A-8—Meridian Number and Percentage of Detail-Level Claims by Benefit Type

Service Type	Benefit Type	Total In-Network Claims	Paid Claims		Total Out-of-Network Claims	Out-of-Network Paid Claims	
		Number	Number	Percent	Number	Number	Percent
IP	MH/SUD	51,852	34,337	66.2%	10,176	8,124	79.8%
	M/S	355,723	183,057	51.5%	40,086	20,001	49.9%
OP	MH/SUD	2,592,577	2,265,071	87.4%	148,591	109,297	73.6%
	M/S	22,661,656	18,690,965	82.5%	2,139,460	1,681,377	78.6%
ER	MH/SUD	112,158	97,684	87.1%	20,292	17,186	84.7%
	M/S	1,646,932	1,370,643	83.2%	350,163	292,997	83.7%
Total	**MH/SUD**	**2,756,587**	**2,397,092**	**87.0%**	**179,059**	**134,607**	**75.2%**
	M/S	**24,664,311**	**20,244,665**	**82.1%**	**2,529,709**	**1,994,375**	**78.8%**

Figure A-8—Meridian Paid and Denied Detail-Level Claims Distributions



Overall, the analysis showed minimal differences in the percentage of detail-level paid claims between MH/SUD and M/S claims for both INN (87.0 percent and 82.1, respectively) and OON (75.2 percent and 78.8 percent, respectively). Only OP OON exhibited a moderate difference in the percentage of detail-level paid claims for MH/SUD and M/S services, while all IP exhibited substantial differences. The percentage of MH/SUD detail-level claims were paid at a higher rate than M/S detail-level claims for all service types except for OP OON. The remaining subcategories exhibited less than a 5-percentage-point difference.

Overall, when comparing the header-level paid claims by service and benefit type to the detail-level paid claims by service and benefit type, both INN and OON showed minimal differences. All IP and OP OON exhibited variances. The header-level paid claims analysis for IP INN reflected a minimal difference (2.8 percent) in the percentage of paid claims between MH/SUD and M/S, while the detail-level paid claims analysis reflected a substantial difference (14.8 percent). For IP OON, the header-level paid claims analysis reflected a moderate difference (7.8 percent) while the detail-level paid claims analysis reflected a substantial difference (29.9 percent). However, for all IP at both the header and detail level, MH/SUD claims were paid at a higher rate than M/S claims. For OP OON, the header-level paid claims analysis reflected a minimal difference (4.2 percent) while the detail-level paid claims analysis reflected a moderate difference (5.0 percent).

During the webinar review, HSAG and Meridian discussed variances by paid and denied ratios by INN and OON, as well as category of service at both the header and detail levels. Meridian reported its process to review denials overall and to identify claim trends by M/S and MH/SUD, as well as efforts to educate providers on opportunities to reduce rejections. Meridian reviewed the data and reported that the

main driver of denial gaps was related to provider billing errors, including duplicate submissions, timely filing, failure to obtain authorization (which occurred at a higher rate for MH claims), incorrect modifier billing, billing for non-covered services, and billing outside of National Council on Compensation Insurance (NCCI) coding guidelines. For inpatient claims, the payment methodology also played a factor, as billing guidelines can be complex. To help ensure parity in the payment, Meridian has developed provider notices around correct billing to help providers with additional guidance. These guides, along with provider webinars, enhance the providers' ability to get a paid claim with a first-time submission. The guides are developed based on consistent review of the top denials, providing tips on correct billing based on identified denial drivers. Meridian also offered that, for IP claims, M/S claims pay diagnosis-related group (DRG) methods, so claims denied at header level will deny all detail lines. Since M/S claims have significantly more detail lines billed and all lines will deny, the percentage of denied details will appear more significant in M/S claims. For OP denials at the detail line, Meridian reported that MH/SUD claims historically have issues with modifier billing and incorrect diagnosis ranges for services, which has driven the OP denial rate higher at the detail level for MH/SUD. HSAG acknowledged the health plan's response.

Overall MHP Compliance Rating

Based on the review of the MHP attestation form, NQTL submission form, and claims analysis, HSAG assigned an overall rating of *Compliant*.

Molina Healthcare of Illinois, Inc. (Molina)

MHP Attestation

HSAG reviewed the health plan's attestation form submission and noted the following changes:

- The health plan reported review and updates to clinical policies.
- The health plan reported continued use of MCG criteria for medical necessity determinations.
- The health plan reported that its utilization management delegate began managing review of certain oncology and cardiology services prior authorization requests.
- The health plan reported additions and removals of prior authorization codes, as reviewed and compared to national guidelines and approved by its internal prior authorization committee.

HSAG had no concerns regarding the health plan's descriptions of updates completed during the evaluation period.

NQTL Submission Form Review

Molina submitted its provider reimbursement NQTL comparative analysis. The health plan's submission was found to be thorough and complete. The health plan concluded that its reimbursement approach and methodology for provider reimbursement were substantially consistent with parity between MH/SUD and M/S benefits. HSAG and HFS reviewed the information, including responses related to payment methodologies, reimbursement rates, contracting, pharmacy, and alternative payment models and had no concerns with the health plan's analysis. HFS reminded the health plan of the requirement to include local data in its analyses.

Claims

The health plan submitted its 2023 claims header and detail line-level data.

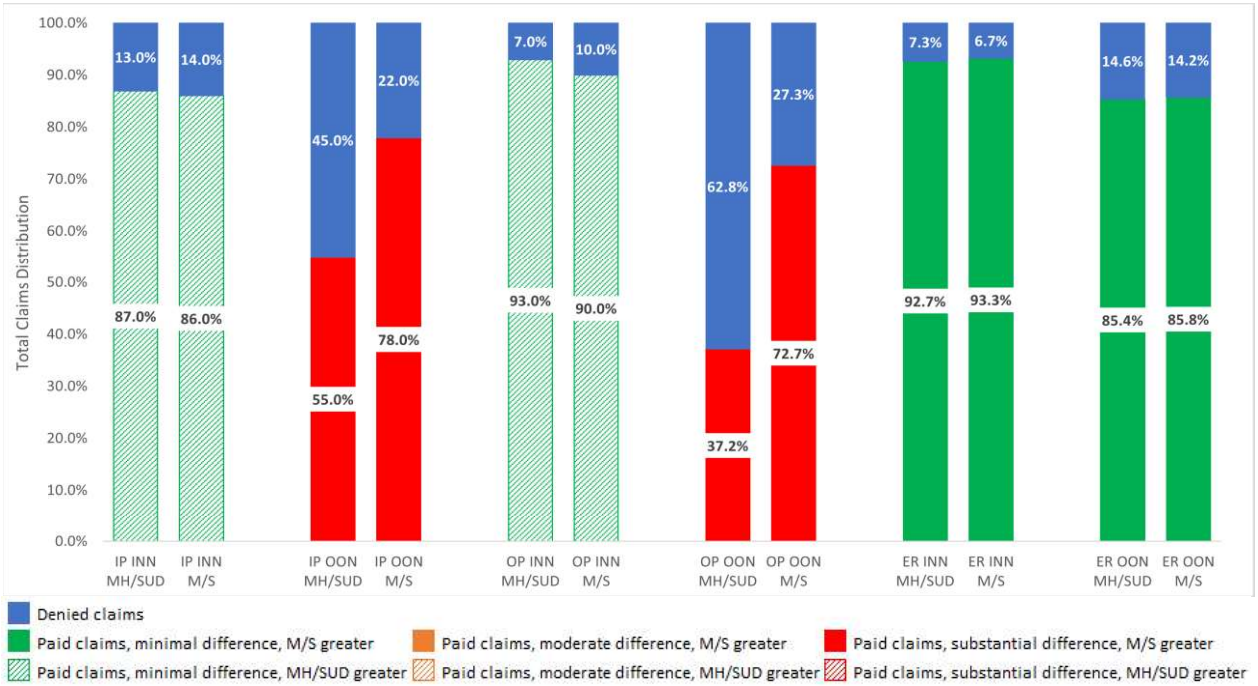
Table A-9 and Figure A-9 present a summary of the results from the analysis of header-level paid claims by service and benefit type for Molina.

Table A-9—Molina Number and Percentage of Header-Level Claims by Benefit Type

Service Type	Benefit Type	Total In-Network Claims	Paid Claims[1]		Total Out-of-Network Claims	Out-of-Network Paid Claims[1]	
		Number	Number	Percent	Number	Number	Percent
IP	MH/SUD	15,587	13,553	87.0%	963	530	55.0%
	M/S	58,170	50,054	86.0%	4,695	3,661	78.0%
OP	MH/SUD	424,412	394,674	93.0%	16,244	6,042	37.2%
	M/S	3,264,123	2,937,637	90.0%	620,463	450,915	72.7%
ER	MH/SUD	13,124	12,167	92.7%	2,710	2,315	85.4%
	M/S	196,632	183,393	93.3%	37,569	32,227	85.8%
Total	**MH/SUD**	**453,123**	**420,394**	**92.8%**	**19,917**	**8,887**	**44.6%**
	M/S	**3,518,925**	**3,171,084**	**90.1%**	**662,727**	**486,803**	**73.5%**

[1] Differences of 10 percentage points or more where a greater percentage of M/S claims were paid compared to MH/SUD claims are presented in red text.

Figure A-9—Molina Paid and Denied Header-Level Claims Distributions



Overall, the analysis showed a minimal difference in the percentage of header-level paid claims between MH/SUD and M/S claims for INN (92.8 percent and 90.1 percent, respectively), with MH/SUD claims being paid at a higher rate than M/S claims. However, for overall OON claims, the analysis showed a substantial difference in the percentage of header-level paid claims between MH/SUD and M/S (44.6 percent and 73.5 percent, respectively) claims, with M/S claims being paid at a higher rate than

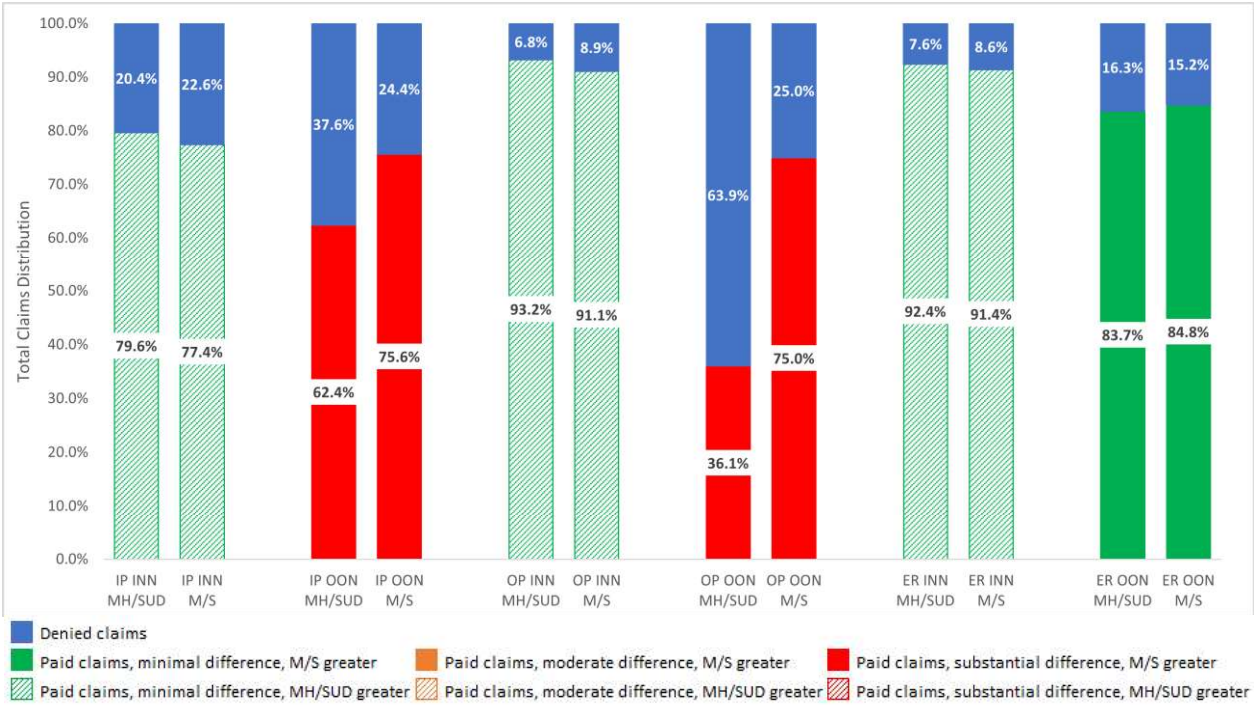
MH/SUD claims. Both OON IP and OON OP exhibited substantial differences in the percentage of header-level paid claims between MH/SUD and M/S claims, and both paid M/S claims at a higher rate than MH/SUD claims. The remaining sub-categories exhibited less than a 5-percentage-point difference in the percentage of header-level paid claims between MH/SUD and M/S claims.

Table A-10 and Figure A-10 present a summary of the results from the analysis of detail-level paid claims by service and benefit type for Molina.

Table A-10—Molina Number and Percentage of Detail-Level Claims by Benefit Type

Service Type	Benefit Type	Total In-Network Claims	Paid Claims[1]		Total Out-of-Network Claims	Out-of-Network Paid Claims[1]	
		Number	Number	Percent	Number	Number	Percent
IP	MH/SUD	40,494	32,241	79.6%	3,765	2,351	62.4%
	M/S	354,586	274,393	77.4%	50,106	37,887	75.6%
OP	MH/SUD	605,719	564,576	93.2%	23,807	8,584	36.1%
	M/S	8,034,001	7,317,541	91.1%	1,320,231	990,038	75.0%
ER	MH/SUD	15,088	13,943	92.4%	2,970	2,485	83.7%
	M/S	268,606	245,434	91.4%	49,429	41,922	84.8%
Total	**MH/SUD**	**661,301**	**610,760**	**92.4%**	**30,542**	**13,420**	**43.9%**
	M/S	**8,657,193**	**7,837,368**	**90.5%**	**1,419,766**	**1,069,847**	**75.4%**

Figure A-10—Molina Paid and Denied Detail-Level Claims Distributions



Overall, the analysis showed a minimal difference in the percentage of detail-level paid claims between MH/SUD and M/S claims for INN (92.4 percent and 90.5 percent, respectively), with MH/SUD claims being paid at a higher rate than M/S claims. However, for overall OON claims, the analysis showed a substantial difference in the percentage of detail-level paid claims between MH/SUD and M/S (43.9 percent and 75.4 percent, respectively) claims, with M/S claims being paid at a higher rate than MH/SUD claims. Both IP OON and OP OON exhibited substantial differences in the percentage of detail-level paid claims for MH/SUD and M/S services, while the remaining subcategories exhibited less than a 5-percentage-point difference. The percentage of M/S detail-level claims were paid at a higher rate than MH/SUD detail-level claims for all OON services.

Overall, when comparing the header-level paid claims by service and benefit type to the detail-level paid claims by service and benefit type, no service type exhibited variances. The only difference between the header-level paid claims and detail-level paid claims analyses were found in ER INN. Both the header and detail level reflected a minimal difference in the percentage of paid claims between MH/SUD and M/S; however, the M/S claims were paid at a higher rate than MH/SUD claims at the header level.

During the webinar review, HSAG and Molina discussed variances by paid and denied ratios by INN and OON as well as category of service at both the header and detail levels. The health plan expressed that data are reviewed at the market and line of business levels and reviewed for parity. The health plan had not identified any concerns regarding parity. HSAG acknowledged the health plan's response.

Overall MHP Compliance Rating

Based on the review of the MHP attestation form, NQTL submission form, and claims analysis, HSAG assigned an overall rating of *Compliant*.

YouthCare Specialty Plan (YouthCare)

MHP Attestation

HSAG reviewed the health plan's attestation form submission and noted that the health plan reports that no changes were made to the organization's delegation arrangements, utilization management processes, provider admission processes, or OON/OOS processes that impacted MHP during the evaluation period. HSAG had no concerns regarding the health plan's attestation.

NQTL Submission Form Review

YouthCare submitted its provider reimbursement NQTL comparative analysis. The health plan's submission was found to be thorough and complete. The health plan concluded that its reimbursement approach and methodology for provider reimbursement were applied no more stringently to MH/SUD than M/S. HSAG and HFS reviewed the information, including responses related to payment methodologies, reimbursement rates, contracting, pharmacy, and alternative payment models and had no concerns with the health plan's analysis.

Claims

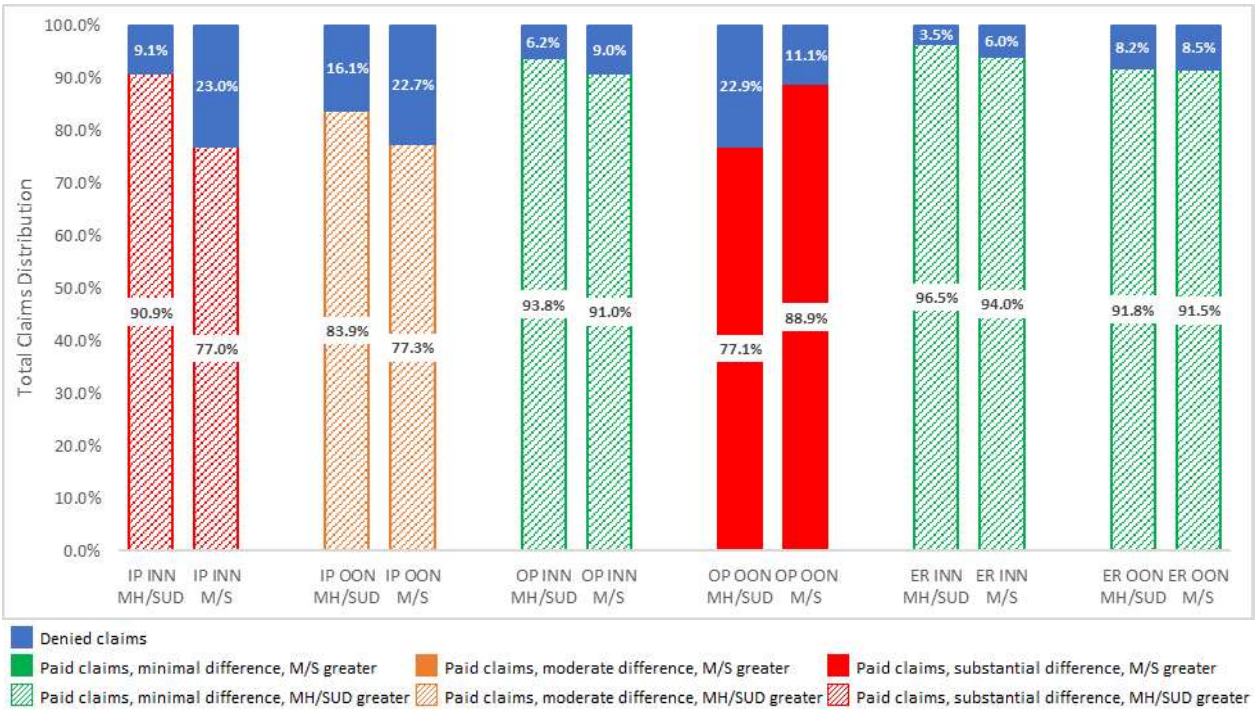
The health plan submitted its 2023 claims header and detail line-level data. Table A-11 and Figure A-11 present a summary of the results from the analysis of header-level paid claims by service and benefit type for YouthCare.

Table A-11—YouthCare Number and Percentage of Header-Level Claims by Benefit Type

Service Type	Benefit Type	Total In-Network Claims	Paid Claims[1]		Total Out-of-Network Claims	Out-of-Network Paid Claims[1]	
		Number	Number	Percent	Number	Number	Percent
IP	MH/SUD	2,885	2,622	90.9%	174	146	83.9%
	M/S	1,834	1,412	77.0%	362	280	77.3%
OP	MH/SUD	378,473	354,996	93.8%	17,227	13,274	77.1%
	M/S	340,062	309,344	91.0%	28,666	25,491	88.9%
ER	MH/SUD	3,707	3,577	96.5%	648	595	91.8%
	M/S	35,407	33,265	94.0%	6,703	6,136	91.5%
Total	**MH/SUD**	**385,065**	**361,195**	**93.8%**	**18,049**	**14,015**	**77.6%**
	M/S	**377,303**	**344,021**	**91.2%**	**35,731**	**31,907**	**89.3%**

[1] Differences of 10 percentage points or more where a greater percentage of M/S claims were paid compared to MH/SUD claims are presented in red text.

Figure A-11—YouthCare Paid and Denied Header-Level Claims Distributions



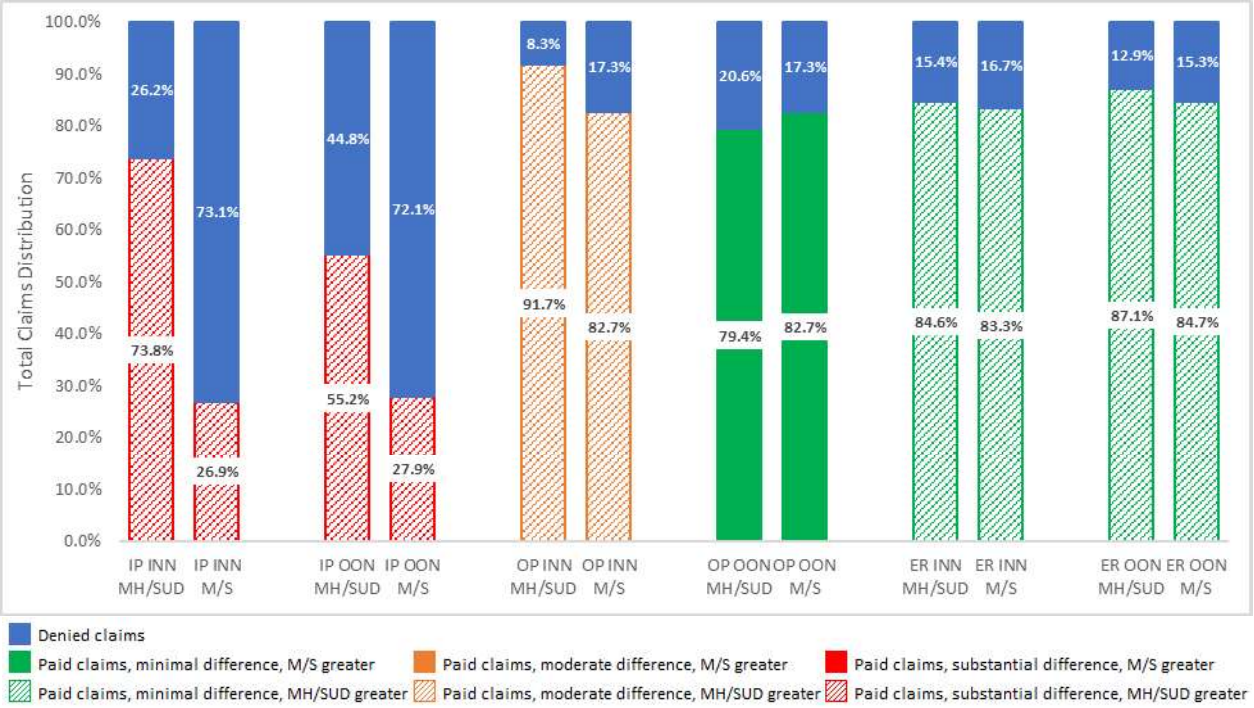
Overall, the analysis showed a minimal difference in the percentage of header-level paid claims between MH/SUD and M/S claims for INN (93.8 percent and 91.2 percent, respectively), with MH/SUD claims being paid at a higher rate than M/S claims. However, for overall OON claims, the analysis showed a substantial difference in the percentage of header-level paid claims between MH/SUD and M/S (77.6 percent 89.3 percent, respectively) claims, with M/S claims being paid at a higher rate than MH/SUD claims. Both OON OP and INN IP claims exhibited substantial differences in the percentage of header-level paid claims between MH/SUD and M/S, where OON OP claims showed M/S (88.9 percent) claims being paid at a higher rate than MH/SUD (77.1 percent) claims. OON IP claims exhibited a moderate difference in the percentage of header-level paid claims between MH/SUD and M/S, while the remaining subcategories exhibited less than a 5-percentage-point difference.

Table A-12 and Figure A-12 present a summary of the results from the analysis of detail-level paid claims by service and benefit type for YouthCare.

Table A-12—YouthCare Number and Percentage of Detail-Level Claims by Benefit Type

Service Type	Benefit Type	Total In-Network Claims	Paid Claims		Total Out-of-Network Claims	Out-of-Network Paid Claims	
		Number	Number	Percent	Number	Number	Percent
IP	MH/SUD	3,632	2,680	73.8%	306	169	55.2%
	M/S	5,498	1,477	26.9%	1,057	295	27.9%
OP	MH/SUD	475,715	436,157	91.7%	27,253	21,635	79.4%
	M/S	747,352	618,367	82.7%	71,240	58,903	82.7%
ER	MH/SUD	9,310	7,880	84.6%	1,061	924	87.1%
	M/S	63,978	53,275	83.3%	10,416	8,823	84.7%
Total	**MH/SUD**	**488,657**	**446,717**	**91.4%**	**28,620**	**22,728**	**79.4%**
	M/S	**816,828**	**673,119**	**82.4%**	**82,713**	**68,021**	**82.2%**

Figure A-12—YouthCare Paid and Denied Detail-Level Claims Distributions



Overall, the analysis showed moderate differences in the percentage of detail-level paid claims between MH/SUD and M/S claims for INN (91.4 percent and 82.4 percent, respectively), while showing minimal differences for OON (79.4 percent and 82.2 percent, respectively). Only OP INN exhibited a moderate difference in the percentage of detail-level paid claims for MH/SUD and M/S services, while all IP exhibited substantial differences. The remaining subcategories exhibited less than a 5-percentage-point difference. The percentage of MH/SUD detail-level claims were paid at a higher rate than M/S detail-level claims for all service types except for OP OON.

Overall, when comparing the header-level paid claims by service and benefit type to the detail-level paid claims by service and benefit type, both INN and OON exhibited variances. For overall INN, the header level showed a minimal difference of 2.6 percent between the percentage of paid MH/SUD and M/S claims, while the detail level showed a moderate difference of 9.0 percent. For overall OON, the header level showed a substantial difference of 11.6 percent between the percentage of paid MH/SUD and M/S claims, while the detail level showed a minimal difference of 2.8 percent. Additionally, IP OON and all OP exhibited variances. The header-level paid claims analysis for IP OON reflected a moderate difference (6.6 percent) in the percentage of paid claims between MH/SUD and M/S, while the detail-level paid claims analysis reflected a substantial difference (27.3 percent). For OP INN, the header-level paid claims analysis reflected a minimal difference (2.8 percent) in the percentage of paid claims between MH/SUD and M/S, while the detail-level paid claims analysis reflected a moderate difference (8.9 percent). However, for IP OON and OP INN at both the header and detail level, MH/SUD claims were paid at a higher rate than M/S claims. For OP OON, the header-level paid claims analysis reflected a substantial difference (11.9 percent) in the percentage of paid claims between MH/SUD and M/S, while the detail-level paid claims analysis reflected a minimal difference (3.3 percent).

During the webinar review, HSAG and YouthCare discussed variances by paid and denied ratios by INN and OON, as well as category of service at both the header and detail levels. YouthCare reported its process to review denials overall and to identify claim trends by M/S and MH/SUD, as well as efforts to educate providers on opportunities to reduce rejections. YouthCare reviewed the data and reported that the main driver of denial gaps was related to provider billing errors, including duplicate submissions, timely filing, failure to obtain authorization (which occurred at a higher rate for MH claims), incorrect modifier billing, billing for non-covered services, and billing outside of NCCI coding guidelines. For inpatient claims, the payment methodology also played a factor, as billing guidelines can be complex. To help ensure parity in the payment, YouthCare has developed provider notices around correct billing to help providers with additional guidance. These guides, along with provider webinars, enhance the providers' ability to get a paid claim with a first-time submission. The guides are developed based on consistent review of the top denials, providing tips on correct billing based on identified denial drivers. YouthCare also offered that, for IP claims, M/S claims pay DRG methods, so claims denied at header level will denial all detail lines. Since M/S claims have significantly more detail lines billed and all lines will deny, the percentage of denied details will appear more significant in M/S claims. For OP denials at the detail line, YouthCare reported that MH/SUD claims historically have issues with modifier billing and incorrect diagnosis ranges for services, which has driven the OP denial rate higher at the detail level for MH/SUD. HSAG acknowledged the health plan's response. HSAG acknowledged the health plan's efforts.

Overall MHP Compliance Rating

Based on the review of the MHP attestation form, NQTL submission form, and claims analysis, HSAG assigned an overall rating of *Compliant*.

Appendix B. Definitions

Department of Labor (DOL) MHPAEA Definitions[8]

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.

[8] Department of Labor. *Self-Compliance Tool of the Mental Health Parity and Addiction Equity Act (MHPAEA).* Available at: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mental-health-parity-compliance-tool.pdf. Accessed on: Oct 30, 2024.

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[9]

Claims Report

Adjudicated Claim: A Clean Claim that the MCO has either Paid or Denied.

Clean Claim: A claim that is HIPAA compliant and therefore passes the minimum Strategic National Implementation Process (SNIP) edits (Levels 1–4). Further, a clean claim is a claim from a Provider for Covered Services that can be adjudicated without obtaining additional information from the Provider of the Covered Service or from a third party, except that it shall not mean a claim submitted by or on behalf of a Provider who is under investigation for fraud or abuse or a claim that is under review for determining whether it was Medically Necessary. For purposes of an Enrollee's admission to a nursing

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

facility, a "clean claim" means that the admission is reflected on the patient credit file that the MCO receives from HFS.

Denied/Denied Claim: A denied claim is one in which the payment of a claim was denied by the MCO to a Provider corresponding to HFS defined administrative reasons/codes. These claims are HIPAA compliant and may be fully processed by the MCO claims system, but are denied for payment due to enforcement of payer defined policies. These denials are typically due to the Provider not meeting payer policy requirements around prior authorization, documentation, timeliness, benefits, a service limitation, contractual issue, duplicate bills, TPL benefits and non-contracted Providers.

Paid Claim: An Adjudicated Claim that the MCO has determined is payable and has remitted the payment to the provider.

Payable Claim: An Adjudicated Claim that the MCO has determined is payable, i.e. has not denied or rejected, but has not yet remitted the payment to the provider.

Pended Claim/Claims Pending: A Clean Claim that is awaiting final adjudication.

Rejected Claim: Rejected claims are:

1) Claims submitted to your organization that were accepted through the EDI, but subsequently removed/deleted from your adjudication system.

2) Claims that rejected through the EDI translator for failing any SNIP level validations.

3) Any custom business rules implemented in EDI that reject claim submissions.

A rejected billing claim is one in which the determination of payment cannot be made. These claims may enter payer claims system (front-end) but do not pass further into adjudication and payment processing (back-end) due to missing administrative elements on the claim.

Covered Services Categories

Behavioral Health—Mental Health: Conditions related to emotional wellness, trauma, mental 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. (per Contract eff. 1/1/2018)

Behavioral Health—Substance Abuse: Behavioral Health: Conditions related to 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). (per Contract eff. 1/1/2018)

Non-Behavioral Health: Conditions that are neither Behavioral Health—Mental Health and Behavioral Health—Substance Abuse.

Network Status

In-Network: Clean Claims received from a contracted Provider.

Out-of-Network: Clean claims received from a non-contracted Provider.