Compliance Actions Under State and Federal Mental Health and Substance Use Disorder Coverage and Parity Laws

Joint Annual Report to the General Assembly

Produced by:

Illinois Department of Insurance

Illinois Department of Healthcare and Family Services

August 2020

August 7, 2020

To the Honorable Members of the General Assembly:

Section 370c.1(h)(3) of the Illinois Insurance Code requires the Department of Insurance, in conjunction with the Department of Healthcare and Family Services, to submit an annual report to the General Assembly regarding the agencies' respective activities in enforcement of Sections 356z.23, 370c, and 370c.1 of the Illinois Insurance Code, as well as the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), and any federal regulations or guidance relating to the compliance and oversight of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and 42 U.S.C. 18031(j). *See* 215 ILCS 5/370c.1(h)(3).

In accordance with Section 370c.1(h)(3) of the Illinois Insurance Code, we are pleased to submit the August 2020 edition of the Joint Annual Report to the General Assembly on Compliance Actions Under State and Federal Mental Health and Substance Use Disorder Coverage and Parity Laws. The report contains significant information from a national and Illinois perspective regarding the current condition of regulated entities' compliance with these important laws.

Respectfully,

Robert H. Muriel
Director of Insurance

Theresa Eagleson
Director of Healthcare and Family Services

Contents

Methodology to Ensure Compliance

Illinois Department of Insurance

The Department of Insurance (DOI) utilizes market conduct examinations in order to verify a health insurance issuer's compliance with mental health and substance use disorder (MH/SUD) coverage and parity laws contained in Sections 356z.14, 356z.23, 370c, and 370c.1 of the Illinois Insurance Code and DOI regulations, which are interpreted consistently with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. The scope of the examination includes, but is not limited to, activities as they pertain to parity in MH/SUD benefits within the company's health insurance business.

The objective of the examinations is to evaluate if the company designed, implemented, and managed MH/SUD benefits no less favorably than medical/surgical benefits. The specific review processes for the examination include, but are not limited to, the following:

1. Review the procedures and guidelines related to utilization review to ensure that such guidelines and utilization review processes on MH/SUD services are no more stringently applied that those applied to medical/surgical services.

2. Evaluate a sample of MH/SUD claims during the examination to compare services to medical/surgical and to ensure denials were appropriate based on medical necessity criteria.

3. Evaluate the universe of appeals during the examination to determine if the appeal decisions were based on appropriate clinical criteria and policies.

4. Evaluate the medical necessity criteria, policies, and procedures to ensure the company was not imposing more restrictive requirements and determination for MH/SUD treatments and services than on medical/surgical treatment and services.

5. Determine that the MH/SUD benefits provided in the classification identified by 45 CFR § 146.136(c)(2)(ii)(A) are paid in parity with benefits in the same medical/surgical classifications.

6. Evaluate financial requirements and quantitative treatment limitations (QTL) to ensure that any such requirements and limitations were consistently applied through MH/SUD and medical/surgical benefits, and that any financial

requirements and QTLs imposed meet the two-thirds threshold of "substantially all" requirements outlined in 45 CFR § 146.136(c)(3)(i).

7. Evaluate non-quantitative treatment limitations (NQTL) to ensure that such limitations were consistently applied through MH/SUD and medical/surgical benefits and that the company was not being more restrictive as outlined in 45 CFR § 146.136(c)(4)(i)-(ii).

8. Evaluate pre-certification/prior-authorization, step therapy policies, and procedural requirements for MH/SUD treatments to ensure that any such requirements were no more restrictive than the comparable medical/surgical policies and procedural requirements.

9. Determine that the policies and procedure for the selection, tier placement, and quantity limitations of MH/SUD treatment drugs on the formulary were no less favorable to the insured than policies and procedures used for the selection, placement, and limitations of medical/surgical drugs.

Outside of market conduct examinations, since 2018, the DOI has required every company to submit information in an MHSUD Supporting Documents Template for every major medical, HMO, or HMO Point-of-Service policy that the company files for approval, both on and off the ACA Health Insurance Marketplace. This template is designed to assist the DOI, when deciding whether to approve a policy to be sold in Illinois, in performing an initial, high-level review of the policy for compliance with regulations under the federal Mental Health Parity and Addiction Equity Act. In particular, it instructs companies to explain how their policy complies with parity requirements relating to aggregate lifetime and annual dollar limits, financial requirements, QTLs, NQTLs, and the ability of healthcare providers and insured individuals to access a company's medical necessity criteria. Please see Attachment I of this report for reference. Although this template was first put into use after the time periods reviewed in the market conduct exams discussed below, the DOI's future exams will be able to compare a company's responses on this template to its actual conduct during the applicable policy periods.

Illinois Department of Healthcare and Family Services

To provide a base for ensuring compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA), the Department of Healthcare and Family Services (HFS), along with partners from the Illinois Department of Human Services, participated in a targeted training opportunity, called the Medicaid Parity Policy Academy, sponsored by the Centers for Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration

(SAMHSA). Participation in the national Medicaid Parity Policy Academy helped to equip state staff with knowledge and technical resources necessary to ensure compliance with parity laws and regulations and set the stage for ongoing education and monitoring.

The Illinois Medicaid Managed Care Program (HealthChoice Illinois) delivers fully integrated healthcare, inclusive of behavioral health services, to Illinois Medical Assistance Program recipients through four statewide MCOs, with a fifth health plan option available in Cook County. Specific language regarding MHPAEA compliance was added to the HealthChoice Illinois contracts that went into effect January 1, 2018. This contract language is included as Attachment II to this report for reference.

In late 2017, HFS began a parity monitoring process to ensure the contracted MCOs implemented these contract deliverables in policy and practice. Each MCO completed the Illinois MCO Parity Analysis Template (please see Attachment III) that was developed by HFS in collaboration with the Department of Human Services' Divisions of Mental Health (DMH) and Substance Use Prevention and Recovery (SUPR). The Parity Analysis Template examines the provision of Medical/Surgical and Mental Health / Substance Use Disorder services under four benefit classifications: Inpatient, Outpatient, Emergency Care, and Pharmacy. The MCOs analyzed the financial requirements, quantitative treatment limitations, aggregate lifetime and annual dollar limits, and non-quantitative treatment limits associated with each of the benefit classifications to determine if they met the requirements of the MHPAEA.

The Parity Analysis Template serves as the basis for ensuring MCO compliance with the MHPAEA. Following initial completion and approval from HFS, the contracted MCOs implemented internal procedures to monitor ongoing compliance in line with the Compliance Monitoring Plan they outlined in their approved Parity Analysis Templates. Each MCO is required to submit an updated parity analysis to HFS for review and approval prior to implementing any potential benefit or operational changes that may affect MHPAEA compliance. Additional methods for ensuring ongoing MCO compliance with the MHPAEA are being reviewed and considered by HFS.

Compliance Activities in 2019/2020

Market Conduct Examinations: Illinois Department of Insurance

Since 2019, the DOI has completed five market conduct examinations evaluating compliance with MH/SUD coverage and parity laws for the following companies:

- CIGNA Healthcare of Illinois
- UnitedHealth Group, specifically:

        - UnitedHealthcare Insurance Company
        - UnitedHealthcare of Illinois
        - UnitedHealthcare Insurance Company of the River Valley
    - CIGNA Health and Life Insurance Company
    - Health Care Services Corporation (Parent Company to Blue Cross Blue Shield)
    - Celtic Insurance Company

Benefit Classifications Examined

Consistent with federal regulations, the DOI examined each company for compliance with parity laws separately within every benefit classification where the issuer provided coverage. The federally required benefit classifications are:

- Inpatient, in-network
- Inpatient, out-of-network
- Outpatient, in-network
- Outpatient, out-of-network
- Emergency Care
- Prescription Drugs

A health insurance issuer has the option to create two subclassifications within the outpatient classifications. If the issuer chooses to use these outpatient subclassifications, then parity must be achieved within each outpatient subclassification separately. The two subclassifications are:

- Office visits
- All other outpatient items and services (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items)

Under this system, in-patient, in-network MH/SUD benefits are compared against inpatient, in-network medical benefits; prescription drug MH/SUD benefits are compared against prescription drug medical/surgical benefits; MH/SUD office visits (if the issuer uses the outpatient subclassifications) are compared against medical/surgical office visits; and so on. These classifications and subclassifications help structure a fair comparison between the various benefits that an issuer covers.

Subject Matters of Examinations

The examination of Cigna Health and Life Insurance Company was a comprehensive examination of their individual dental and group health insurance business that included thorough evaluation of MH/SUD coverage and parity compliance. The other four examinations were targeted specifically to evaluate MH/SUD coverage and parity compliance. The subject matter of each market conduct examination included, but was not limited to:

- QTLs, such as limits on the frequency of treatment, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment that are expressed numerically
- NQTLs, such as medical necessity criteria, pre-certification or prior authorization requirements, step-therapy protocols, and prescription drug formulary design and tier placement
- Utilization review processes
- Claims denial and appeals
- Dollar limits on benefits

Conclusion of Examinations

Each market conduct examination in which the DOI has found violations of law has resulted in a stipulation and consent order requiring the company to correct all activities where violations were found, pay a civil forfeiture, and provide proof of compliance to the DOI. After the order is executed, the order and the final report are posted publicly on the DOI website. The following is a summary of findings by company for the recent round of examinations:

- CIGNA Healthcare of Illinois paid $582,000 for failing to use medical necessity guidelines from the American Society of Addiction Medicine (ASAM) as required by statute, and for not allowing providers to request an exception to the company's step therapy requirement for prescriptions.
  - Total Number of Finable Violations: 6
  - Signed Order: 4/29/2020

- UnitedHealth Group paid $550,000 for violations including failing to use ASAM guidelines, requiring prior authorization from the company before a provider can prescribe the patient Buprenorphine to help fight substance use disorder, and requiring prior authorization for prescribing certain ADHD medications.
  - Total Number of Finable Violations: 10
  - Signed Order: 7/10/2020

- CIGNA Health and Life Insurance Company paid $418,000 for failing to use ASAM guidelines and imposing step therapy for a class of drugs only when used to treat depression.
  - Total Number of Finable Violations: 5
  - Signed Order: 4/29/2020

- HCSC paid $325,000 for requiring prior authorization from the company before a provider could prescribe the patient Buprenorphine to help fight substance use disorder.

- Total Number of Finable Violations: 2
- Signed Order: 3/20/2020

- Celtic paid $208,000 for failing to perform proper internal testing to confirm that all plans are in parity.
  - Total Number of Finable Violations: 5
  - Signed Order: 1/17/2019

Parity Audits: Illinois Department of Healthcare and Family Services

HFS underwent a full parity monitoring process in late 2017-2018 to ensure that the MCOs implemented both policy and practices in compliance with MHPAEA. Each MCO was required to complete the Illinois MCO Parity Analysis Template (Attachment III). MCOs were required to report all Financial Requirements, Quantitative Treatment Limitations (QTL), Aggregate Lifetime Limits, Annual Dollar Limits and Non-Quantitative Treatment Limitations (NQTL) for Medical/ Surgical (M/S) and Mental Health/Substance Use Disorder (MH/SUD) services in each classification. Specific NQTLs include Claims Rejection Rates, Medical Necessity Criteria, Prior Authorization policies, Concurrent Review policies, Network Admission Criteria as well as any other limitation utilized by the MCO.

Upon review of each MCO's submission, it was determined that some had areas that appeared to be non-compliant with MHPAEA. In response to these findings, the MCOs were required to submit a Corrective Action Plan and provide additional documentation to HFS demonstrating compliance. This following summary table includes the MCO, any deficiencies noted and the MCO's Corrective Action:

Plan Name	Deficiency Noted	Corrective Action
Blue Cross Blue Shield of Illinois	Concurrent Review - The frequency of appeals/overturns for M/S is significantly higher than the rate of appeal/overturns for MH/SUD for Outpatient.	Provided additional information related to the percentages of overturns that showed compliance.
	The Emergency services section was not completed.	Section was completed, resubmitted and compliant.
Aetna	Financial Requirements section was not completed.	Section was completed, resubmitted and compliant.
Next Level	QTL - 148 label names are categorized as M/S and 96 as MH. NextLevel reported having implemented and maintained QTLs on 244 distinct label names/SUD. As the QTL does not apply to 2/3 of the M/S benefit, it did not meet the substantially all test.	NextLevel Health contracted a new PBM company, effective January 1, 2018. With the new formulary, there are 685 unique drugs with a QTL of which 83 (12.1%) are MH/SUD and 602 (87.9%) are Med/Surg, which

		brings the plan into compliance on this metric.
Molina	Inpatient Concurrent Review was not addressed.	Section was completed, resubmitted and compliant.
	Outpatient claims rejections for MH/SUD were significantly higher than for M/S.	Additional information was provided and compliant.
Harmony	Pharmacy claims rejections for MH/SUD were significantly higher than for M/S.	Additional information was provided and compliant.
Humana	Inpatient and Outpatient claims rejections were for MH/SUD were higher than for M/S.	Additional information was submitted indicating that the percentage was within acceptable limits for MHPAEA requirements. Additional monitoring of rejection rates will be implemented.
County Care	Pharmacy QTL - It appeared that all MH/SUD prescription drugs were subject to QTLs while not all M/S prescription drugs are subject to QTLs.	Completed a full review of QTLs, identified parity violation. Implemented a full review of all QTL and will implement new standards to address parity violation. Additional monitoring of Pharmacy QTLs will be implemented.
	Inpatient Concurrent Review included conflicting information.	Clarifying information was provided that was compliant.
	Outpatient claims rejection rates were higher for MH/SUD than M/S.	Additional information was provided and compliant.
Meridian	Inpatient and Outpatient claims rejection rates were higher for MH/SUD than M/S.	Additional information was provided and compliant.
Illinicare	QTL testing on the Inpatient, Outpatient or Emergency services was not provided.	A full analysis of QTLs is being conducted and will be submitted for compliance review.
	Information regarding the total percentage of claims rejections for both M/S and MH/SUD was not provided.	Additional information was submitted that required further follow-up to ensure compliance.
	Response did not include estimations of the average frequency of concurrent review for M/S or MH/SUD nor did the response indicate appeal/overturn rates.	Additional information was submitted that established compliance regarding the average frequency of concurrent review. However, a lower frequency of appeals/overturns for MH/SUD was reported. Illinicare submitted a plan to review and remedy this potential parity violation.

		Additional monitoring of concurrent review appeals/overturns will be implemented.
	The response indicates that there are more restrictive and stringent prior authorization requirement for inpatient MH/SUD services than there are for M/S.	Additional information was provided and compliant.

Educational or Corrective Actions Taken in 2019/2020

Illinois Department of Insurance

The DOI has undertaken the following educational and corrective actions since 2019:

- The Access to Care and Treatment Parity Outreach and Education Program conducted face-to-face meeting with citizens, delivered formal presentations, provided printed materials, and offered one-on-one guidance to educate citizens on obtaining coverage and parity. This includes education on consumers' rights and responsibilities, and whom to contact at the DOI when they need assistance navigating insurance or filing a complaint when their rights have been violated.

- Between November 2019 and January 30, 2020, Get Covered Illinois created digital advertisements, radio advertisements, and television advertisements placed statewide to highlight consumer's mental health parity rights under the law and how the DOI is here to support them in seeking relief if their rights have been violated. The radio spots were both in English and in Spanish.

- Through the creation of printed material completed, we were able to better to educate the public on what their rights are under the law. A multi-fold "palm card" was printed and distributed. This card helped educate the public on key insurance terms, provided guidance on their primary care physical, and outlined all essential health benefits. The palm card was printed in clear language that states to the consumer how their parity rights may be violated and how they can seek relief through the DOI if they suspect their rights are being violated.

- Examinations resulted in fines as described in the Market Conduct Examinations section above with orders for the companies to submit proof of having come into compliance with all applicable laws.

Illinois Department of Healthcare and Family Services

Following the review of each MCO's Parity Analysis Template, HFS required Plans of Correction from any MCO with a noted deficiency. The MCOs were required to provide documentation and additional information to HFS to demonstrate they had come into compliance with the requirements of MHPAEA, and to outline the protocols the MCOs established to monitor ongoing compliance.

While the parity analysis template and the Plans of Correction represent the initial step in compliance monitoring, HFS recognizes that ongoing and proactive monitoring is necessary to ensure that MCO compliance with the MHPAEA is maintained. In addition to the protocols described in this report, HFS is in the process of establishing a formal parity compliance monitoring that aligns with the monitoring requirements found in 215 ILCS 5/370c and any recommendations that come from the Working Group. It is anticipated that the parity compliance monitoring plan will include the following elements:

- Analysis of required self-reports from MCOs that will compare the application of NQTLs in each classification for both M/S and MH/SUD;
- Data analytics by HFS based on encounter data to show claims rejection rates and other NQTLs that can be detected from existing service data;
- Provider complaints submitted through the HFS Provider Portal and reported by the plans;
- Consumer grievances and appeals received by HFS and reported by the plans; and,
- Ongoing feedback from consumer and provider groups.

Attachment I

MHSUD Supporting Documents Template

Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767

Mental Health/Substance Use Disorder – Supporting Documentation Template
TO BE COMPLETED BY COMPANY
Company Name:
SERFF TOI:
SERFF SUB TOI:
SERFF Tracking #:
ELECTRONIC REFERENCES - FEDERAL
Code of Federal Regulations
United States Code
ELECTRONIC REFERENCES - ILLINOIS
Illinois Insurance Code
Administrative Rules
Illinois Company Bulletins

Supporting Documentation Template Directions

- The template must be completed to support the information included in all filings for individual, small group, or large group major medical, Health Maintenance Organization (HMO), or Point-of-Service (POS) products.
- This document is to be downloaded and submitted with this filing in SERFF. Alteration of this document will result in rejection of the filing.

As part of the policy filing review process, the Illinois Department of Insurance (DOI) will conduct a review and analysis of plan mental health/substance use disorder benefits to ensure compliance with State and federal regulations, standards, and to confirm any financial requirement or treatment limitation applied to mental health or substance use disorder benefits is not more restrictive than the predominant financial requirement or treatment limitation applied to substantially all medical/surgical benefits in the same classification.

(Note: Illinois required supporting documentation must be submitted in addition to any template/supporting documentation required by CMS/CCIIO. The DOI understands that there may be some overlap in information provided; however, the State's additional submission requirements for mental health/substance use disorder parity are needed to support the State's independent review for compliance with federal and state standards and regulations.)
Please respond to the following questions and/or request for information:

Aggregate Lifetime and Annual Dollar Limits - 45 CFR 146.136(b)

1) How does your plan comply with the aggregate lifetime and annual dollar limit requirements set forth in 45 CFR 146.136(b)?

If a plan does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

If a plan includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits, it must either— (i) Apply the aggregate lifetime or annual dollar limit both to the medical/ surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical/ surgical benefits and mental health or substance use disorder benefits; or (ii) Not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is less than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits.

Financial/Quantitative Treatment Limitations - 45 CFR 146.136(c)(2)

2) How does your plan comply with the financial and quantitative treatment limitation requirements set forth in 45 CFR 146.136(c)?

A plan that provides both medical/surgical benefits and mental health or substance use disorder benefits may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. Whether a financial requirement or treatment limitation is a predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in a classification is determined separately for each type of financial requirement or treatment limitation.

Non-quantitative Treatment Limitations - 45 CFR 146.136(c)(4)

3) How does your plan comply with the non-quantitative treatment limitation requirements set forth in 45 CFR 146.136(c)(4)?

It is not required that the same non-quantitative treatment limitations are used for mental health/substance use disorder benefits as for medical/surgical benefits. However, processes, strategies, evidentiary standards and other factors, used to determine when a mental health/substance use disorder benefit is subject to a non-quantitative treatment limitation must be comparable to and not more stringent than those used for medical/surgical benefits in each classification. Also, a non-quantitative treatment limitation must not be designed to restrict access to mental health/substance use disorder benefits. Non-quantitative treatment limitations can include, but are not limited to, the following:

a. Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
b. Formulary design for prescription drugs;
c. For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
d. Standards for provider admission to participate in a network, including reimbursement rates;
e. Plan methods for determining usual, customary, and reasonable charges;
f. Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
g. Exclusions based on failure to complete a course of treatment; and
h. Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

Medical Necessity - 45 CFR 146.136(d)

4) How does your plan make the criteria for medical necessity determinations with respect to mental health or substance use disorder benefits available to any current or potential participant, beneficiary, or contracting provider upon request in accordance with 45 CFR 146.136(d)?

Attachment II
HealthChoice Illinois MHPAEA Contract Deliverables

5.8.10 Parity in Mental Health and Substance Use Disorder Benefits.

5.8.10.1 Contractor may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder Covered Services.

5.8.10.2 Contractor will not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to Enrollees (whether or not the benefits are furnished by the same MCO).

5.8.10.3 When an Enrollee is provided mental health or substance use disorder benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), Contractor shall provide mental health or substance use disorder benefits to the Enrollee in every classification in which medical/surgical benefits are provided.

5.8.10.4 Contractor may not apply any cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient, outpatient, emergency care, prescription drugs) that accumulates separately from any established for medical/surgical benefits in the same classification.

5.8.10.5 Contractor may not impose any non-quantitative treatment limitation (NQTL) for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

5.8.10.6 Contractor shall establish and demonstrate compliance with 42 CFR Part 438, subpart K regarding parity in mental health and substance use disorder benefits. Contractor shall provide the necessary documentation, reporting, and analyses in the format and frequency required by the Department.

Attachment III

Illinois MCO Parity Analysis Template

INTRODUCTORY STATEMENT

The purpose of this Illinois MCO Parity Analysis Template is to provide detailed information and guidance to help MCOs assess compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA). The template was developed utilizing the CMS Parity Compliant Toolkit (Toolkit), published in January 2017, as the foundational document. The Toolkit can be referenced for additional information regarding completion of any of the sections of this template. The template is to be completed in its entirety by each MCO to ensure a full and complete analysis of each MCO's compliance with the MHPAEA.

The template is organized into the following four sections:

I. Benefit Classification Definitions and Mapping

II. Analysis of Financial Requirements, Quantitative Treatment Limitations, and Aggregate Lifetime / Annual Dollar Limits

III. Non-Quantitative Treatment Limits Analysis

IV. Compliance Monitoring Plan

I. BENEFIT CLASSIFICATION DEFINITIONS AND MAPPING

To conduct a parity analysis, the State must first define the four classifications of benefits under which each Medical / Surgical (M/S) and Mental Health / Substance Use Disorder (MH/SUD) service falls. For the purpose of Illinois' parity analysis, the following benefit classification definitions will be utilized:

Definitions

Inpatient: medical (including behavioral health) services that are provided in a hospital or other facility that require at least one overnight stay with a physician's written order for admission. Other facilities include nursing facilities, intermediate care facilities for individuals with ID/DD, and other behavioral health residential facilities. Inpatient services include room and board, nursing services, diagnostic or therapeutic services, and medical, surgical and behavioral health services.

Outpatient: diagnostic, therapeutic, and rehabilitative services that are provided to individuals in a facility or other community setting that does not require a physician's written order for admission.

Emergency Care: services needed to evaluate or stabilize an emergency medical condition and/or an emergency behavioral health condition. These services are provided in a variety of settings including an emergency department / emergency room, urgent care setting, etc. Emergency services are provided under medical supervision and include: a) Immediate and intensive interventions designed to help stabilize the recipient and prevent hospitalization; and, b) Continuity of care through discharge planning identification of referral resources for ongoing community stabilization and outpatient treatment.

Pharmacy: covered medications, drugs and associated supplies that legally require a medical prescription to be dispensed.

To continue a parity analysis, the State must determine under which classification each covered service falls (i.e., mapping services to classifications). For the purpose of Illinois' parity analysis, the following benefit classification / service mapping will be utilized for MCOs to complete this assessment process:

Benefit Type	Inpatient	Outpatient	Pharmacy	Emergency Care
M/S	Hospice Hospital Services Maternity Services Physician Services Skilled Nursing Facility Services Surgical Services Transplant Services	Ambulatory Surgery Dental Services Diagnostic Services Dialysis Service and Supplies Durable Medical Equipment Family Planning Services Hearing Services Home Health Services Hospital Services Laboratory Services Maternity Services Non-Emergency Transportation (NET) Physician Services Podiatry Care Services Preventive Services Private Duty Nursing Radiology Services Rehabilitative Services (PT, OT, ST) Smoking Cessation	Brand Generic Prescription OTC	Emergency Room Services Transportation/Ambulance

Benefit Type	Inpatient	Outpatient	Pharmacy	Emergency Care
		Vision Services EPSDT Chiropractic Services Prosthetics Hospice 1915c) Waiver services: Adult Day Care Homemaker Individual Provider (Personal Assistant) Respite Home Health Aide OT/PT/ST Environmental Accessibility Adaptations Home Delivered Meals Skilled Nursing Intermittent Nursing Personal Emergency Response System Specialized Medical Equipment and Supplies Day Habilitation Prevocational Services Supported Employment – Individual and Group		
MH/SUD	Hospital Services Nursing Facility Services Substance Abuse Treatment	EPSDT Substance Abuse Treatment: Level 1 - Outpatient Level 2 - Intensive Outpatient	Brand Generic Prescription OTC	Emergency Room Services Emergency Transportation / Ambulance Crisis Intervention

Benefit Type	Inpatient	Outpatient	Pharmacy	Emergency Care
	SUD-Psychiatric Residential Treatment Facility Physician Services Psychiatric Services EPSDT 1915c) waiver: Child Group Home	Level 3 – Day Treatment Medically Monitored Detox Medication Assisted Treatment Non-Emergency Transportation (NET) Medicaid Community Mental Health Services: Crisis Intervention Mental Health Assessment Individual Treatment Plan Psychological Assessment Community Support G/I/R/Team Therapy / Counseling I/G/F Case Management Mental Health Client Centered Consultation Transition Linkage and Aftercare Psychosocial Rehabilitation Assertive Community Treatment Intensive Outpatient Medication Administration Medication Training Medication Monitoring 1915c) Waiver services: Behavioral Services		

II. ANALYSIS OF FINANCIAL REQUIREMENTS, QUANTITATIVE TREATMENT LIMITATIONS, AND AGGREGATE LIFETIME AND ANNUAL DOLLAR LIMITS

Utilizing the classification definitions and the services mapping above, MCOs should complete the following tables to analyze the financial requirements (FR), quantitative treatment limitations (QTL), aggregate lifetime and annual dollar limits (AL/ADL) associated with each classification indicated. In each category, the MCO should identify the services that are subject to the specific limitation, the type of limitation applied and the dollar amount or percentage of the limitation. Further information on how to complete each of these analyses can be found in section 5 of the Toolkit at: https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf.

1. **Financial Requirements Testing (FR) –** Financial Requirements (FRs) are payments by enrollees for services received that are in addition to payments made by the MCO such as copayments, coinsurance, deductibles, and out-of-pocket maximums. FRs that apply to MH/SUD benefits within a classification may not be more restrictive than the *predominant* FR that applies to *substantially all* M/S benefits in that classification.

   Substantially all means that an FR must apply to at least two-thirds of the expected payments in a year for all M/S benefits in the same classification.

   Predominant means that the level of the type of FR (e.g., co-payment) applied to a MH/SUB benefit also must apply to more than half of the payments for M/S benefits in the classification that are subject to that type of FR.

Classification	Medical/Surgical FR (type and $ amount or percentage)	Mental Health / SUD FR (type and $ amount or percentage)	Substantially All Test (indicate if the FR passed or failed)	Predominant Test (indicate if the FR passed or failed)	Outcome Justification (include brief description of FR analysis for each classification with justification of pass / fail outcome)
Inpatient					
Outpatient					
Emergency					
Pharmacy					

2. **Quantitative Treatment Limitations (QTL) –** Quantitative Treatment Limitations (QTLs) are limits on the scope or duration of benefits that are represented numerically, such as day limits or visit limits. QTLs that apply to MH/SUD benefits within a classification may not be more restrictive than the predominant QTL that applies to substantially all M/S benefits in that classification.

Classification	Medical/Surgical limits (specific service and limitation)	Mental Health/SUD limits (specific service and limitation)	Substantially All Test (indicate if the QTL passed or failed)	Predominant Test (indicate if the QTL passed or failed)	Outcome Justification (include brief description of QTL analysis for each classification with justification of pass / fail outcome)
Inpatient					
Outpatient					
Emergency					
Pharmacy					

3. **Aggregate Lifetime and Annual Dollar Limits (AL/ADL) –** AL/ADL are dollar limits on the total amount of a specified benefit over a lifetime or on an annual basis. An AL/ADL cannot be applied to MH/SUD benefits unless it applies to at least one-third of M/S benefits. If the AL/ADL applies to less than one-third of M/S benefits, then the AL/ADL must be eliminated. If the AL/ADL applies to at least two-thirds of M/S benefits then it must be applied no more restrictively to MH/SUD benefits. If the AL/ADL applies to between one-third and two-thirds of the M/S benefits, then it may be applied to MH/SUD benefits if it is no more restrictive than the weighted average of the limit applied to M/S benefits. For additional information related to calculating AL/ADLs, please see Section 5 of the Toolkit: https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf.

Classification	Medical/Surgical limits (specific service and limitation)	Mental Health/SUD limits (specific service and limitation)	At Least 1/3 Test (indicate if AL/ADL applies to at least 1/3 of M/S benefits)	Restrictive Test (indicate if passed 1/3 test and if applied no more restrictively than M/S AL/ADL)	Outcome Justification (include brief description of AL/ADL analysis for each classification with justification of pass/fail for 1/3 and Restrictive Tests)
Inpatient					
Outpatient					
Emergency					

Pharmacy					

4. **<u>Explain any areas that failed the Substantially All or Predominant Tests and the plan for bringing those areas into compliance:</u>**

<u>THE FOLLOWING IS EXAMPLE LANGUAGE – PLEASE DELETE BEFORE DRAFTING YOUR RESPONSE:</u> "As stated in the above chart, MCO identified a potential issue of non-compliance with the MHPAEA regarding the state's outpatient benefits design and quantitative treatment limitations. In accordance with current Illinois Medicaid requirements, outpatient mental health/SUD benefits currently have day-based session limitations in place. The MHPAEA provides that no QTLs may apply to MH/SUD benefits in a classification if the QTL of that type does not also apply to substantially all (two-thirds) M/S benefits in the same classification. Without similar day-based session limitations on at least two thirds of the medical and surgical benefits in the outpatient classification, the QTL cannot be applied to the MH/SUD under this new rule."

III. NON-QUANTATIVE TREATEMENT LIMITS ANALYSIS

Non-Quantitative Treatment Limits (NQTL) are any limits on the scope or duration of benefits, such as prior authorization or network admission standards. An NQTL may not apply to MH/SUD benefits in a classification unless the NQTL for MH/SUD benefits in the classification are **<u>comparable to</u>** and **<u>applied no more stringently</u>** than the NQTL for M/S benefits in the classification. In analyzing the comparability and stringency of the NQTL in the classification, the MCO should review policies and procedures, as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the MH/SUD and M/S NQTL.

Some examples of NQTLs include, but are not limited to,:

1) Claims Rejection Rates
2) Medical management standards
   - Medical necessity criteria development
   - Prior authorization
   - Concurrent review
   - Retrospective review
   - Outlier management
   - Experimental/investigational determinations
   - Fail first requirements (e.g., Refusal to pay for higher-cost therapies until a lower-cost therapy has not been effective)
   - Exclusions (e.g., based on a failure to complete treatment)
   - Medical appropriateness reviews
   - Practice guideline selection/criteria
   - Requirements for lower cost therapies to be tried first

3) Network admission standards

- Reimbursement rates
- Geographic restrictions
- Specialty requirements or exclusions
- Facility type requirements or additional requirements for certain facility types
- Network tiers

4) Out-of-network access standards
5) Methods for determining usual, customary, and reasonable charges
6) Formulary design for prescription drugs
7) Prescription drug benefit tiers

The first step in conducting an NQTL analysis is to identify all of the NQTLs applicable to MH/SUD benefits in each classification. A type of NQTL must be tested in each classification in which it applies, and the MCO must identify ANY limits on the scope or duration of a MH/SUD benefit. Some NQTLs (e.g., prior authorization requirements) are readily identifiable. Other NQTLs require more in-depth analysis of written policies and procedures, and their operations related to utilization and quality management, provider network admission standards, reimbursement rates, prescription drug tiering factors, medication dispensing requirements, and other NQTLs embedded in operations.

Once NQTLs are identified for a classification, the MCO must collect information about the processes, strategies, evidentiary standards, and other factors applicable to each type of NQTL relative to M/S and MH/SUD benefits. The MCO will then conduct the NQTL analysis on the basis of that information to determine compliance with parity requirements of **comparability** and **stringency**.

The table below should be used to document the NQTLs by classification along with the analysis of the NQTL's application to M/S and to MH/SUD benefits within the classification. Any supporting documentation (e.g., policies, procedures, data, reports, etc.) should be noted in the last column and submitted with the MCO's completed Parity Analysis Template. Some example NQTLs are listed under each classification, along with example questions that should be answered for each identified NQTL. MCOs must identify ANY limits that apply in each classification and should add additional rows to the table to fully discuss any limits not already included in the table.

For further examples of NQTLs and their analyses, please refer to section 6 of the Toolkit at https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf.

NQTL Parity Analysis Table: To complete the table below, identify all NQTLs that apply to each classification (pre-printed examples are offered for consideration but ARE NOT EXHAUSTIVE, all additional NQTLs must be analyzed). Indicate how the NQTL is applied for both M/S services AND MH/SUD services. Indicate under MH/SUD how the NQTL meets or does not meet criteria for comparability and stringency when compared to M/S. Reference any policy, procedure, data, reports, etc. in the last column.

NQTL	Medical/Surgical	Mental Health / Substance Use Disorder	Documentation and/or Confirmation of Information to Support Analysis
Inpatient: medical (including behavioral health) services that are provided in a hospital or other facility that require at least one overnight stay with a physician's written order for admission. Other facilities include nursing facilities, intermediate care facilities for individuals with ID/DD, and other behavioral health residential facilities. Inpatient services include room and board, nursing services, diagnostic or therapeutic services, and medical, surgical and behavioral health services.			
Claims Rejection Rates Per Service			

NQTL	Medical/Surgical	Mental Health / Substance Use Disorder	Documentation and/or Confirmation of Information to Support Analysis
Medical Necessity and Appropriateness Criteria and Application – What criteria are applied to make a medical necessity/ appropriateness determination and how are they developed or selected? Describe the processes, strategies, evidentiary standards, and other factors applicable to developing/selecting your medical necessity and appropriateness criteria. What are the processes, strategies, evidentiary standards, and other factors applied in assigning medical necessity/ appropriateness reviews to inpatient benefits? What are the written and operating processes, strategies, evidentiary standards, and other factors applied during a medical necessity/ appropriateness review? Specifically address how frequency of review is determined and potential results following such a review. Do your medical necessity or appropriateness criteria include any of the following: - Fail first requirements or step-therapies (e.g., prescription drugs)? If yes, describe the processes, strategies, evidentiary standards, and other factors in writing and in operation for fail first requirements. - Exclusions based on failure to complete a course of treatment (e.g., tobacco use disorder treatment)? If yes, describe the processes, strategies, evidentiary standards, and other factors in writing and in operation for these exclusions.			

NQTL	Medical/Surgical	Mental Health / Substance Use Disorder	Documentation and/or Confirmation of Information to Support Analysis
Prior Authorization Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to inpatient M/S services, and the administration of this requirement. Describe the processes, strategies, evidentiary standards, or other factors applied in writing and in operation when assigning prior authorization to MH/SUD inpatient services for which prior authorization is required.			
Concurrent Review What are the processes, strategies, evidentiary standards, and other factors, in writing and in operation, that are applicable to concurrent review for inpatient services? Provide average denial rates and appeal overturn rates for concurrent review for M/S and MH/SUD. Identify the factors (e.g., cost of treatment, high cost growth, variability in cost and quality, elasticity of demand, provider discretion in determining diagnosis, type or length of treatment, clinical efficacy of treatment or service, licensing and accreditation of providers, fraud potential) that determine the services selected for concurrent review. What evidentiary standards support their use? Estimate the average frequency of concurrent review across services for which you conduct utilization review (e.g., every 3 days, every 20 visits, every refill).			

Network Admission Requirements What are your network admission requirements? Describe the written and operational processes, strategies, evidentiary standards, or other factors applied in setting network admission standards and implementing them. Include information regarding network adequacy. Are any practitioner types (e.g., social workers, recreational therapists), facility types (e.g., chemical dependency facilities, skilled nursing facilities), or specialty providers excluded in writing or in operation from providing covered benefits? If yes, describe the written and operating processes, strategies, evidentiary standards, or other factors applied for this exclusion. Are there any geographic limitations on provider inclusion? If yes, describe the written and operating processes, strategies, evidentiary standards, or other factors applied for this limitation. Describe the written and operating processes, strategies, evidentiary standards, or other factors applied in determining standards for access to out-of-network benefits. Indicate whether and how each of the listed factors affects how professional provider reimbursement rates are determined: -Service type -Geographic market -Service demand -Provider supply -Practice size -Medicare reimbursement rates -Licensure -Other			

NQTL	Medical/Surgical	Mental Health / Substance Use Disorder	Documentation and/or Confirmation of Information to Support Analysis
Other			
NQTL	**Medical / Surgical**	**Mental Health / Substance Use Disorder**	**Documentation and/or Confirmation of Information Included in the Tool**
Outpatient: diagnostic, therapeutic, and rehabilitative services that are provided to individuals in a facility or other community setting that do not require an overnight stay.			
List any services that are subject to an NQTL and describe more fully below:			
Claims Rejection Rates Per Service			

NQTL	Medical/Surgical	Mental Health / Substance Use Disorder	Documentation and/or Confirmation of Information to Support Analysis
Medical Necessity and Appropriateness Criteria and Application (requirements outlined in Inpatient services section apply)			
Prior Authorization (requirements outlined in Inpatient services section apply)			
Concurrent Review (requirements outlined in Inpatient services section apply)			
Network Admission Requirements (requirements outlined in Inpatient services section apply)			

NQTL	Medical/Surgical	Mental Health / Substance Use Disorder	Documentation and/or Confirmation of Information to Support Analysis
Other			
EMERGENCY: services needed to evaluate or stabilize an emergency medical condition and/or an emergency behavioral health condition. These services are provided in a variety of settings including an emergency department / emergency room, urgent care setting, etc. Emergency services are provided under medical supervision and include: a) Immediate and intensive interventions designed to help stabilize the recipient and prevent hospitalization; and, b) Continuity of care through discharge planning identification of referral resources for ongoing community stabilization and outpatient treatment.			
Claims Rejection Rates			
Medical Necessity and Appropriateness Criteria and Application (requirements outlined in Inpatient services section apply)			
Prior Authorization (requirements outlined in Inpatient services section apply)			

NQTL	Medical/Surgical	Mental Health / Substance Use Disorder	Documentation and/or Confirmation of Information to Support Analysis
Concurrent Review (requirements outlined in Inpatient services section apply)			
Network Admission Requirements (requirements outlined in Inpatient services section apply)			
Other			
Pharmacy: are covered medications, drugs and associated supplies that legally require a medical prescription to be dispensed.			
Claims Rejection Rates Per Medication			

NQTL	Medical/Surgical	Mental Health / Substance Use Disorder	Documentation and/or Confirmation of Information to Support Analysis
Formulary Design/Construction Are prescription drug benefits tiered? If yes, describe the processes, strategies, evidentiary standards, and other factors in writing and in operation that determine how prescription drug benefits are tiered. List the factors that determine the tiers (e.g., cost, brand name vs. generic). Indicate whether the condition treated affects tier assignment of a medication.			
Medical Necessity and Appropriateness Criteria and Application (requirements outlined in Inpatient services section apply)			
Prior Authorization (requirements outlined in Inpatient services section apply)			
Concurrent Review (requirements outlined in Inpatient services section apply)			
Network Admission Requirements (requirements outlined in Inpatient services section apply)			

NQTL	Medical/Surgical	Mental Health / Substance Use Disorder	Documentation and/or Confirmation of Information to Support Analysis
Other			

SUMMARY OF NQTL ANALYSIS INCLUDING: 1) THE IDENTIFICATION OF ANY AREAS OF NON-COMPLIANCE, AND 2) A PLAN TO ADDRESS NON-COMPLIANCE:

THE FOLLOWING IS EXAMPLE LANGUAGE – PLEASE DELETE BEFORE DRAFTING YOUR RESPONSE: "MCO identified the NQTLs applicable to the MH/SUD benefits in each classification. Once the NQTLs were identified, information was collected from the business about the processes, strategies, evidentiary standards, and other factors used in applying the NQTL (in writing and in operation) to assess the comparability and stringency to which the NQTL is applied between Med/Surg. and the MH/SUD benefits in all of the four classifications. The NQTL analysis was conducted for each type of classification. Pursuant to CMS' guidance in Section 6 of the Toolkit, each type of NQTL was tested only once in a classification, regardless of the types or number of services it limits. MCO then analyzed the results to determine if parity was met.

It is MCO's opinion that the non-quantitative treatment limitations are substantially consistent with parity standards."

IV. COMPLIANCE MONITORING PLAN

THE FOLLOWING IS EXAMPLE LANGUAGE – PLEASE DELETE BEFORE DRAFTING YOUR RESPONSE: "MCO will implement and maintain monitoring procedures to ensure continued compliance with state requirements and the Mental Health Parity and Addiction Equity Act ("MHPAEA").

In collaboration with MCO's Product department, Compliance will review potential benefit changes, require an updated parity analysis to be submitted, and approve changes if compliance requirements are met. In addition, Compliance will collaborate with business operational units on identifying key processes and procedures that could affect compliance with the MHPAEA and require updated parity analysis be submitted prior to implementing any operational changes.

After parity has been assessed as complete within a state market, Compliance will monitor the trending patterns of medical/surgical and behavioral health data to identify potential anomalies from baseline statistics established with the successful implementation of MHPAEA practices. If detected, such deviations will be reviewed and analyzed to ensure parity is maintained in accordance with state and federal requirements. Should monitoring efforts identify potential non-compliance, Compliance will request formal corrective action from the applicable business unit and perform follow-up procedures to validate action has been taken to remediate the potential non-compliance."

CONTACT INFORMATION FOR MCO'S PARITY ANALYSIS COORDINATOR

Name:

Email:

Phone:

Submission Date: