Mental Health Parity Report

SFY 2023

IOWA Health and Human Services

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Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance Summary

SFY 2023 (July 1, 2022 – June 30, 2023)

EXECUTIVE SUMMARY

Iowa Medicaid provides health coverage to over 700,000 Iowans every year, including eligible low-income adults, children, pregnant women, older adults and people with disabilities. Medicaid in Iowa, is a collection of specific units, each having an area of expertise, and all working together to accomplish the goals of the Medicaid program.

Three managed care organizations (MCOs) operate in Iowa, Wellpoint (formerly Amerigroup), Iowa Total Care (Centene) and Molina. The MCOs provide Medicaid coverage for all but approximately 44,000 lives which are fee-for-service. The program employs passive assignment, assigning new members an MCO upon eligibility and then providing a window for choice. Two other MCOs have operated in the state, AmeriHealth Caritas and United Healthcare, but left prior to 2020.

While Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government.

The Centers for Medicare & Medicaid Services (CMS) final regulations (42 CFR Part 438, 440, 456, and 457) provide guidance for compliance with the Mental Health Parity and Equity Addiction Act of 2008 (MHPAEA). In accordance with the final Medicaid rule, provisions of the MHPAEA apply to coverage provided to Iowa Medicaid members by Medicaid Managed Care Organizations (MCOs), through Alternative Benefit Plans (ABPs), and through the Children's Health Insurance Program (CHIP) plans.

Iowa Medicaid acknowledges that there is a gap between the report for SFY2018 and the current report. Rather than attempting to go back and complete reports that require point in time analysis and might not be an accurate representation of the data, the Agency has chosen to move forward with an evaluation of SFY 2023 managed care data. It will use that study design to also collect SFY2024 FFS data and produce a comprehensive report that will be replicated going forward.

For SFY 2023, Iowa Medicaid ("Agency") undertook an evaluation of program benefits delivered through its MCO contracts to evaluate and document compliance with the MHPAEA and/or identify potential parity issues that require corrective action. FFS data will be collected and added to the analysis for SFY 2024.

Process

The evaluation followed the processes and evaluation methodology established in CMS's "Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs."

To collect consistent information from each MCO, the Agency provided a training to the MCOs, which was recorded for those who could not attend and required play back. Using the CMS toolkit as a guideline, the Agency worked with Health Management Associates (HMA) to create a standardized template that was provided to the MCOs for data collection. The template was explained during the training. In addition, references from the CMS toolkit were used to provide guidance. Additional information and clarification took place in monthly meetings such as the Claims and Benefits, Behavioral Health, Quality, and other MCO touch base meetings.

Using surveys provided by the MCOs, the Agency conducted an analysis of the processes, strategies, evidentiary standards and other factors associated with each of five domains:

- Aggregate lifetime and annual dollar limits (AL/ADLs),
- Financial requirements (FR),
- Quantitative treatment limitations (QTLs),
- Non-quantitative treatment limitations (NQTLs), and
- Availability of information.

The analysis reviewed comparability and stringency of requirements for mental health/substance use disorder (MH/SUD) benefits to medical/surgical (M/S) benefits.

Conclusions

The MCOs' approach of exempting all MH/SUD services from copayments and AL while applying limited copayments and AL to certain M/S services demonstrates compliance with and potentially exceeds parity requirements for AL/ADLs.

The MCOs' approach of exempting all MH/SUD services from copayments and AL while applying limited copayments and AL to certain M/S services demonstrates compliance with and potentially exceeds parity requirements for financial requirements (FRs).

Regarding QTLs, one MCO demonstrated non-compliance in the outpatient classification, while the other MCOs appear to be in compliance with QTL parity requirements. Most processes related to NQTLs appear comparable (summarized in Table Y). However more detailed documentation is necessary to fully determine compliance with parity requirements.

The current system appears to meet basic requirements for availability of information but could be enhanced to improve accessibility and transparency of information for beneficiaries and providers.

Recommendations

The Agency recommends the MCOs create and maintain a centralized, searchable online location for all medical necessity criteria, clearly labelled and accessible to both beneficiaries and providers. Not all plans currently provide a dedicated phone number for requesting medical necessity criteria.

To fully comply with 2025 transparency requirements, the MCOs should enhance documentation and communication of both the accessibility of medical necessity criteria and the specific criteria applied in denial determinations.

FFS information should be collected and analyzed along with MCO data for an evaluation of full compliance for Iowa Medicaid.

INTRODUCTION

The MHPAEA was passed in 2008, and amended by the Affordable Care Act of 2010, to require that group health plans and health insurance issuers who provide coverage for MH/SUD benefits place no greater restrictions on MH/SUD benefits than on M/S benefits.

Under the MHPAEA requirements, state Medicaid agencies must verify that limitations on MH/SUD benefits are no more restrictive than limitations placed on medical/surgical benefits.

Mental Health and Substance Use Disorder (MH/SUD) parity testing is a critical process that ensures Medicaid beneficiaries have equitable access to mental health and substance use disorder services compared to medical/surgical (M/S) services.

This analysis is essential for maintaining compliance with federal regulations and ensuring appropriate access to behavioral health services.

The Agency has performed one evaluation, “Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance Summary” in December 2018 that is available on the Agency’s website. The 2018 reporting process determined that the parity requirements of MHPAEA were satisfied for care delivered through MCOs, CHIP and ABPs.

Since that time the composition of MCOs has changed, two MCOs, Amerihealth Caritas and United Healthcare have left the state, and two MCOs, Iowa Total Care (Centene) and Molina have joined one of the original MCOs, Wellpoint (formerly Amerigroup) in the state. Although no Mental Health Parity reviews were completed during those transitions, the Agency convenes bi- weekly meetings with representatives from the MCOs to discuss issues that may involve items specific to mental health services provided to members. In the future, the parity analysis will be updated and submitted to CMS prior to any change in managed care or state plan benefits pursuant to (42 CFR § 438.920(b)).

The Agency recognizes and appreciates the importance of MHPAEA in providing the highest quality of care possible to members. The Agency has dedicated staff and resources to help ensure fair access to mental health services and that access to MH/SUD services are no more restricted than to comparable physical health services. To assist the Agency in this MHPAEA compliance evaluation process, the Iowa Medicaid Quality Improvement Organization (QIO) completed an analysis of MCO self-surveys and evaluated MH/SUD and M/S services to gauge their level of compliance with mental health parity requirements. The Agency's analysis is consistent with the CMS's guides, "An Implementation Roadmap for State Policymakers Applying Mental health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs" and "Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs." The Agency did not collect FFS data for SFY 2023 but will use the study design from this report to collect both MCO and FFS data going forward.

The report outlines the methodology, key definitions, results of parity testing, and conclusions.

METHODOLOGY

Using the CMS toolkit as a guideline, the Agency worked with Health Management Associates (HMA) to create a standardized template that was provided to the MCOs for data collection. The template was explained during the training. In addition, references from the CMS toolkit were used to provide guidance. Additional information and clarification took place in monthly meetings such as the Claims and Benefits, Behavioral Health, Quality, and other MCO touch base meetings.

Using information received, the Agency conducted side-by-side comparisons and analyses of the processes, strategies, evidentiary standards and other factors associated with each NQTL for MH/SUD and M/S services, by classification for each benefit package. These factors were reviewed for comparability and stringency.

DEFINING MENTAL HEALTH AND SUBSTANCE USE DISORDERS, MEDICAL/ SURGICAL CONDITIONS

For the purposes of the parity analysis, Iowa HHS adopted the most recent version of the International Classification of Diseases (ICD), the ICD-10-CM, as its standard for defining MH/SUD Services and Medical and Surgical services. ICD-10-CM is the current version of the ICD, which is identified in the final Medicaid/CHIP parity rule as an example of a "generally recognized independent standard of current medical practice" for defining MH/SUD and Medical and Surgical conditions.

Iowa HHS defines behavioral health benefits as a benefit specifically designed to treat mental health or substance use disorder conditions. Behavioral Health conditions are those conditions listed in ICD-10-CM, Chapter 5, "Mental, Behavioral Health and Neurodevelopmental Disorders. The conditions listed in Chapter 5: subchapter 1, "Mental Disorders due to known physiological conditions" and subchapter 8, "Pervasive and Specific Developmental Disorders" were excluded because the etiology of these conditions is a medical condition, and treatment would address medical concerns first.

Substance use disorder benefits are for items or services for substance use disorders, as defined by the Agency and in accordance with applicable Federal and State law.

Medical/ surgical benefits are for items or services for medical conditions or surgical procedures, as defined by the Agency and in accordance with applicable Federal and State law, but do not include mental health or substance use disorder benefits.

The services cross walk for benefit packages was defined by the Agency.

DEFINING BENEFITS CLASSIFICATIONS, AND MAPPING BENEFITS TO THE CLASSIFICATIONS

Classification of services is divided into four categories:

- **Emergency Care:** All covered services or items delivered in an emergency department (ED) setting or to stabilize an emergency/crisis, other than in an inpatient setting.
- **Inpatient:** All covered services or items provided to a beneficiary when a physician has written an order for admission to a facility.
- **Outpatient:** All covered services or items that are provided to a beneficiary in a setting that does not require a physician's order for admission and do not meet the definition of emergency care.

- **Prescription drugs:** Covered medications, drugs and associated supplies requiring a prescription, and services delivered by a pharmacist who works in a free-standing pharmacy.

TESTING FINANCIAL REQUIREMENTS FOR PARITY

Definition:

Financial requirements (FRs) encompass various payment-related elements including coinsurance, deductibles, copayments, out-of-pocket maximums, and similar service-related requirements. Under the parity rule (42 CFR § 438.910), any financial requirements applied to Mental Health/Substance Use Disorder (MH/SUD) benefits must not be more restrictive than those predominantly applied to Medical/Surgical (M/S) benefits. The regulation explicitly prohibits the establishment of separate financial requirements exclusively for MH/SUD benefits. Furthermore, the parity rules prevent the implementation of cumulative financial requirements for MH/SUD benefits that accumulate independently from those established for M/S benefits within the same classification. For the purposes of analysis and discussion, the term FR encompasses aggregate lifetime (AL) and annual dollar limits (ADL), as well as cumulative financial requirements.

Survey:

MCOs were asked to report whether any cost sharing or financial requirement is being applied within any benefit classification. A Financial Requirements template was provided to each MCO for completion.

Results:

We examined MCO reported data on FRs, or AL/ADLs on the M/S benefits for any of the benefit packages (Medicaid, CHIP, or ABPs), and whether it is possible to determine the results of the two-part test for FRs and AL/ADLs without performing a more in-depth cost analysis.

There are no copayments, coinsurance, deductibles or other financial requirements applied to either MH/SUD or M/S benefits, except for benefit packages ABP (IHAWP) and CHIP (Hawki) which require copays for non-emergency use of the emergency room (2 of the 3 MCOs). The MCOs state that the copays apply equally to both M/S and MH/SUD services. However, it was also noted that the MH/SUD diagnoses are all considered emergent by the Agency.

Very limited AL were identified within M/S services and there is no AL identified for MH/SUD. There was no need for further testing since AL applies to less than 1/3 of M/S benefits.

1. Overall compliance assessment

The plans' approach of exempting all MH/SUD services from copayments and AL while applying limited copayments and AL to certain M/S services demonstrates compliance with and potentially exceeds parity requirements.

2. Recommendations

Due to the very limited financial requirements of MCSs, the Agency has no recommendations.

TESTING QUANTITATIVE TREATMENT LIMITATIONS FOR PARITY

Definition

Quantitative treatment limitations (QTLs) reference 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 of duration of treatment. QTLs are expressed numerically.

To maintain parity between Mental Health/Substance Use Disorder (MH/SUD) and Medical/Surgical (M/S) benefits, the following rules must be met:

1. Any QTLs applied to MH/SUD benefits must be equal to or less restrictive than the primary QTLs that apply to the majority of M/S benefits.
2. QTLs cannot be selectively applied to MH/SUD benefits while excluding M/S benefits.
3. All cumulative QTLs must align with general parity requirements, ensuring equal treatment between MH/SUD and M/S benefits.

In essence, these rules ensure that mental health and substance use disorder benefits receive equal treatment compared to medical and surgical benefits regarding quantitative limitations on coverage.

Survey

Each MCO completed a Quantitative Treatment Limitations Template survey on a template provided by the Agency. Each MCO was asked to list MH/SUD benefits with QTLs by benefit classification (Inpatient, Outpatient, Prescription, Emergency Care) for each benefit package (Medicaid, CHIP, ABPs).

Results

Table X provides a summary of QTLs and the parity analysis for each MCO by benefit classification.

Table X. Quantitative Treatment Limits Parity Analysis for Managed Care Organizations by Benefit Classification

Benefit Classification	Managed Care Organization		
	Iowa Total Care	Molina	Wellpoint
Inpatient			
MH/SUD benefits	Prior authorization required for psychiatric/SUD services No specific day limits identified	No day limits for psychiatric/SUD hospitalization Prior authorization required for IHAWP with some limitations	No day limits identified Prior authorization required for psychiatric/SUD hospitalization, PMIC
M/S benefits	Prior authorization required for all inpatient services 120-day limit for LTC services (IHAWP only)	IHAWP: SNF limited to 120 day stays Prior authorization required for non-emergent admissions	No day limits identified Prior authorization required for most services No financial requirements
Comparative Analysis (Substantially All Test, Predominant Level Test)	Both MH/SUD and M/S require similar prior authorization. No QTLs identified that apply to substantially all (2/3) M/S benefits	Substantially All Test: The 120-day SNF limit does not apply to substantially all M/S benefits Predominant Level Test: N/A since limit doesn't pass Substantially All Test	Substantially All Test: Passes as QTLs apply consistently Predominant Level Test: Passes as authorization requirements are comparable
Compliance Determination	Compliant	Compliant	Compliant
Outpatient			
MH/SUD benefits	ACT: 1 treatment per week Peer Support: 12 treatments per month Psychotherapy: 1-1.5 hours per week, 40-60 hours per 12 months Testing/evaluation: 8 hours per 12 months	No explicit visit limits identified Prior authorization required for some services	Crisis services: 5-day limit before authorization Psych testing: 3-unit limit before authorization No financial requirements
M/S benefits	Vision: 1 visit per 12 months Fluoride: 4 treatments per 12 months	IHAWP has specific visit limits: Occupational therapy: 60 visits per year	Rehabilitation: $1,920 annual cap

	Various therapy services: 60 visits per 12 months Skilled nursing: 5 visits per week	Physical therapy: 60 visits per year Speech therapy: 60 visits per year Respiratory therapy: 60 visits per year	Home care: 5-visit limit before authorization Various supply limits (e.g., diabetic supplies)
Comparative Analysis (Substantially All Test, Predominant Level Test)	Substantially All Test: Hour limits: Applied to 0.09% of M/S benefits (fails 2/3 threshold) Treatment limits: Applied to 11.2% of M/S benefits (fails 2/3 threshold)	Substantially All Test: Visit limits do not apply to substantially all M/S benefits Predominant Level Test: N/A	Substantially All Test: Passes as QTLs apply to both benefit types Predominant Level Test: Passes as visit/unit limits are comparable
Compliance Determination	Non-compliant	Compliant	Compliant
Prescription			
MH/SUD benefits	Quantity limits specified in PDL Prior authorization requirements	30 day supply limit for most medications 90 day supply for contraceptives 72 hour emergency supply 7 day supply for Latuda	31-day supply limit 90-day for certain medications No copays
M/S benefits	Same PDL quantity limits Same prior authorization requirements	30 day supply limit for most medications 90 day supply for contraceptives 72 hour emergency supply	31-day supply limit 90-day for oral contraceptives No copays
Comparative Analysis (Substantially All Test, Predominant Level Test)	Equal application of limits through PDL No separate QTLs identified	Substantially All Test: Supply limits apply to substantially all medications Predominant Level Test: 30 day limit is predominant	Substantially All Test: Passes as same limits apply Predominant Level Test: Passes as limits are identical
Compliance Determination	Compliant	Compliant	Compliant
Emergency Care			
MH/SUD benefits	No QTLs identified	No QTLs identified	No QTLs identified
M/S benefits	No QTLs identified	No QTLs identified	No QTLs identified
Comparative Analysis (Substantially All Test, Predominant Level Test)	N/A - no QTLs to analyze	N/A - no QTLs to analyze	N/A - no QTLs to analyze

Compliance Determination	Compliant	Compliant	Compliant

1. Overall compliance assessment

Iowa Total Care: The analysis reveals non-compliance in the outpatient classification due to QTLs being applied to MH/SUD benefits when similar limits are not applied to substantially all M/S benefits. Other classifications appear compliant with parity requirements.

Molina: The benefit packages appear to be in compliance with QTL parity requirements. Where QTLs exist, they are applied equally to both MH/SUD and M/S benefits, not more restrictive for MH/SUD services, based on standard medical management practices, and supported by clinical evidence and guidelines.

Wellpoint: The plan appears compliant with QTL parity requirements across all four classifications. Where QTLs exist, they are applied comparably between MH/SUD and M/S benefits. The plan uses similar authorization requirements and visit/supply limits that do not discriminate against MH/SUD services.

2. Recommendations
   To be compliant with parity rules, Iowa Total Care could
   - Remove numerical treatment limitations on outpatient MH/SUD services including weekly/monthly session limits for ACT and Peer Support, and hour limits for psychotherapy and testing services
   - Consider using medical necessity criteria instead of hard limits
   - ITC acknowledged non-compliance with QTLs of treatment limits and hours limits mandated in their contract with the Agency.

The Agency recommends that all MCOs:

- Implement a monitoring system to ensure any new QTLs meet parity requirements before implementation
- Regularly monitor utilization patterns to ensure QTLs are not creating barriers to accessing MH/SUD care
- Review QTLs annually to ensure continued compliance as benefit packages evolve
- Maintain clear documentation of parity analysis and compliance determinations
- Report QTLs separately by benefit package
- Provide training to staff on parity requirements and compliance monitoring

Note that this analysis is based on the information provided by the MCOs. A more detailed assessment may be warranted if additional benefit details become available.

TESTING NONQUANTITATIVE TREATMENT LIMITATIONS FOR PARITY

Definition

Nonquantitative Treatment Limitations (NQTLs) represent managed care organization provisions that limit the scope or duration of benefits without using numerical expressions. These include various management tools such as medical necessity criteria, medical management protocols (including prior authorization and concurrent review), and reimbursement rate structures. According to the final regulations, any NQTL application to Mental Health/Substance Use Disorder (MH/SUD) benefits must meet strict parity requirements. Specifically, both in written policy and actual operation, all processes, strategies, evidentiary standards, and other factors used to apply NQTLs to MH/SUD benefits within any classification must be comparable to and no more stringently applied than those used for Medical/Surgical (M/S) services in the same classification. Furthermore, the regulations explicitly prohibit the implementation of any NQTLs that exclusively target MH/SUD benefits.

Survey

The survey template requested for each classification of benefits, and for each benefit, the MCO describes the process, strategy, and evidentiary standards for each of these five categories:

- Prior Authorization
- Retrospective Review
- Network Provider Admission
- Establishing Charges
- Concurrent Review

Results

We reviewed processes, strategies, and evidentiary standards within each benefit classification (Inpatient, Outpatient, Prescription, Emergency Care) to evaluate comparability and stringency in NQTLs between MH/SUD and M/S services. Due to the size of the data, the report only includes a summary of the data provided for compliance.

1. Overall compliance assessment

The majority of processes related to NQTLs appear comparable (summarized in Table Y). However more detailed documentation is necessary to fully determine compliance with parity requirements.

2. Recommendations

Overall, while the basic framework for NQTL parity appears to be in place, more detailed documentation and monitoring would help ensure consistent application and true parity between MH/SUD and M/S services.

Table Y. Summary of parity compliance for Non-Quantitative Treatment Limits, by MCO.

	Managed Care Organization		
	Iowa Total Care	Molina	Wellpoint
Prior Authorization	Compliant	Compliant	Prior authorization requirements appear generally comparable between MH/SUD and M/S services. However, the use of different clinical criteria sets (MH/SUD uses Wellpoint clinical guidelines and M/S uses Milliman (MCG) criteria) could potentially lead to inconsistent application
Retrospective Review	Compliant	Compliant	Compliant
Network Provider Admissions	Compliant	Compliant	Requirements appear comparable, though documentation is limited
Establishing Charges	Compliant	Compliant	Insufficient information to fully assess parity in rate-setting processes
Concurrent Reviews	Compliant	Compliant	Compliant

ASSESSING THE AVAILABILITY OF INFORMATION

Definition

The Medicaid/CHIP parity rule establishes two critical information disclosure requirements regarding Mental Health/Substance Use Disorder (MH/SUD) benefits. First, when requested, the criteria used for medical necessity determinations for MH/SUD benefits must be accessible to all beneficiaries (including MCO enrollees and potential enrollees, Alternative Benefit Plan beneficiaries, and CHIP beneficiaries who are enrolled or potentially enrolled with a managed care entity) as well as affected Medicaid/CHIP providers. Second, whenever reimbursement or payment for MH/SUD benefits is denied, the specific reason for such denial must be communicated to the affected beneficiary, whether they are an MCO enrollee, ABP beneficiary, or CHIP beneficiary enrolled in a health plan. As of 2025, these transparency requirements remain fundamental to ensuring proper implementation of parity protections in Medicaid and CHIP programs.

Survey

MCOs were asked to report relevant critical information disclosures. A Survey template created by the Agency was provided to each MCO for completion.

Results

We reviewed processes, strategies, and evidentiary standards evaluate transparency requirements of both M/S and MH/SUD services. Findings are summarized in Table Z.

Table Z. Availability of Information criteria by Managed Care Organization

	Managed Care Organization		
Criteria for Medical Necessity Determination	Iowa Total Care	Molina	Wellpoint
Clearly labeled, searchable, and easy to locate online	Medical necessity criteria available through determination notification letters, member handbook, and provider manual. No explicit mention of criteria being clearly labeled and searchable online	Documents do not explicitly indicate that medical necessity criteria are clearly labeled and searchable online. Medical necessity criteria are only available to providers and not directly to members. This appears to fall short of the requirement that criteria should be readily available to both beneficiaries and providers	All medical necessity criteria are reported to be available online. Member and provider handbooks provide directions to access criteria. Specific details about the online accessibility (searchability, labeling) are not provided
Located in one location	Documentation suggests information is spread across multiple sources: Member handbook, Provider manual, and Determination letters. No indication that all medical necessity criteria are consolidated in one location.	No evidence that criteria are consolidated in one location. The survey indicates use of multiple sources for criteria including Milliman criteria, Molina Clinical Policies, State requirements, and Federal guidelines. No indication of a centralized location where beneficiaries can access all applicable criteria.	The documents indicate multiple sources for criteria including Wellpoint criteria for mental health services, Milliman criteria for medical/surgical services, and State PDL for pharmacy. No clear indication that all criteria are consolidated in one location.

Phone number for individuals to request copies of medical necessity criteria	A toll-free customer service line is provided for members to request medical necessity criteria. This is mentioned in both determination letters and the member handbook.	No specific phone number is mentioned in the documents for requesting medical necessity criteria. This appears to be a gap in meeting transparency requirements.	Survey response indicates "Members can request criteria and Wellpoint will provide it upon request". However, no specific phone number is provided in the documentation and the process for making such requests is not clearly detailed.
Criteria for Reason for Denial of Payment			
Notice of adverse benefit determination and the reason for any denial of reimbursement or payment to beneficiaries.	NCQA standards followed for medical necessity determinations. Determination letters are generated and mailed to members. All adverse determinations (including full denials and partial approvals) are communicated to providers by phone and mailed letter.	Survey response indicates that notices of adverse determinations are provided. This applies to both medical/surgical and behavioral health services	Notice of Decision to deny service request is provided in letter mailed to members with reasons cited for the denial and including appeal rights and instructions. This applies across all benefit classifications (inpatient, outpatient, pharmacy, emergency).
The reason for a denial includes the applicable medical necessity criteria as applied to that enrollee. This should include providing any processes, strategies, or evidentiary standards used in applying the medical necessity criteria to that enrollee	Follows NCQA standards for all medical necessity determinations. Determination letters outline next steps following service reduction or adverse determination. Letters include peer-to-peer and appeal/dispute processes. Medical necessity criteria used includes State's service definitions, Iowa Administrative Code, Provider manuals, InterQual (IQ) criteria, and ASAM criteria for	Various criteria sources used including Milliman guidelines, Federal/state requirements, Molina clinical policies, and Evidence-based guidelines from specialty associations. It is not explicitly stated whether the specific criteria applied to an individual case are included in denial notifications	Determinations consider Member's clinical history, Impact of previous treatment, Concurrent services, Potential for averting more intensive treatment, Potential for maintaining improvements, Accessibility factors, and Member's provider choice. It is not explicitly stated whether denial notices include the specific criteria and standards applied to individual cases

	substance use disorders		

1. Overall compliance assessment

The current system appears to meet basic requirements but could be enhanced to improve accessibility and transparency of information for beneficiaries and providers.

2. Recommendations

The Agency recommends the MCOs create and maintain a centralized, searchable online location for all medical necessity criteria, clearly labelled and accessible to both beneficiaries and providers. Not all plans currently, provide a dedicated phone number for requesting medical necessity criteria.

To fully comply with 2025 transparency requirements, the plans should enhance documentation and communication of both the accessibility of medical necessity criteria and the specific criteria applied in denial determinations.

Ongoing monitoring

State regulators are constantly engaged in the review and assessment of data MCOs are required to routinely report regarding service authorization requests and denials, grievances and appeals regarding the administration and reimbursement of benefits, and network design and adequacy, among others. (Reference dashboard?)

Posting of Agency Parity Compliance Documentation

The Agency will submit this document to CMS and post publicly via the Iowa Medicaid website.

Challenges with the NQTL Analysis

Federal challenges

The federal government has encountered significant challenges in regulating Non-Quantitative Treatment Limitations (NQTLs), as documented in various reports, including the landmark "2022 MHPAEA Report to Congress." The challenges have been particularly evident in three key areas: inadequate comparative analyses, overly stringent application of NQTLs to behavioral health services, and substantial deficiencies in analytical documentation. Notably, when 156 comparative analyses were initially reviewed, none met the required standards of sufficiency. Common deficiencies included incomplete benefit identifications, lack of detailed descriptions, insufficient factor identification, and inadequate stringency analysis.

In response, federal agencies including the Departments of Labor, Health and Human Services, and Treasury have implemented multiple corrective strategies. These include issuing clarifying guidance documents, fostering collaboration with industry stakeholders, strengthening oversight through increased audits and investigations, and expanding education and training initiatives. Additionally, the Department of Labor has actively pursued congressional support for enhanced enforcement measures, including the implementation of civil monetary penalties for parity violations, strengthening ERISA enforcement authority, and expanding telehealth and remote care service accessibility.

Iowa challenges

The challenges identified at the federal level closely parallel the obstacles encountered in Iowa concerning NQTL analysis. In Iowa, insurers have faced challenges with inconsistent application and varied interpretations of NQTLs, varied interpretations of NQTL’s, and insufficient detail in comparative analyses.

In addition, changes in managed care organization covering the state has complicated data collection and compliance with review and analysis.

MHPAEA Final Rules released September 9, 2024

A set of MHPAEA Final Rules was released September 9, 2024, going into effect on January 1, 2025. Key changes in the latest set of Final Rules are:

- Mandating content requirements for performing a **comparative analysis** of the design and application of each non-quantitative treatment limitation ("NQTL") applicable to MH/SUD benefits.
- Setting forth **design** and application requirements and relevant **data evaluation requirements** to ensure compliance with NQTL rules.
- Increasing scrutiny of **network adequacy** for MH/SUD benefits.
- Introducing **core treatment coverage requirements** to the meaningful benefit standard.

Survey responses evaluated in this report were conducted prior to the most recent set of MHPAEA Final Rules.

APPENDIX A

Non-Quantitative Treatment Analysis by Managed Care Organization

1. Iowa Total Care

1.1. Prior Authorization Requirements

1.1.1 Analysis

1.1.1.1 Process

For both MH/SUD and M/S services, prior authorization reviews are conducted via phone, fax, or web portal
Both use same timeframes: 14 days standard, 72 hours urgent for M/S; 24 hours for MH/SUD
Both use similar two-level review process with initial review and escalation to appropriate specialist
Notifications provided similarly via mail/phone for both

1.1.1.2 Strategies

Both use medical necessity criteria derived from Agency definitions and provider manuals
Both use InterQual criteria as standardized evidence-based support
MH/SUD additionally uses ASAM criteria for substance use disorders
Authorization guidelines aligned with state requirements for both

1.1.1.3 Evidentiary Standards

Both use standardized clinical criteria (InterQual)
Both consider length of stay and intensity of service
Both based on clinical appropriateness standards
Additional evidence-based ASAM criteria for SUD is appropriate given specialized nature

1.1.2 Conclusion

The prior authorization requirements appear comparable and no more stringent for MH/SUD than M/S benefits. The additional use of ASAM criteria for SUD is clinically appropriate and does not represent more stringent requirements.

1.1.3 Recommendations

Document rationale for different timeframes (24 hours vs 14 days)
Consider aligning notification methods across all services

Maintain documentation of comparable application in practice

1.2 Retrospective Reviews

1.2.1 Analysis

1.2.1.1 Process

Both MH/SUD and M/S use same 30-day timeframe for determinations
Both require documentation supporting medical necessity
Both consider only information available at time of service
Both document reviews in electronic system

1.2.1.2 Strategies

Both align with state requirements and fee schedules
Both focus on medical necessity and appropriate care
Neither more restrictive than state requirements

1.2.1.3 Evidentiary Standards

Both use InterQual criteria
Both based on medical necessity documentation
Both consider same types of clinical information

1.2.2 Conclusion

Retrospective review processes appear comparable with no evidence of more stringent application for MH/SUD services.

1.2.3 Recommendations

Maintain consistent documentation standards
Monitor approval rates to ensure comparable application
Consider developing standardized documentation templates

1.3 Network Provider Admission

1.3.1 Analysis

1.3.1.1 Process

Identical requirements for both MH/SUD and M/S providers:
Must be enrolled in Iowa Medicaid
Must complete online application
Must submit credentialing information
Must meet NCQA standards

1.3.1.2 Strategies

Network adequacy standards applied equally

Focus on local/regional care delivery for both
Same credentialing requirements applied

1.3.1.3 Evidentiary Standards

Both follow NCQA standards
Both require same licensing/certification
Both subject to same contractual requirements

1.3.2 Conclusion

Network admission requirements are identical for both MH/SUD and M/S providers, demonstrating parity.

1.3.3 Recommendations

Monitor network adequacy across both categories
Document any variations in credentialing decisions
Maintain consistent application of standards

1.4 Establishing Charges

1.4.1 Analysis

1.4.1.1 Process

Both MH/SUD and M/S use state Medicaid fee schedules
Reimbursement rules applied consistently
Same payment methodologies used

1.4.1.2 Strategies

Consistent with state contract requirements
Based on established fee schedules
Applied uniformly across provider types

1.4.1.3 Evidentiary Standards

State fee schedules
Medicaid reimbursement rules
Contractual requirements

1.4.2 Conclusion

Charging and reimbursement practices appear comparable with no evidence of disparity.

1.4.3 Recommendations

Document any variations in payment methodologies
Monitor reimbursement patterns

Maintain transparency in rate setting

1.5 Concurrent Reviews

1.5.1 Analysis

1.5.1.1 Process

Both use same methods (phone, fax, web portal)
Both require review on last day of authorization
Both complete reviews within 24 hours
Similar notification processes

1.5.1.2 Strategies

Both based on medical necessity criteria
Both align with state requirements
Both focus on ongoing care needs

1.5.1.3 Evidentiary Standards

Both use InterQual criteria
Both consider length of stay and intensity
Both use similar clinical guidelines

1.5.2 Conclusion

Concurrent review processes appear comparable and applied consistently across both categories.

1.5.3 Recommendations

Monitor review timeframes for consistency
Document clinical rationale for decisions
Ensure consistent application of criteria

2. Molina

2.1. Prior Authorization Requirements

2.1.1 Analysis

2.1.1.1 Process

Both MH/SUD and M/S use same procedures for prior authorization via phone, fax, or web portal
Both use MCG criteria and clinical policies
Both require review of medical necessity and appropriateness
Both use same timeframes (14 days standard, 72 hours urgent)

2.1.1.2 Strategies

Both evaluate for experimental/investigational status, overutilization, and high cost
Both use evidence-based criteria and clinical guidelines
MH/SUD additionally uses ASAM criteria for substance use disorders
Both align with state requirements

2.1.1.3 Evidentiary Standards

Both use federal/state requirements and evidence-based guidelines
Both use MCG criteria and specialty association guidelines
Documentation requirements are similar
Clinical review processes are comparable

2.1.2 Conclusion

The prior authorization requirements appear comparable and no more stringent for MH/SUD than M/S benefits. The additional use of ASAM criteria for SUD is clinically appropriate and does not represent more stringent requirements.

2.1.3 Recommendations

Document rationale for using ASAM criteria
Ensure consistent application of timeframes
Monitor authorization approval rates across benefits
Maintain documentation of comparable processes

2.2 Retrospective Reviews

2.2.1 Analysis

2.2.1.1 Process

Both use 14-day turnaround time for standard reviews
Both monitor utilization patterns and member complaints

Both review for medical necessity and appropriateness
Both use same documentation requirements

2.2.1.2 Strategies

Both focus on detecting under/overutilization
Both use data analysis and monitoring
Both implement provider education when needed
Both align with state requirements

2.2.1.3 Evidentiary Standards

Both use utilization reports and monitoring data
Both analyze member complaints
Both use quantitative analysis comparing to benchmarks
Both identify thresholds for review

2.2.2 Conclusion

Retrospective review processes appear comparable with no evidence of more stringent application for MH/SUD services.

2.2.3 Recommendations

Maintain consistent documentation standards
Monitor approval rates to ensure comparable application
Document rationale for any variations in review processes

2.3 Network Provider Admission

2.3.1 Analysis

2.3.1.1 Process

Both require state Medicaid enrollment
Both use same credentialing criteria
Both verify licensure and certification
No additional requirements beyond state standards

2.3.1.2 Strategies

Both focus on maintaining adequate networks
Both use same contracting procedures
Both provide standard contracts
Both pursue value-based arrangements

2.3.1.3 Evidentiary Standards

Both verify provider qualifications
Both review performance indicators
Both follow same credentialing timeframes
Both use same quality review process

2.3.2 Conclusion

Network admission requirements are comparable with no evidence of more stringent standards for MH/SUD providers.

2.3.3 Recommendations

Monitor network adequacy across both categories
Document any variations in credentialing decisions
Ensure consistent application of standards

2.4 Establishing Charges

2.4.1 Analysis

2.4.1.1 Process

Both use state fee schedule as basis
Both allow provider negotiation
Both pursue value-based arrangements
No differentiation in base rates

2.4.1.2 Strategies

Both align with state requirements
Both use standard fee schedules
Both allow provider-specific rates
Both focus on quality outcomes

2.4.1.3 Evidentiary Standards

Both use state-established rates
Both document any variations
Both maintain transparency
Both align with market standards

2.4.2 Conclusion

Reimbursement practices appear comparable with no evidence of disparity between MH/SUD and M/S benefits.

2.4.3 Recommendations

Document rationale for any rate variations
Monitor reimbursement patterns
Maintain transparency in rate setting

2.5 Concurrent Reviews

2.5.1 Analysis

2.5.1.1 Process

Both monitor for medical necessity
Both ensure contract compliance
Both follow federal/state regulations
Both use same review timeframes

2.5.1.2 Strategies

Both require clinical review
Both use sufficient clinical information
Both monitor appropriateness of care
Both ensure policy compliance

2.5.1.3 Evidentiary Standards

Both use federal/state regulations
Both follow accreditation standards
Both use clinical guidelines
Both document review decisions

2.5.2 Conclusion

Concurrent review processes appear comparable and applied consistently across both categories.

2.5.3 Recommendations

Monitor review timeframes for consistency
Document clinical rationale for decisions
Ensure consistent application of criteria
Maintain documentation of processes

3. Wellpoint

3.1. Prior Authorization Requirements

3.1.1 Analysis

3.1.1.1 Process

Both MH/SUD and M/S services follow similar prior authorization processes

- Standard timeframe: 14 calendar days for both types of services
- Expedited timeframe: 72 hours for both when medically necessary

Same extension rules apply (up to 14 additional days).
Both require minimum necessary clinical information for review

3.1.1.2 Strategies

Medical necessity criteria used for both service types
MH/SUD uses Wellpoint clinical guidelines
M/S uses Milliman (MCG) criteria
Both use panels of experts to develop criteria
Both allow peer-to-peer reviews

3.1.1.3 Evidentiary Standards

Both require evidence-based clinical guidelines
Both use nationally recognized standards
Both consider clinical appropriateness and medical necessity
Both require documentation of medical necessity criteria elements

3.1.2 Conclusion

The prior authorization requirements appear generally comparable between MH/SUD and M/S services, with similar processes, timeframes, and clinical review standards. However, the use of different clinical criteria sets (Wellpoint vs MCG) could potentially lead to inconsistent application.

3.1.3 Recommendations

Implement regular monitoring to ensure consistent application of criteria
Document rationale for using different criteria sets
Consider unified criteria where appropriate
Conduct periodic audits of authorization decisions

3.2 Retrospective Reviews

3.2.1 Analysis

3.2.1.1 Process

30-day timeframe for both MH/SUD and M/S reviews
Similar documentation requirements
Same appeal rights
Consistent notification requirements

3.2.1.2 Strategies

Both use medical necessity criteria
Similar clinical review processes
Comparable documentation requirements

3.2.1.3 Evidentiary Standards

Both require clinical documentation
Both use evidence-based guidelines
Similar medical necessity criteria

3.2.2 Conclusion

Retrospective review processes appear comparable between MH/SUD and M/S services.

3.2.3 Recommendations

Monitor denial rates between MH/SUD and M/S
Ensure consistent application of review criteria
Document any variations in processes

3.3 Network Provider Admission

3.3.1 Analysis

3.3.1.1 Process

Similar credentialing requirements
Comparable application processes
Standard verification procedures

3.3.1.2 Strategies

NCQA standards for both
Similar network adequacy requirements
Comparable credentialing timeframes

3.3.1.3 Evidentiary Standards

State licensure requirements
Board certification requirements

Professional liability insurance requirements

3.3.2 Conclusion

Network admission requirements appear comparable, though documentation is limited.

3.3.3 Recommendations

Develop more detailed documentation of network admission criteria
Monitor rejection rates between provider types
Ensure consistent application of standards

3.4 Establishing Charges

3.4.1 Analysis

3.4.1.1 Process

Limited information available in provided documents
Fee schedules appear to be applied similarly
Comparable payment methodologies

3.4.1.2 Strategies

Market-based rate setting
Similar negotiation processes
Comparable fee schedule updates

3.4.1.3 Evidentiary Standards

Medicare rates as benchmark
Market comparisons
Cost analysis

3.4.2 Conclusion

Insufficient information to fully assess parity in rate-setting processes.

3.4.3 Recommendations

Develop more detailed documentation of rate-setting methodology
Ensure transparent processes
Monitor payment parity

3.5 Concurrent Reviews

3.5.1 Analysis

3.5.1.1 Process

Similar timeframes (24 hours)

Comparable clinical review requirements
Similar extension provisions

3.5.1.2 Strategies

Both use medical necessity criteria
Similar clinical documentation requirements
Comparable review frequencies

3.5.1.3 Evidentiary Standards

Evidence-based clinical guidelines
Similar documentation requirements
Comparable medical necessity criteria

3.5.2 Conclusion

Concurrent review processes appear comparable between MH/SUD and M/S services.

3.5.3 Recommendations

Monitor denial rates and patterns
Ensure consistent application of review criteria
Document any variations in processes
Implement regular audits of review decisions

Overall, while the basic framework for NQTL parity appears to be in place, more detailed documentation and monitoring would help ensure consistent application and true parity between MH/SUD and M/S services.