Report to Assess Medical or Surgical Benefits, and Benefits for Mental Health and Substance Use Disorders

As Required by

House Bill 10, 85th Legislature,

Regular Session, 2017

Health and Human Services

Commission

September 2018

TEXAS
Health and Human
Services

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Executive Summary

The *Report to Assess Medical or Surgical Benefits and Benefits for Mental Health or Substance Use Disorders* is submitted in compliance with Section 4 of House Bill (H.B.) 10, 85th Legislature, Regular Session, 2017.

Findings from the report include:

1. Medical and surgical (MS) claims represented the majority of the claims for both Medicaid and Children's Health Insurance Program (CHIP) managed care organizations (MCOs) (88.5 percent and 92.1 percent, respectively).
2. A higher percentage of mental health condition and substance use disorder (MHSUD) claims (26.0 percent) were denied as compared to MS claims (18.8 percent) for Medicaid claims but not for CHIP claims. In CHIP, MS claims (19.6 percent) were slightly more likely to be denied compared to MHSUD claims (17.4 percent).
3. MHSUD claims in both Medicaid and CHIP (5.4 percent of Medicaid and 2.4 percent of CHIP) were more likely than MS claims (3.1 percent of Medicaid and 1.7 percent of CHIP) to be subject to prior authorization (PA). Most MHSUD prior authorization requests were subsequently approved in Medicaid (93.9 percent) and CHIP (93.0 percent). MS claims in both programs were more likely than MHSUD claims to be denied or partially denied as not medically necessary. However, in both Medicaid and CHIP, PAs for MHSUD claims were more likely to be approved than MS claims.
4. A greater proportion of MHSUD claims with an adverse determination (12.5 percent in Medicaid, and 11.4 percent in CHIP) were internally appealed compared to MS claims (6.8 percent in Medicaid and 7.3 percent in CHIP), and MHSUD claims were more likely to be upheld or partially upheld (80.0 percent in Medicaid and 82.1 percent in CHIP) compared to MS claims (57.6 percent in Medicaid and 56.5 percent in CHIP).[1]
5. Few MHSUD claims proceeded from an internal appeal to a state fair hearing (for Medicaid claims) or to an independent review organization (IRO) (for

[1] A claim is upheld if a decision that had been made is maintained.

CHIP claims). Even fewer of these claims were overturned at this review level.

1. Introduction

H.B. 10 aims to assess and ensure that the provision of MHSUD benefits are in parity with MS benefits for insurance plans that the Texas Department of Insurance (TDI) regulates, including Medicaid MCOs, by:

- Establishing an ombudsman for behavioral health;
- Establishing a mental health condition and substance use disorder parity work group;
- Providing coverage for mental health conditions and substance use disorders that is under the same terms and conditions as a plan's medical and surgical benefits and coverage;
- Adopting related rules; and
- Preparing a report that studies benefits for MS expenses and MHSUD expenses provided by Medicaid and CHIP MCOs (Section 4).

Specifically, Section 4 of H.B. 10 requires the Health and Human Services Commission (HHSC) to conduct a study and prepare a report comparing benefits provided by Medicaid MCOs for MS expenses to those for MHSUD. As required by H.B. 10, HHSC collected and compared data on MS and MHSUD benefits that were:

- Subject to prior authorization or utilization review;
- Denied as not medically necessary or experimental or investigational;
- Internally appealed, including data that indicates whether the appeal was denied; or,
- Subject to an independent external review, including data that indicates whether the denial was upheld.

HHSC also collected and compared data on MHSUD and MS benefits from Children's Health Insurance Program (CHIP) MCOs. This report addresses the requirement in Section 4 of H.B. 10 for Medicaid and CHIP MCOs.

2. Background

In fulfillment of H.B. 10, HHSC collected and evaluated Medicaid and CHIP MCOs' claims data. The analyses in this report compare the two categories of benefits, MS and MHSUD.

The MCOs completed a survey that requested claims information by:

- Benefit category - MHSUD benefit or MS benefit;
- Benefit classification - inpatient, outpatient, emergency services, or pharmacy;
- Age group - under 21 years of age, or 21 years of age and older; and
- Network - in-network or out-of-network.

MCOs were instructed to report the claims information for state fiscal year (SFY) 2017. To address the requirements of H.B. 10, the report aggregates data across benefit classification, age group, and network, and reports the findings for each requirement by benefit category. However, interpretations of the findings on some elements are limited. MCO response rates diminished significantly as they were asked to report claims data with greater detail. As such, the report includes data on the percentage of covered lives represented in each analysis. This informs whether conclusions can be drawn due to the data not being representative of all Medicaid and CHIP member claims. In addition, within the report, there are some charts in which the percentages do not add to 100 percent. This is due to rounding errors or discrepancies that occurred when the data were broken down and reported in greater detail.

More information regarding the survey methodology can be found in Appendix A. If data are valid, HHSC will analyze the data by benefit classification, age group, and network, and disseminate any additional findings in the future.

3. Overview of State Fiscal Year 2017 Claims Information

Together, the Medicaid MCOs reported covering 3.5 million members in SFY 2017.[2] Medicaid MCOs adjudicated over 105.4 million claims. The CHIP MCOs reported covering 424,589 members and adjudicated approximately 5.7 million claims in SFY 2017.[3]

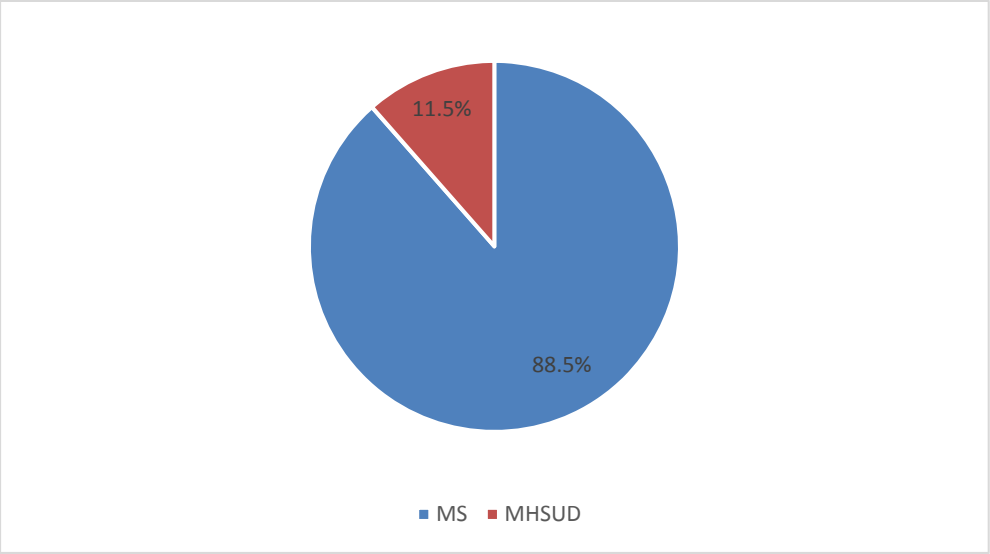
Proportion of Medicaid Claims that were for MS and MHSUD Benefits

The majority of MCOs' Medicaid claims were for MS benefits. Of the 105.4 million Medicaid claims adjudicated in SFY 2017, 11.5 percent (12.1 million) were for MHSUD claims and 88.5 percent (93.3 million) were for MS claims (see Figure 1).

[2] This number of covered member lives represent an average monthly membership across the plans. The numbers can be found here: https://hhs.texas.gov/about-hhs/records-statistics/data-statistics/healthcare-statistics.

[3] This number of covered member lives represent an average monthly membership across the plans. The numbers can be found here: https://hhs.texas.gov/about-hhs/records-statistics/data-statistics/healthcare-statistics.

Figure 1. Proportion of Medicaid Claims that were for MS and MHSUD Benefits

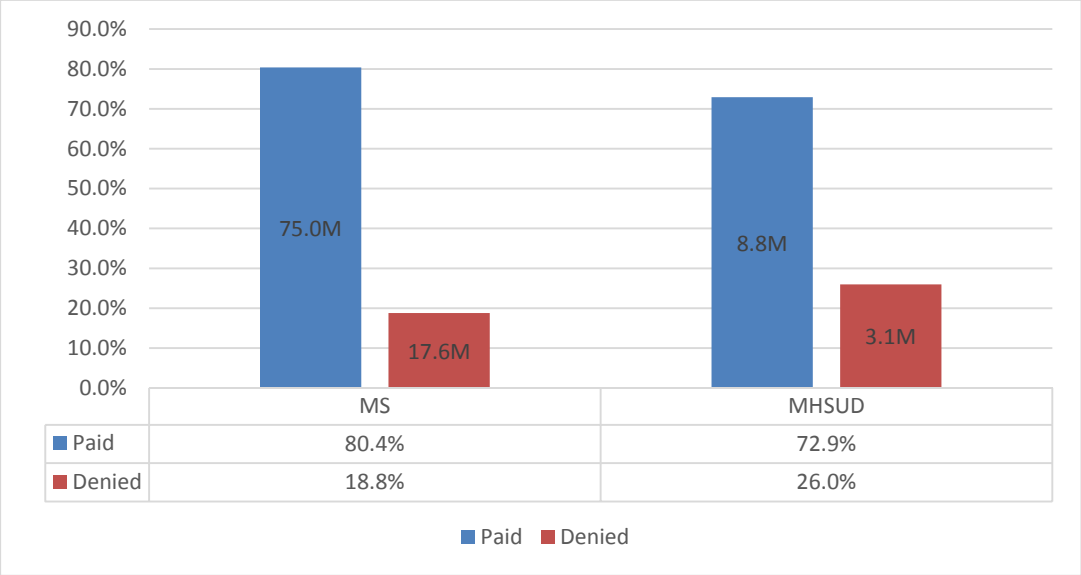


Proportion of Medicaid Claims for MS and MHSUD Benefits That Were Paid or Denied

Adjudicated claims may either be paid or denied. In Medicaid, 80.4 percent of MS claims compared to 72.9 percent of MHSUD claims were paid (see Figure 2).[4] A greater percentage of MS claims were paid at the header level compared to MHSUD claims, and a greater percentage of MHSUD claims (26.0 percent) were denied at the header level compared to MS claims (18.8 percent).

[4] Medicaid and CHIP MCOs were instructed to identify claims that were paid or denied at the header level. A claim is paid at the header level if at least one line on the claim has been paid, and a claim is denied at the header level if all lines on the claim have been denied. A line on a claim represents one service or procedure, and one claim may include multiple services and procedures.

Figure 2. The Proportion of Claims for Medicaid MS and MHSUD Benefits that were Paid or Denied[5]

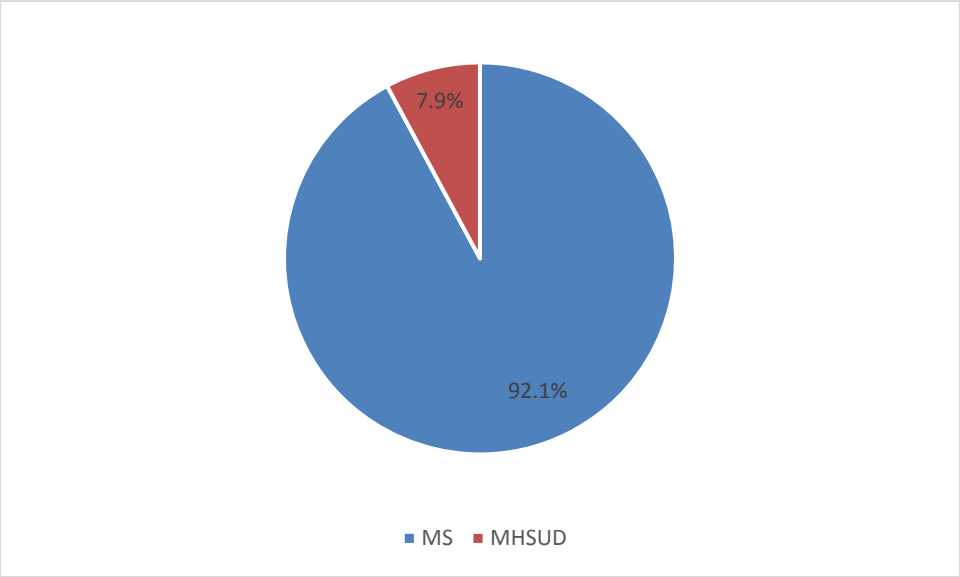


Proportion of CHIP Claims that were for MS and MHSUD Benefits

The majority of CHIP MCO claims were for MS claims. Of the 5.7M claims adjudicated in SFY 2017, 7.9 percent (445,797 claims) were for MHSUD benefits and 92.1 percent (5.2M) were for MS benefits (see Figure 3).

[5] This data represents 100 percent of Medicaid member lives.

Figure 3. Proportion of CHIP Claims That Were for MS and MHSUD Benefits[6]

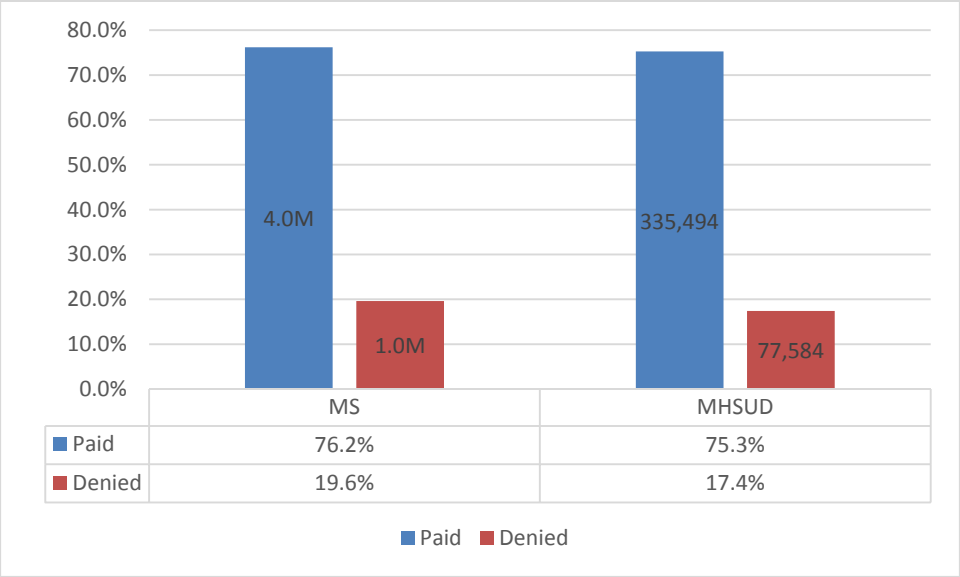


Proportion of CHIP MS and MHSUD Claims That Were Paid or Denied

Adjudicated claims may either be paid or denied. In CHIP, of the 5.7M adjudicated claims, 76.2 percent of MS claims and 75.3 percent of MHSUD claims were paid at the header level. A greater percentage of MS claims (19.6 percent) were denied at the header level compared to MHSUD claims (17.4 percent).

[6] This data represents 100 percent of CHIP covered lives.

Figure 4. Proportion of CHIP MS and MHSUD Claims that Were Paid or Denied[7]



[7] This data represents 100 percent of CHIP covered lives.

4. Overview of Complaints in SFY2017

Complaints represent an expression of dissatisfaction expressed by a complainant, orally or in writing to the MCO, about any matter related to the MCO other than an action.[8] It may include, for example, complaints regarding the quality of care or services provided; aspects of interpersonal relationships with a provider or employee; or failure to respect the member's rights regardless of whether remedial action is requested. HHSC outlines the process for Medicaid and CHIP member and provider complaints in the managed care contracts.[9]

In addition to the processes outlined in the managed care contracts, Medicaid members and providers may contact the Texas Health and Human Services Office of the Ombudsman to assist with resolving any issues or concerns if they are dissatisfied after working directly with the MCO. CHIP members and providers direct their complaints to TDI for assistance with resolving grievances. This section highlights information reported by Medicaid and CHIP MCOs on complaints received from members and providers that were related to a MHSUD or MS benefit.

Complaints in the Medicaid program

Medicaid MCOs reported receiving 6,060 complaints in SFY 2017. There were 5,773 complaints related to MS benefits and 287 complaints related to MHSUD benefits.

MCOs are required to resolve all Medicaid provider and member complaints, respond fully and completely to each complaint, and track the status and final disposition of each complaint. Table 1 below depicts the disposition of the complaints. In this report, a substantiated complaint is where the resolution is fully or partially in the complainant's favor, and a complaint that is not substantiated is one where the resolved complaint was in the MCO's favor. The definition does not align with the definition of substantiated complaints adopted by the Executive

[8] Information on Medicaid member and provider complaint processes is outlined in section 4.3.6.5 (Member Complaint and Appeal Process) of the managed care contract. Information on CHIP member and provider complaint processes is outlined in Section 8.4.1 of the managed care contract.

[9] https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/contracts/uniform-managed-care-contract.pdf

Commissioner for use across the Health and Human Services (HHS) system in HHS Circular C-052. Staff from the Medicaid and CHIP Services department, the HHS Office of the Ombudsman, and legal staff are currently working to align the definition used by MCOs with the HHS definition. As part of this effort, staff are considering a requirement for the MCOs to capture not only whether the complaint was substantiated, but also what actions were taken in response to the complaint. For example, a substantiated complaint about network adequacy may have led the MCO to outreach providers on behalf of the consumer. Aligning these definitions will allow increased future analysis across the system, comparing complaints received by HHSC staff with those received by the MCOs.

Table 1. Disposition of Medicaid Complaints

	MS[10]	**MHSUD[11]**
Substantiated	38.0%	23.3%
Not Substantiated	17.4%	18.5%

Complaints in the CHIP program

CHIP MCOs reported receiving 828 complaints in SFY 2017. There were 780 complaints related to MS benefits and 48 complaints related to MHSUD benefits. The table below depicts the disposition of the complaints.

Table 2. Disposition of CHIP Complaints

	MS[12]	**MHSUD[13]**
Substantiated	19.9%	43.8%
Not Substantiated	6.2%	4.2%

[10] This data represents 90.3 percent of Medicaid covered lives.

[11] This data represents 94.2 percent of Medicaid covered lives.

[12] This data represents 93.4 percent of member lives.

[13] This data represents 92.2 percent of member lives.

5. Benefits Subject to Prior Authorization

Through the use of prior authorization (PA), an MCO may engage in processes prior to member receipt of services to determine whether a procedure or service is medically necessary and thereby approved for payment. The MCOs reported the number of claims that were subject to PA in the survey.

The findings below are based on MCO survey data from all 19 Medicaid MCOs and all 16 CHIP MCOs on PA activities, therefore representing 100 percent of Medicaid and CHIP member lives.[14] As specified in the managed care contracts, emergency services cannot be subject to PA.[15] Therefore, the Medicaid and CHIP MCOs did not supply data on PAs related to emergency services.

Prior Authorizations in the Medicaid Program

In SFY 2017, 3.3 percent (3.5M claims) of the 105.4M adjudicated Medicaid claims were subject to PA.[16] When evaluated by benefit category, 3.1 percent of all MS claims and 5.4 percent of MHSUD claims were subject to PA. As a percentage of submitted claims, a greater proportion of MHSUD claims compared to MS claims were subject to PA.

Prior Authorizations in the CHIP Program

In SFY 2017, 1.8 percent (93,745 claims) of the 5.3M adjudicated claims in the CHIP program were subject to PA.[17] Of all adjudicated claims, 1.7 percent of MS claims and 2.4 percent of MHSUD claims were subject to PA. As a percentage of submitted claims, MHSUD claims had a greater proportion of claims subject to PA.

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[14] The number of MCOs participating in Medicaid and CHIP can fluctuate. In SFY 2017, there were 19 Medicaid MCOs and 16 CHIP MCOs.

[15] Information on prior authorizations and emergency services is outlined in section 8.2.2.1 (Emergency Services) of the managed care contract.

[16] Medicaid prior authorization data are based on 100 percent of covered lives.

[17] CHIP prior authorization data presented here are based on 92.2 percent of member lives.

6. Benefits Denied as Not Medically Necessary, Experimental, or Investigational

The data below depict the outcomes of PAs related to medical necessity. The purpose of conducting PAs is to assess the medical necessity of a benefit.[18] Though the survey stated that MCOs report on "benefits denied as not medically necessary or experimental or investigational", HHSC clarified to the MCOs that because experimental and/or investigational medical, surgical or other health-care procedures or services are not employed or recognized by Medicaid, this question focused on medical necessity denials. Therefore, the data presented here are for medical necessity denials.

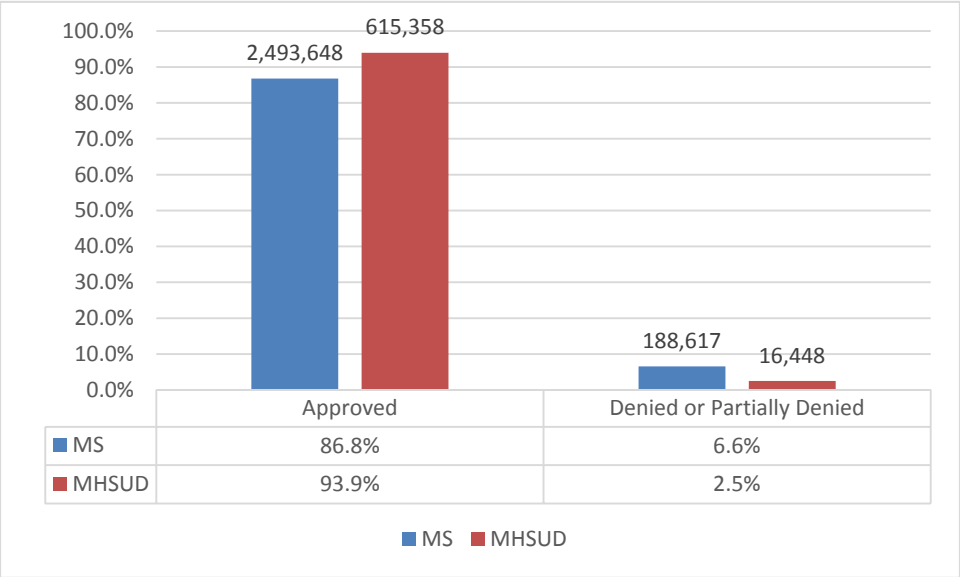
Medicaid Claims that Were Denied as Not Medically Necessary

The percentage of PAs approved for MHSUD benefits (93.9 percent) was greater compared to MS benefits (86.8 percent), and the percentage of PAs that were denied or partially denied as not medically necessary was greater among MS benefits (6.6 percent) compared to MHSUD benefits (2.5 percent, see Figure 9).[19]

[18] The definition of medical necessity can be found in the managed care contract.

[19] A partially denied PA represents a request for prior authorization in which only part of the request is approved.

Figure 9. Disposition of Medicaid Claims Subject to Prior Authorization by MS and MHSUD Benefits[20]



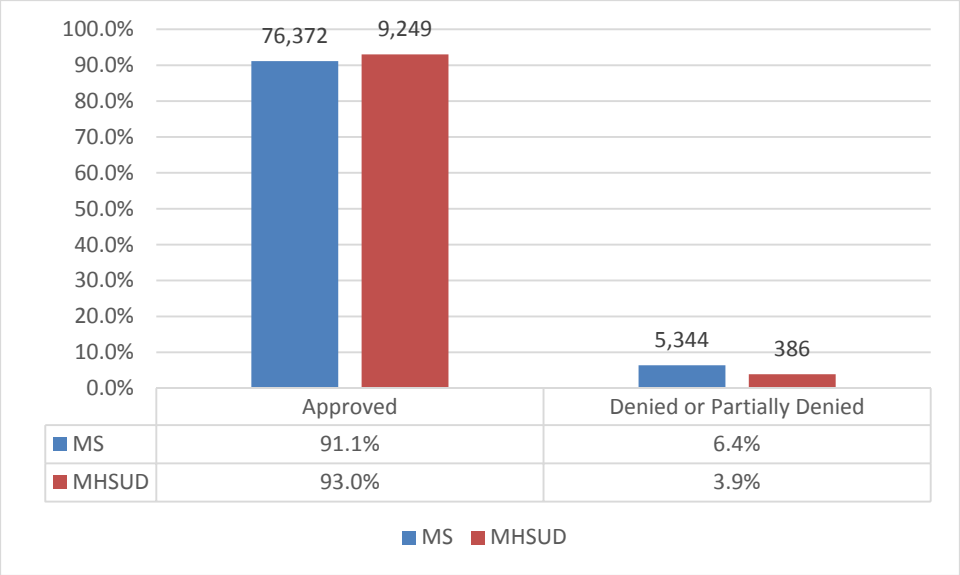
CHIP Claims that Were Denied as Not Medically Necessary

Similar to the Medicaid data, proportionally, more MHSUD claims in CHIP were subject to PAs than MS claims. Also, the percentage of PAs approved for MHSUD claims (93.0 percent) was greater than that for MS claims (91.1 percent), and more MS PAs (6.4 percent) were either denied or partially denied as not medically necessary compared to MHSUD claims (3.9 percent; see Figure 10).

Figure 10. Disposition of CHIP Claims Subject to Prior Authorization by MS and MHSUD Benefits[21]

[20] The data presented in this figure represent 100 percent of covered lives.

[21] The data presented in this figure represents 85.5 percent of covered lives.


100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
76,372
9,249
5,344
386
Approved
Denied or Partially Denied
MS
91.1%
6.4%
MHSUD
93.0%
3.9%
MS
MHSUD

7. Benefits Internally Appealed

In Medicaid, an MCO internal appeal is the formal process by which a member or his or her representative requests a review of the MCO's actions. In CHIP, the appeals process consists of a formal process in which a utilization review agent addresses the MCO's actions. Medicaid and CHIP member appeal processes can be found in the managed care contracts.[22] MCOs are required to develop, implement, and maintain an appeal procedure that complies with state and federal laws and regulations. MCOs are also required to record and log details of the appeal.[23]

The data presented here represent appeals that Medicaid and CHIP MCOs have received that are consistent with the definition of appeals specified in the managed care contracts.

Disposition of Medicaid Claims that were Internally Appealed

Based on data representing 88.2 percent of Medicaid member lives, 7.2 percent of Medicaid claims reported to have an adverse determination (20,254 were denied or partially denied as not medically necessary) were internally appealed. A greater proportion of MHSUD claims with an adverse determination were internally appealed (12.5 percent) compared to MS claims (6.8 percent).

Of claims that were internally appealed, a greater proportion of MHSUD claims were either upheld (72.8 percent) or partially upheld (7.2 percent) compared to MS claims where 53.2 percent were upheld and 4.4 percent were partially upheld. A decision that is upheld is maintaining a decision that had already been made; whereas a decision that is overturned is determining that a decision is incorrect or invalid. Internal appeals related to MS benefits were more likely to be overturned compared to MHSUD benefits.

The figure below (see Figure 11) depicts the outcomes of the internal appeals.

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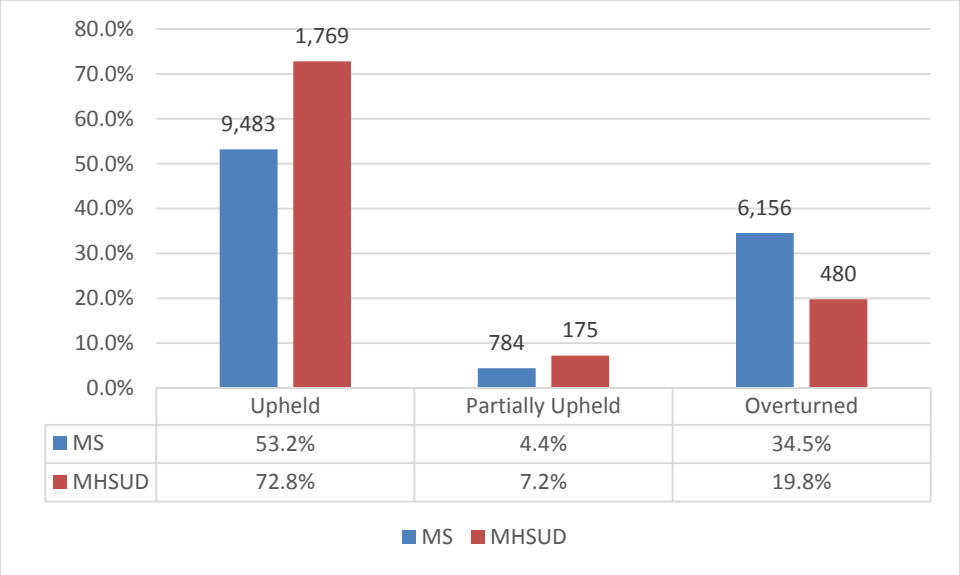
[22] In the managed care contract, see section 8.2.6 for Medicaid and section 8.4.2 for CHIP.

[23] See section 8.2.6.2 of the managed care contract for more information.

Figure 11. Final Disposition of Internally Appealed Medicaid Claims by Benefit Category[24]



Disposition of CHIP Claims that were Internally Appealed

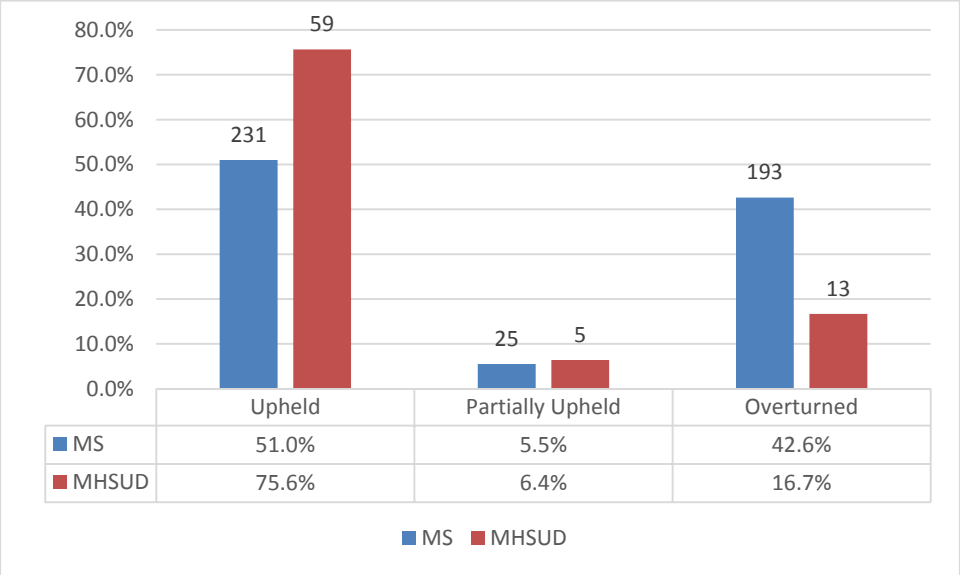
Based on data representing 85.5 percent of CHIP member lives, of the CHIP claims that were reported to have an adverse determination (6,889 claims), 7.7 percent were internally appealed. MHSUD claims with an adverse determination were more likely to be internally appealed (11.4 percent) compared to MS claims (7.3 percent).

Similar to Medicaid claims that had been internally appealed, MHSUD claims in the CHIP program were more likely to be upheld (75.6 percent) or partially upheld (6.4 percent) compared to MS claims where 51.0 percent were upheld, and 5.5 percent were partially upheld. MS internal appeals were more likely to be overturned (42.6 percent) compared to MHSUD (16.7 percent) internal appeals.

The figure below (see Figure 12) depicts the outcomes of the internal appeals.

[24] The data presented in this figure represent 87.7 percent of covered lives.

Figure 12. Final Disposition of Internally Appealed CHIP Claims by Benefit Category[25]



[25] The data presented in this figure represent 85.5 percent of CHIP covered lives.

8. Benefits Subject to a Fair Hearing or Independent External Review

In both Medicaid and CHIP programs, if after exhausting the MCO internal appeals process, the member is dissatisfied with the internal appeals decision or process, the member may seek another level review. In the Medicaid program, a state fair hearing is a proceeding held before an impartial HHSC hearings officer in which a client appeals an agency action. Medicaid members may initiate a state fair hearing after the member has exhausted the MCO's appeal process.[26]

In the Medicaid program, when a member requests a state fair hearing, the MCO completes the request for a state fair hearing and submits the form to the appropriate state fair hearings office. HHSC has access to all state fair hearing requests. However, the data presented here are based on MCO survey data in the Medicaid and CHIP programs.

In the CHIP program, if the member is dissatisfied with the MCO's resolution, the member may report the alleged violation to TDI and the member can access an IRO.[27]

Medicaid Claims with an Adverse Determination Appealed to a State Fair Hearing

As reported earlier, 7.2 percent of Medicaid claims with an adverse determination were internally appealed, and 5.7 percent of these internally appealed claims were subsequently appealed to a state fair hearing. The information presented in this section is based on data reported by MCOs representing 88.2 percent of Medicaid covered lives.

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[26] For more information on the state's Medicaid Fair Hearing process, see the Uniform Fair Hearings Rules, 1 Texas Administrative Code Chapter 357 or Code of Federal Regulations, 42 CFR Subpart F: Grievance and Appeal System.

[27] More information on the IRO process can be found here: http://www.tdi.texas.gov/pubs/consumer/cb057.html

When evaluated by benefit category, of the MS claims that were internally appealed, 6.4 percent (1,143) proceeded to a state fair hearing, and of the MHSUD claims that were internally appealed, less than 1 percent (0.6 percent, or 14 claims) proceeded to a state fair hearing.

Of the 1,143 MS claims with adverse determinations appealed to a fair hearing, 2 were partially upheld, 193 were overturned, and 731 were upheld. The disposition of the remaining adverse determinations was not reported. Of the 14 MHSUD claims with adverse determinations appealed to a fair hearing, 1 was overturned and 9 were upheld; the disposition of the remaining adverse determinations were not reported.

CHIP Claims with an Adverse Determination Appealed to an IRO

Of the CHIP claims that had an adverse determination, four of the claims (0.06 percent) were appealed to an IRO. All of the appeals to an IRO were for MS benefits, none were for MHSUD benefits. Of these four claims appealed to an IRO, three were upheld and one was overturned. This data represents 85.5 percent of CHIP covered lives.

9. Conclusion

As required by Section 4 of H.B. 10, this report provides a claims-level analysis of benefits for MS and MHSUD claims using Medicaid and CHIP MCO survey responses. Across Medicaid and CHIP MCOs, MS claims represented the bulk of claims. And, across Medicaid and CHIP MCOs, less than four percent of all claims were subject to PA. MHSUD claims were more likely than MS claims to require a PA; however, over 90 percent of MHSUD PAs requests were subsequently approved for both Medicaid and CHIP. Few of these claims were denied as not medically necessary. Greater than 85 percent of MS claims subject to PA also were subsequently approved.

The MCO survey data also indicated that approximately seven percent of claims with an adverse determination were internally appealed. When a Medicaid claim was internally appealed through the MCO, less than twenty percent of MHSUD and less than one-third of MS claims were overturned. In the CHIP program, almost half of MS internal appeals were overturned compared to less than one-fifth of MHSUD claims. Finally, only a handful of claims in the CHIP program (7) proceeded to the next level review (state fair hearing or TDI IRO process), none of which were for MHSUD claims.

Though this report provides a view of claim-level activity and the outcomes of claims processing as a result of MCO utilization review processes, a claims-level analysis is not able to provide evidence of compliance with mental health parity requirements. Disparities between MS and MHSUD claims approvals, denials, and requests for authorizations may or may not indicate a parity violation. Furthermore, claims-level analyses may or may not indicate that the same terms and conditions regarding benefits and coverage applicable to an MCO's medical and surgical also are applicable to an MCO's mental health and substance use disorder benefits. A qualitative analysis is needed to ensure MCOs are in compliance with state and federal mental health parity requirements. HHSC submitted a qualitative analysis of its Medicaid and CHIP MCOs to CMS in December 2017, and is still working with CMS to validate the data. The qualitative analysis may be a better indicator of parity compliance, and HHSC will share the results once CMS has approved them[28].

[28] https://hhs.texas.gov/services/health/medicaid-chip/programs/mental-health-substance-use-disorder-parity

List of Acronyms

Include a list of all acronyms that appear in the report. Add each new entry in its own row of this table. (Delete this instruction before publishing.)

Acronym	Full Name
CHIP	Children's Health Insurance Program
H.B.	House Bill
HHS	Health and Human Services
HHSC	Health and Human Services Commission
IRO	Independent Review Organization
M	Million
MCO	Managed Care Organization
MHPAEA	Mental Health Parity and Addiction Equity Act
MS	Medical and Surgical
MHSUD	Mental Health and Substance Use Disorder
NQTL	Non-Quantitative Treatment Limitation
PA	Prior Authorization
QTL	Quantitative Treatment Limitation
SFY	State Fiscal Year
TDI	Texas Department of Insurance

Appendix A. Procedures and Data Collection Instruments

Participants

Medicaid MCOs and CHIP MCOs were required to participate in the H.B. 10 survey. All nineteen Medicaid MCOs and CHIP MCOs responded to the survey.

Data Collection Instruments and Design

To address the requirements specified in H.B. 10, HHSC requested that the MCOs complete a survey in a Microsoft Excel file that addressed H.B. 10 requirements using SFY 2017 claims data (September 1, 2016 to August 31, 2017). The data collection instrument required the MCOs used claims-based data to address questions related to:

- Number of complaints received and substantiated;
- Total claims adjudicated, claims paid, and claims denied;
- Claims subject to utilization reviews (prior authorization, concurrent review) and the outcomes (denied as not medically necessary; partially denied as not medically necessary);
- Claims that were internally appealed and their outcomes (upheld, partially upheld, and overturned); and,
- Claims that were appealed to a fair hearing and the outcomes of the appeals.

Two files accompanied the "HB10 HHSC Data Request": (1) A Microsoft Word document that provided detailed instructions on how to complete the data request; and (2) a Microsoft Excel file that contained reference files necessary for completing the data request - information on classifying benefits as mental health and substance use disorder or as medical/surgical benefit.

For each of the questions, MCOs were instructed to report the data in the following manner:

- By benefit category - MHSUD benefit, MS benefit;
- By benefit classification - inpatient benefit, outpatient benefit, emergency services, and pharmacy benefit;
- By age group - under 21 years of age, and 21 years of age and older; and,
- By network - in-network, out-of-network.

Procedures

HHSC collaborated with TDI to develop the survey and the accompanying instructional files, and HHSC tailored its instruments and instructions to reflect terminology that is in the contract between HHSC and the Medicaid and CHIP MCOs.

Once the Medicaid and CHIP MCOs received the data request, they had four weeks to complete it. HHSC data analytics staff coordinated with each MCO on its data submission as needed to ensure data accuracy and completeness. HHSC worked individually with each MCO as needed to answer any questions.

Data Considerations

Though the data collection instrument asked MCOs to provide information on benefit classification (inpatient, outpatient, emergency services, and pharmacy), age group (under 21, and 21 and older), network (in-network, out-of-network), this report focuses only on differences in benefit category (MS and MHSUD). This report aggregates data across MCOs, benefit classification, age group, and network and focuses analyses on differences, if any, in benefit category. The response rate diminishes significantly as the MCOs were asked to report claims data with greater detail. In these scenarios, the information presented excludes missing or erroneous data and indicates the percentage of covered lives for which the data represent. [29]

Furthermore, there are some charts in which the percentages do not add to 100 percent. This is due to rounding errors or discrepancies that occurred when the data was broken down and reported in greater detail.

Any interpretation of the data presented in this report should be done with caution and take into consideration the percentage of covered member lives for which the data represent.

[29] Erroneous data represent some MCO submissions that were outliers.