Oregon Health Authority

2026 Mental Health Parity Evaluation Protocol

February 2026

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Overview

Background

Mental Health Parity (MHP) regulations are intended to ensure that coverage and access to services for the treatment of mental health (MH) and substance use disorder (SUD) conditions are provided in parity with treatments provided for medical and surgical (M/S) conditions. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) governs how MH/SUD treatments delivered by managed care organizations and limitations on MH/SUD benefits must be comparable to and applied no more stringently than the limitations applied to M/S benefits. Provisions of the MHPAEA became applicable to the Oregon Health Plan (OHP) in October 2017 when the Medicaid Parity Final Rule (42 Code of Federal Regulations [CFR] §438 Subpart K) went into effect. The rule requires parity in the following key areas:

- Aggregate lifetime and annual dollar limits (AL/ADLs)
- Financial requirements (FRs)—e.g., copays
- Quantitative treatment limitations (QTLs)—e.g., day and visit limits
- Non-quantitative treatment limitations (NQTLs)—e.g., prior authorization

Additional MHP regulations require that criteria for medical necessity determinations for MH/SUD benefits be made available to beneficiaries and providers upon request, as well as the reason for denial of reimbursement or payment for MH/SUD benefits. States must also implement monitoring procedures to ensure continued compliance and to identify when changes in benefit design or operations could affect compliance with parity requirements. Finally, Section 3 of Oregon House Bill 3046 (HB 3046), enrolled in 2021 and effective in 2022, outlined additional MHP reporting requirements for Coordinated Care Organizations (CCOs) and OHP fee-for-service (FFS), culminating in the presentation of a comprehensive report to the Oregon Legislature annually.

To comply with the federal and State requirements, the Oregon Health Authority (OHA) contracted with Health Services Advisory Group, Inc. (HSAG) as its external quality review organization (EQRO) to conduct an evaluation of parity for MH/SUD benefits as relative to M/S benefits provided under OHP managed care benefit packages in accordance with requirements in 42 CFR §438, Subpart K and Oregon HB 3046.

Table 1-1 lists the organizations that will be included in this review and the designated CCO short names. The remainder of this document describes the protocol for conducting the CY 2026 MHP Evaluation and general guidelines for CCO and OHP FFS participation.

Table 1-1—List of Organization Names and Short Names

Organization Name	Short Name
Advanced Health	AH
AllCare CCO, Inc.	AllCare
Cascade Health Alliance, LLC	CHA
Columbia Pacific CCO, LLC	CPCCO
Eastern Oregon CCO, LLC	EOCCO
Health Share of Oregon	HSO
InterCommunity Health Network	IHN
Jackson Care Connect	JCC
PacificSource Community Solutions–Central Oregon	PCS-CO
PacificSource Community Solutions–Columbia Gorge	PCS-CG
PacificSource Community Solutions–Marion Polk	PCS-MP
Trillium Community Health Plan, Inc.–Southwest	TCHP-SW
Trillium Community Health Plan, Inc.–Tri-County	TCHP-TC
Umpqua Health Alliance, LLC	UHA
Yamhill Community Care Organization	YCCO
Oregon Health Plan Fee-for-Service	OHP FFS

Objectives

The primary objectives of the MHP evaluation are to:

- Evaluate parity in the administration of MH/SUD benefits compared to M/S benefits covered by the OHP manage care and FFS program, including the:
  - Evaluation of operational documentation related to treatment limitations to determine compliance with federal and state requirements
  - Analysis of claims, utilization management, and provider enrollment patterns
  - Assessment of the adequacy of the MH/SUD provider network and timeliness of access to treatment and services
- Identify each organization's strengths, opportunities for improvement, and recommendations to ensure compliance and improve MH/SUD services
- Collect and incorporate MHP community partner (CP) feedback and guidance to support the design of annual MHP assessments and final determination of compliance.

- Support OHA in preparing the annual MHP report to the Oregon Legislative Assembly as required by HB 3046, Section 3.

2. Methodology

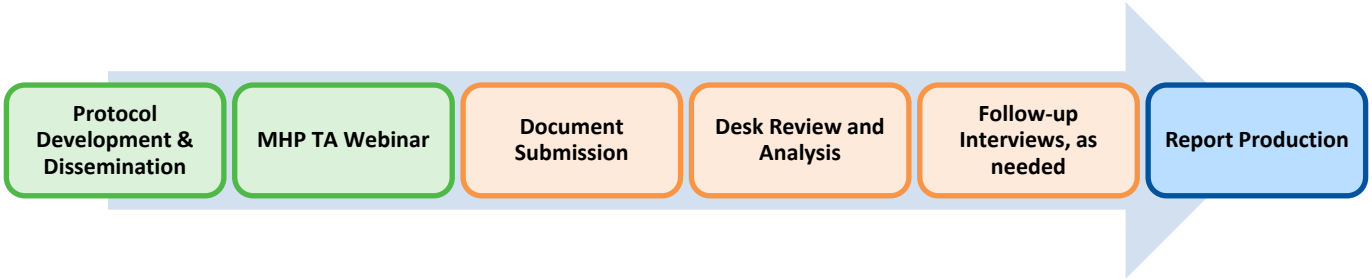
Introduction

The MHP Evaluation assesses the extent to which coverage and access to services for the treatment of MH/SUD conditions were provided in parity with treatments provided for M/S conditions. The evaluation includes a review of treatment limitations used by the organizations to manage MH/SUD and M/S benefits; a review of claims and utilization management data to identify key patterns and outcomes associated with the administration of covered benefits; and an evaluation of the adequacy of the MH/SUD provider network and members' timely access to MH/SUD treatment and services. The MHP Evaluation is conducted in a three-year cycle with Year 1 involving a comprehensive review of the policies, procedures, and processes associated with each CCO's and OHP FFS's treatment limitations and the application to MH/SUD and M/S benefits. Subsequent reviews (i.e., Year 2 and Year 3) include a review of the CCOs' and OHP FFS' attestation of continued compliance with parity requirements for MH/SUD and M/S benefits, with supplemental information provided by the CCOs and OHP FFS for prior year findings resulting in a rating of *Partially Compliant* or *Not Compliant*.

Technical Methods of Data Collection

Specific activities performed for the MHP Evaluation are illustrated in Figure 2-1 and described below.

Figure 2-1—2026 MHP Analysis Activities



1. **Protocol Development and Dissemination:** In collaboration with OHA, the MHP Evaluation Protocol, which presents details and guidance to the CCOs and OHP FFS, to describe the scope and processes for conducting the MHP analysis. The tools utilized for the analysis, identified below, were developed with the protocol, and based on guidance outlined in the Centers for Medicare & Medicaid Services' (CMS') *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*.[1] The MHP Evaluation

[1] Centers for Medicare & Medicaid Services. *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*, January 17, 2017. Available at: https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf. Accessed on: January 20, 2026.

uses OHA's *Guide to Mapping Oregon Medicaid Benefits and Services* (updated February 25, 2022)[2] to define MH/SUD and M/S benefits.

- **MHP Treatment Limitation Review Tool**—A standardized questionnaire used by the CCOs and OHP FFS to submit documentation demonstrating compliance with MHP requirements; collects information on the policies, procedures, and/or practices that could impact parity in the administration of MH/SUD and M/S benefits.
- **MHP Data Submission Template**—A Microsoft Excel-based template used by the CCOs and OHP FFS to report data on inpatient (IP), outpatient (OP), and pharmacy (Rx) claims and UM data; MH/SUD and M/S provider enrollment and credentialing data; and associate member-level records.
- **OHP FFS Appointment Availability Questionnaire[3]—**A questionnaire used by OHP FFS to describe its methodology for monitoring appointment availability.

2. **MHP Technical Assistance (TA) Webinar:** HSAG will host the MHP Technical Assistance (TA) Webinar on March 18, 2026. The webinar will provide an overview of MHP regulations; details of the MHP Evaluation Protocol and tools; an overview of the MHP Evaluation timeline; a review of required documentation and submission guidelines, analysis, and reporting processes; and an opportunity for questions and answers. HSAG will provide a guidance document to the CCOs and OHP FFS to support complete and accurate submission of all information related to AL/ADLs, FRs, QTLs, and NQTLs. Additionally, HSAG and OHA will produce, and update throughout the study, a Frequently Asked Questions document to provide clarification to the CCOs and OHP FFS on any questions received during and after the webinar.
3. **Document Submission:** The CCOs and OHP FFS will complete the MHP Treatment Limitation Review Tool, and all applicable supporting documentation, as well as submit its claims, UM, and provider enrollment data through the MHP Data Submission Template. All requested data must be submitted on or before June 1, 2026.
4. **Desk Review and Analysis:** HSAG will conduct a desk review of each CCO's and OHP FFS' submitted documentation and data to evaluate parity between MH/SUD and M/S services and benefits. HSAG will perform an analysis of the claims, UM, and provider enrollment data to assess the impact of MH/SUD and M/S operations on claims and utilization decisions. Reported rates will be validated against member-level detail (MLD) records and used to develop an administrative profile for each CCO and OHP FFS. HSAG will also perform an assessment of the CCOs' and OHP FFS' MH/SUD provider network to assess the adequacy, availability, and timeliness of access to MH/SUD services. The evaluation will incorporate a multi-dimensional approach using a series of measures to support network reporting. When necessary, HSAG will follow up with the CCOs, OHP FFS, or OHA to obtain missing documentation and receive clarification on submissions.
5. **Report Production:** HSAG will compile preliminary results from all information obtained for each CCO and OHP FFS. Per HB 3046, HSAG will summarize the results of its review and present the

[2] Oregon Health Authority. *Guide to Mapping Oregon Medicaid Benefits and Services*, February 25, 2022. Available at: https://www.oregon.gov/oha/HSD/OHP/Tools/Guide%20to%20Mapping%20Oregon%20Medicaid%20Benefits%20and%20Services.pdf. Accessed on: Jan 20, 2026.

[3] Information on the CCOs' collection and assessment of MH/SUD appointment availability will be obtained through their submission of the 2026 DSN Narrative Review Tool.

findings to OHA and its CPs to solicit input on the assessment of the CCOs' and OHP FFS's compliance with the requirement for parity between MH/SUD and M/S covered benefits, identifying areas in which MHP is not achieved and corrective actions were required to ensure future parity. Upon receipt of feedback from OHA and its CPs, HSAG will draft a final MHP Evaluation report for submission to OHA and the Oregon State Legislature, no later than December 31, 2026.

6. **Corrective Action Plan and Implementation:** If a parity finding is documented for a CCO or OHP FFS, OHA will work with the CCOs and OHP FFS to address and resolve the issues to ensure compliance with State and federal requirements. All other findings will be assessed during subsequent MHP Evaluations.

Description of Data Obtained

To assess the CCO's and OHP FFS's compliance with the federal, State, and contract requirements for parity between the MH/SUD and M/S covered benefits, HSAG will obtain information from multiple documents and sources completed and submitted by each organization. Table 2-1 lists the data sources HSAG will use to determine each CCO's and OHP FFS's performance and the time period to which the data will apply.

Table 2-1—Description of CCO and OHP FFS Data Sources

Data Obtained	Time Period to Which the Data Applied
Completed MHP Treatment Limitation Review Tool, including narrative responses to all applicable questions and supplemental documentation.	January 1, 2025 – December 31, 2025
Completed MHP Data Submission Template, including: • Membership counts. • Summary results for aggregated claims/encounters, UM decisions, and provider enrollment/credentialing and terminations. • Detailed, member-level utilization decision data. • Detailed, provider-level enrollment/credentialing and termination decision data.	January 1, 2025 – December 31, 2025
OHA's Quarter 1 (Q1) 2026 DSN Provider Capacity Report: Analysis and Review results for network capacity, accessibility, and network adequacy. Note: For CCOs only.	As of March 31, 2026
OHP FFS provider network data based on an inventory of individual and facility/clinic/business/healthcare MH/SUD service providers (see Appendix B).	As of March 31, 2026
OHP FFS member enrollment and demographic data (see Appendix B).	As of March 31, 2026
Appointment availability results and monitoring methodology.	January 1, 2025 – December 31, 2025

Data Obtained	Time Period to Which the Data Applied
• For CCOs–responses to the 2026 DSN Narrative Review Tool related to the policies, processes, and results of CCOs' monitoring of the availability of appointments of MH/SUD and M/S services. • For OHP FFS–responses to appointment availability questions outlined in the OHP FFS Appointment Availability Questionnaire (see Appendix C).	

HSAG will obtain additional information for the MHP Evaluation through interactions, discussions, and interviews with the CCO's and OHP FFS' key staff members, as necessary. Furthermore, HSAG will incorporate feedback from OHA based on meetings with the four CP groups (i.e., consumers, CCOs, providers, and behavioral health [BH] policy advocates).

Data Aggregation and Analysis

HSAG will generate both qualitative and quantitative results based on submitted documentation to assess parity.

MHP Treatment Limitation Review

For its review of the MHP Treatment Limitation Review Tool, HSAG will assess each CCO's and OHP FFS's responses across two evaluation domains:

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

HSAG will use the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant,* as defined in Table 2-2, to indicate the degree to which each CCO's and OHP FFS's performance was compliant with parity requirements based on whether the treatment limitations on MH/SUD benefits identified by the organization were comparable to and applied no more stringently than the limitations applied to M/S benefits. This scoring methodology aligns with CMS' *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs.*[4] HSAG will review all supportive documentation provided as well as information available from the prior MHP analyses, where appropriate.

[4] Ibid.

Table 2-2—Rating Definitions for MHP Compliance Determinations

Rating	Definition
Compliant	Indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency*.
Partially Compliant	Indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was: • *Comparable* but were applied with different *stringency,* or • Not *comparable* but were applied with equivalent *stringency*. OR • Documentation was incomplete (i.e., one or more evaluation elements were not addressed), but organizational structure was identified.
Not Compliant	Indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was not *comparable* and applied with different *stringency*. If documentation and evidence was insufficient to demonstrate an adequately defined program, a rating of *Not Compliant* was also applied.

From the ratings assigned to each tool element, HSAG will calculate a total compliance score for each applicable treatment limitation tool element. HSAG calculates the total score for each organization by totaling the number of *Compliant* (1 point) elements, the number of *Partially Compliant* (0.5 points) elements, and the number of *Not Compliant* (0 points) elements. Elements *Not Applicable* to the organization are scored NA, and not included in the total score.

Administrative Data Profile

To further understand the impact of CCO and OHP FFS policies and procedures on the management of MH/SUD and M/S benefits, HSAG will analyze data collected between January 1, 2025, and December 31, 2025, across three key domains. The data will include aggregate counts for claims/encounters and UM decisions for MH/SUD and M/S services as well as MH/SUD provider enrollment and termination data. HSAG will review all submitted data for consistency and conduct a comparative analysis to identify trends between MH/SUD and M/S services, between the CCOs and OHP FFS, and statewide. Data collected to support the Administrative Data Profiles included services covered through four OHP benefit packages (i.e., CCOA, CCOB, CCOE, and CCOG).[5]

Although descriptive, the Administrative Data Profile will be used to observe key patterns and outcomes associated with the administration of MH/SUD and M/S covered benefits. To further assess parity, HSAG will evaluate the extent to which key administrative outcome metrics differ between MH/SUD and M/S services. HSAG will use deviation ratings of *None, Moderate,* and *Substantial,* as defined in Table 2-3, to

[5] OHP benefit levels include CCOA (physical, behavioral, and oral health benefits); CCOB (i.e., physical and behavioral health benefits); CCOE (i.e., behavioral health benefits only); and CCOG (i.e., behavioral and oral health benefits).

indicate the degree to which each CCO's and OHP FFS' reported profile metrics differed across MH/SUD and M/S services.

Table 2-3—Deviation Rating Definitions for Administrative Data Profile

Deviation Rating	Definition
None	Difference between MH/SUD and M/S profile metric is **less than** five (5) percentage points.
Moderate	Difference between MH/SUD and M/S profile metric is: • **greater than or equal** to five (5) percentage points, and • **less than** 10 percentage points.
Substantial	Difference between MH/SUD and M/S profile metric is **greater than or equal to** 10 percentage points.

Adequacy of MH/SUD Provider Networks

The adequacy of the CCOs' and OHP FFS' MH/SUD provider networks will be evaluated through several interrelated measures of members' access to MH and SUD services.

Provider Network Capacity

HSAG will conduct a review of the CCOs' and OHP FFS' provider network data files and synthesize the results to understand the provider network infrastructure in place to provide MH/SUD services to members. Using CCO data captured in OHA's Q1 2026 DSN Provider Capacity Report: Analysis and Review and OHP FFS' member and provider data submissions, HSAG will aggregate the data and report two core metrics:

- **Provider Counts**—The number and percentage of MH, SUD, psychology (PSY), and psychiatry (PSYC) providers serving adult and pediatric populations, as well as the number and percentage of methadone (MTD) facility providers.
- **Provider-to-Enrollee Ratios**—The ratio of MH, SUD, PSY, and PSYC providers to members stratified by adult and pediatric populations, as well as the ratio of MTD facility providers to all members.

Time and Distance

HSAG will assess the geographic distribution of MH and SUD adult and pediatric providers relative to adult and pediatric member populations as the percentage of members having access to an MH provider, SUD provider, psychiatrist, or MTD facility within acceptable travel times and distances to the nearest provider. Effective January 1, 2024, the CCOs were required to align monitoring and reporting with updated travel times and distances. These requirements revised provider designations based on taxonomy, expanded urbanicity definitions, and acceptable travel times and distances based on urbanicity and a

provider type's access priority and frequency of member need, known as a "tier." Table 2-4 outlines the acceptable travel times and distances by urbanicity and provider tier.

Table 2-4—Acceptable Travel Times and Distances by Urbanicity and Provider Tier

Urbanicity Classification	Definition	Provider Tier	Acceptable Travel Time	Acceptable Travel Distance
Large Urban	Conjoined urban areas with a total population of at least 1 million people or with a population density greater than 1,000 people per square mile.	Tier 1	10 Minutes	5 Miles
		Tier 2	20 Minutes	10 Miles
Urban	An area with greater than 40,000 people within a 10-mile radius of a city center.	Tier 1	25 Minutes	15 Miles
		Tier 2	30 Minutes	20 Miles
Rural	An area greater than 10 miles from the center of an urban area.	Tier 1	30 Minutes	20 Miles
		Tier 2	75 Minutes	60 Miles
Extreme Access	County with a population density of 10 or fewer people per square mile.	Tier 1	40 Minutes	30 Miles
		Tier 2	95 Minutes	85 Miles

Table 2-5 presents the MH and SUD provider and facility types included in the MHP Evaluation by provider tier.

Table 2-5—List of Provider and Facility Types by Provider Tier

Tier 1	**Individual Provider:** Mental Health (MH) and Substance Use Disorder (SUD)
Tier 2	**Individual Provider:** Psychiatry (PSYC) **Facility Provider:** Methadone Clinic (MTD)

Note: For the purposes of time and distance analyses, OHA combines MH providers, PSY, and MH residential providers. As such, time and distance results are not reported separately for PSY.

Table 2-6 presents network adequacy indicators and standards included in the 2026 MHP Evaluation.

Table 2-6—Network Adequacy Standards

Provider Type	Provider Tier[1]	Definition	Compliance Standard
Individual Provider, Adult	Tier 1	Percentage of adult members within acceptable driving time or distance[2] to the nearest provider serving adults members[3].	95 percent
	Tier 2		
Individual Provider, Pediatric	Tier 1	Percentage of pediatric members within acceptable driving time or distance[2] to the nearest provider serving pediatric members[3].	95 percent
	Tier 2		
Facility Provider	Tier 2	Percentage of members within acceptable driving time or distance[2] to the nearest provider.	95 percent

[1] See Table 2-5 for the specific provider types included in each tier.
[2] See Table 2-4 for the definition of acceptable driving time and distance.
[3] Member populations served by individual providers are defined by the *Age_Group* indicator reported by CCOs in the *Q1 DSN Provider Capacity Report* data files.

HSAG will use OHA's Q1 2026 DSN Provider Capacity Report: Analysis and Review findings to identify and report on CCOs' provider network capacity and compliance with time and distance standards.

Appointment Availability

In 2026, HSAG will review the CCOs' responses to the 2026 DSN Provider Narrative Review Tool and OHP FFS' submission of the OHP FFS Appointment Availability Questionnaire to understand how each organization monitors the availability of appointments to MH/SUD and M/S services and providers. HSAG's evaluation will qualitatively assess the scope and consistency of each CCOs' and OHP FFS' methodology and approach to monitoring appointment availability across MH/SUD and M/S services. Additionally, when available, HSAG will review and assess appointment availability metrics presented by the CCOs and OHP FFS to determine their compliance with federal and state requirements, as well as the extent to which performance across MH/SUD and M/S standards are comparable.

MHP Community Partner Input

In alignment with the requirements in HB 3046, OHA will continue meeting with four different CP groups to solicit feedback from the community and provide input on both the assessment of parity as well as the direction of future MHP analyses. The CP groups are composed of consumers (including OHP members), CCOs, behavioral health policy advocates, and providers.

Discussions and feedback from the initial CP meetings will be documented by OHA staff members and submitted to HSAG for review and inclusion in the 2026 MHP Evaluation report.

Reporting

Once findings are formulated and scoring is applied (where applicable), the review will be finalized, and preliminary findings will be presented to OHA and the MHP CP groups. HSAG, in collaboration with OHA and its CP groups, will make final determinations regarding each CCO's and OHP FFS' compliance with parity requirements. HSAG will incorporate feedback from OHA into its analysis and produce a statewide draft report summarizing the findings and identifying strengths, opportunities for improvement, and required actions that must be implemented to ensure parity within the Oregon Medicaid Managed Care program. OHA will have an opportunity to review the draft report and provide feedback. A final MHP report will be prepared and submitted to OHA following any required revisions to be submitted to the Oregon Legislature no later than December 31, 2026. CCO- and OHP FFS-specific results will be incorporated as appendices to the report.

Pursuant to 42 CFR §438.364, final MHP results will be aggregated across all CCOs and reported to CMS in the State's annual technical report (ATR) that encompasses results from all external quality review (EQR) activities conducted in 2026, including the degree to which CCOs have effectively addressed recommendations made by the EQRO during the previous year's activities. The ATR will be published on OHA's website.

Appendix A. MHP Timeline

Table A-1 outlines the CY 2026 MHP activities and pertinent dates.

Table A-1—CY 2026 MHP Timeline

Task	Date
HSAG posts MHP materials to CCOs and OHP FFS	02/27/26
HSAG conducts 2026 MHP Technical Assistance webinar with CCOs/OHP FFS	03/18/26
OHA conducts CP focus sessions	Spring 2026
CCOs/OHP FFS submit completed documentation to HSAG, including the: • MHP Treatment Limitation Review Tool • MHP Data Submission Template • OHP FFS only – Provider network data • OHP FFS only – Member enrollment and demographic data • OHP FFS only – Appointment Availability Questionnaire	06/01/26
OHA compiles and submits CP feedback to HSAG	06/30/26
HSAG performs desk review of CCO and OHP FFS documentation; prepares administrative profiles, and conducts network adequacy evaluation	June 2026 – September 2026
HSAG presents preliminary findings to CPs	October 2026 – November 2026
HSAG submits MHP Evaluation Draft Report to OHA and individual results appendices to CCOs and OHP FFS	11/12/26
Receive feedback from OHA, CCOs, and OHP FFS	11/25/26
OHA publishes final 2026 MHP Evaluation Report; submits to the OR Legislature	12/31/26

Appendix B. OHP FFS Supplemental Data Guidance

In addition to the MHP Treatment Limitation Review Tool and MHP Data Submission Template, OHP FFS is required to submit three additional data files to support the evaluation of the adequacy of MH/SUD provider networks. These include:

- OHP FFS individual and facility/clinic/business/healthcare services provider network data
- OHP FFS member enrollment and demographic data
- OHP FFS methodology and approach to monitoring appointment availability

OHP FFS Provider Network Data Requirements

To align with CCO provider capacity data, the following guidance is based on OHA's most recent version of the DSN Provider Capacity Report instructions.[6] The OHP FFS Provider Network Data will include an inventory of all individual MH or SUD providers (i.e., physician, mid-level practitioner, or other non-physician), facilities/clinics, or business/healthcare service providers who submitted an MH/SUD claim between January 1, 2025, and December 31, 2025, and is enrolled and active with OHP FFS on March 31, 2026. The data will be comprised of two sections, one for individual provider information and the other for facility/clinic or business/healthcare service provider information.

File Extract Specifications

Table B-1 describes the specific file extraction requirements for the OHP FFS provider network data.

Table B-1—File Extract Specifications

Requirement	Specification
Individual Providers	• Include individual providers enrolled with OHP FFS as of March 31, 2026. • Include all individual specialties reported via relevant taxonomy codes and associated provider locations. Note that this may create multiple records for some providers.
Facility/Clinic or Business/Healthcare Service Providers	• Include facilities/clinics and business/healthcare service providers enrolled with OHP FFS as of March 31, 2026. • Include facilities/clinics and business/healthcare service provider locations and specialties reported via relevant taxonomy codes. Note that this may create multiple records for some service providers. • Facilities/clinics and business/healthcare service providers must have agreed to provide services or items to Medicaid and fully dual-eligible OHP FFS members.

[6] The *DSN Provider Capacity Report Instructions,* the most recent version is located on the CCO Contract Forms webpage: https://www.oregon.gov/oha/hsd/ohp/pages/cco-contract-forms.aspx. Accessed on: February 6, 2026.

Requirement	Specification
Extraction Date	• Extract data as of March 31, 2026. • All enrolled MH and SUD providers with a final, fully adjudicated claims (paid and denied) as of **March 31, 2026**, with dates of service between **January 1, 2025, through December 31, 2025**.
File Format	Files may be submitted in any of the following file formats: • ASCII text file in a pipe (|) delimited format (preferred) • Spreadsheet file (e.g., see OHP FFS Provider Network template) • Other file types, if coordinated with HSAG

Data Element Requirements – Individual Provider Section

Table B-2 describes the specific data element requirements for the individual provider data section.

Table B-2—Data Element Requirements for Individual Provider Section

Data Field Name	Date Field Definition	Data Field Description	Required
NPI	Individual Provider's NPI	**Description:** *This data field must be populated with the Individual Provider's NPI.* **Format/Value:** 10-digit numeric value / active in NPPES Registry (https://npiregistry.cms.hhs.gov/)	Yes, unless HRSN_Flag=Y with associated GrpDMAP_ID and provider has no NPI
Provider_FName	Individual Provider's First Name	**Description:** *This data field must be populated with the Individual Provider's First Name.* **Format/Value:** alphabetic characters, spaces, special characters associated with names	Yes
Provider_MName	Individual Provider's Middle Name	**Description:** *This data field should be populated with the Individual Provider's Middle Name or Initial.* **Format/Value:** alphabetic characters, spaces, special characters associated with names **Null Value:** Blank—do not use NA, N/A, or other conventions	No

Data Field Name	Date Field Definition	Data Field Description	Required
Provider_LName	Individual Provider's Last Name	**Description:** *This data field must be populated with the Individual Provider's Last Name.* **Format/Value:** alphabetic characters, spaces, special characters associated with names	Yes
Taxonomy	Individual Provider's Taxonomy Code	**Description:** *This data field must be populated with the Individual Provider's Taxonomy Code associated with the participating provider's NPI and Division of Medical Assistance Program (DMAP) registration.* ***Note: Each distinct and relevant (i.e., practiced under) Taxonomy Code should be listed as a separate entry.*** **Format/Value:** 10-digit alphanumeric value / active in NUCC Taxonomy Lookup (https://taxonomy.nucc.org/)	Yes
Age_Group	Age Group Served by the Individual Provider	**Description:** *This data field indicates the population of CCO members the Individual Provider is contracted with the CCO to serve based on age.* **Format/Value:** 1-digit alphabetic character / "B" = Both Pediatric and Adult members, "P" = Pediatric members only, "A" = Adult members only	Yes
GrpNPI	Individual Provider's Group's NPI	**Description:** *This data field must be populated with the Individual Provider's affiliated Group Practice or Clinic's NPI.* ***Notes: This element should correspond to the relevant NPI information on the Facility Section of the DSN Report. Each distinct Group Practice and or Clinic where an Individual Provider practices should be listed as a separate entry.*** **Format/Value:** 10-digit numeric value / active in NPPES Registry (https://npiregistry.cms.hhs.gov/)	Yes, unless HRSN_Flag=Y with associated GrpDMAP_ID and provider's organization has no NPI

Data Field Name	Date Field Definition	Data Field Description	Required
GrpName	Individual Provider's Group Practice or Clinic Name	**Description:** *This data field must be populated with the Individual Provider's affiliated Group Practice, Clinic, or Facility name. This element should reflect the name of the physical practice location.* ***Notes: Each distinct Group Practice and or Clinic where an Individual Provider practices should be listed as a separate entry.*** **Format/Value:** alphabetic characters, spaces, special characters associated with names	Yes
GrpDMAP_ID	Individual Provider's Group Practice, Clinic, or Organization' s DMAP ID.	**Description:** *This data field must be populated with the Individual Provider's Group, Clinic, or Organization's ID issued upon enrollment as an Oregon Medicaid provider.* **Format/Value:** 6- or 9-digit numeric value	Yes, if HRSN provider
TIN	Individual Provider's Taxpayer Identification Number (TIN)	**Description:** *This data field must be populated with the Individual Provider's TIN.* **Format/Value:** 9- or 10-digit numeric value	Yes
DMAP_ID	Individual Service Provider's DMAP (Medicaid ID)	**Description:** *This data field must be populated with the Individual Provider's ID issued upon enrollment as an Oregon Medicaid provider.* **Format/Value:** 6- or 9-digit numeric value	Yes

Data Field Name	Date Field Definition	Data Field Description	Required
Address	Individual Provider's Address	**Description:** *This data field must be populated with the Individual Provider's site location (physical street address).* ***Note: Practice name is not captured in this field. The address should reflect the location at which services are rendered. The address should correspond to the address connected to the NPI provided in the GrpNPI field. For providers with no set practice location (e.g., a provider practicing within a mobile clinic), enter "mobile".*** **Format/Value:** alphanumeric values, spaces, special characters associated with names (e.g., 1234 S Main St)	Yes
Address2	Individual Provider's Address 2	**Description:** *This data field identifies the Individual Provider's site location (suite number, etc.).* **Format/Value:** alphanumeric values, spaces, special characters associated with names (e.g., Ste 100) **Null Value:** Blank—do not use NA, N/A, or other conventions	Yes, if applicable
City	Individual Provider's City	**Description:** *This data field must be populated with the Individual Provider's site location (city).* **Format/Value:** alphabetic characters, spaces, special characters associated with names (e.g., Salem)	Yes
State	Individual Provider's State	**Description:** *This data field must be populated with the Individual Provider's site location (state).* **Format/Value:** 2-digit alphabetic characters (e.g., OR) / valid US state	Yes

Data Field Name	Date Field Definition	Data Field Description	Required
ZIP	Individual Provider's ZIP Code	**Description:** *This data field must be populated with the Individual Provider's site location (ZIP).* **Format/Value:** 5- or 9- digit numeric value (e.g., 97301) / valid US ZIP Code	Yes
County	Individual Provider's County	**Description:** *This data field must be populated with the Individual Provider's site location (county).* **Format/Value:** alphabetic characters, spaces, special characters associated with names (e.g., Marion)/ valid US county	Yes

Data Element Requirements – Facility/Clinic/Business/Healthcare Service Provider Section

Table B-3 describes the specific data element requirements for the facility provider section.

Table B-3—Data Element Requirements for Facility Provider Section

Data Field Name	Date Field Definition	Data Field Description	Required
NPI	Facility/Clinic or Business/ Healthcare Service Provider's NPI	**Description:** *This data field must be populated with the Facility/Clinic or Business/Healthcare Service Provider's NPI.* ***Note: This element should correspond to the relevant GrpNPI information on the Individual Provider Section of the DSN Report. NPIs for Facility/Clinic or Business/Healthcare Service Providers without associated providers on the Individual Provider Section of the DSN Report must also be reported here.*** **Format/Value:** 10-digit alphanumeric value / active in NPPES Registry (https://npiregistry.cms.hhs.gov/)	Yes, unless HRSN_Flag=Y and Facility/Clinic/Healthcare Service Provider has no NPI

Data Field Name	Date Field Definition	Data Field Description	Required
FacilityName	Facility/Clinic or Business/Healthcare Service Provider's Name	**Description:** *This data field must be populated with the Facility/Clinic or Business/Healthcare Service Provider's Name.* **Format/Value:** alphabetic characters, spaces, special characters associated with names	Yes
Taxonomy	Facility/Clinic or Business/Healthcare Service Provider's Taxonomy Code	**Description:** *This data field must be populated with the Facility/Clinic or Business/Healthcare Service Provider's Taxonomy Code associated with the participating provider's NPI and DMAP registration.* **Format/Value:** 10-digit alphanumeric value (e.g., 314000000X) / active in NUCC Taxonomy Lookup (https://taxonomy.nucc.org/)	Yes
TIN	Facility/Clinic, or Business/Healthcare Service Provider's Taxpayer Identification Number (TIN)	**Description:** *This data field must be populated with the Facility/Clinic, or Business/Healthcare Service Provider's TIN.* **Format/Value:** 9- or 10-digit numeric value	Yes
DMAP_ID	Facility/Clinic, or Business/Healthcare Service Provider's DMAP Number (Medicaid ID)	**Description:** *This data field must be populated with the Facility/Clinic, or Business/Healthcare Service Provider's number issued to upon enrollment as an Oregon Medicaid provider.* **Format/Value:** 6- or 9-digit numeric value	Yes

Data Field Name	Date Field Definition	Data Field Description	Required
Address	Facility/Clinic, or Business/Healthcare Service Provider's Address	**Description:** *This data field must be populated with the Facility/Clinic, or Business/Healthcare Service Provider's site location (physical street address).* ***Note: Facility name is not captured in this field.*** **Format/Value:** alphanumeric values, spaces, special characters associated with names (e.g., 1234 S Main St)	Yes
Address2	Facility/Clinic, or Business/Healthcare Service Provider's Address 2	**Description:** *This data field must be populated with the Facility/Clinic, or Business/Healthcare Service Provider's site location (suite number, etc.).* **Format/Value:** alphanumeric values, spaces, special characters associated with names (e.g., Ste 100) **Null Value:** Blank—do not use NA, N/A, or other conventions	Yes, if applicable
City	Facility/Clinic, or Business/Healthcare Service Provider's City	**Description:** *This data field must be populated with the Facility/Clinic, or Business/Healthcare Service Provider's site location (city).* **Format/Value:** alphabetic characters, spaces, special characters associated with names (e.g., Salem)	Yes
State	Facility/Clinic, or Business/Healthcare Service Provider's State	**Description:** *This data field must be populated with the Facility/Clinic, or Business/Healthcare Service Provider's site location (state).* **Format/Value:** 2-digit alphabetic characters (e.g., OR)/ valid US state	Yes
ZIP	Facility/Clinic, or Business/Healthcare	**Description:** *This data field must be populated with the Facility/Clinic, or Business/Healthcare Service Provider's site location (ZIP).*	Yes

Data Field Name	Date Field Definition	Data Field Description	Required
	Service Provider's Zip Code	**Format/Value:** 5- or 9-digit numeric value (e.g., 97301)/ valid ZIP Code	
County	Facility/Clinic, or Business/Healthcare Service Provider's County	**Description:** *This data field must be populated with the Facility/Clinic, or Business/Healthcare Service Provider's site location (county).* **Format/Value:** alphabetic characters, spaces, special characters associated with names (e.g., Marion)/ valid US county	Yes

OHP FFS Member Enrollment and Demographic Data

To conduct the time and distance analysis for MH SUD providers, it is necessary to extract OHP FFS member and enrollment data from OHP FFS's data systems.

Submission Guidelines

- All data files must be submitted to HSAG's secure file transfer protocol (SFTP) site: https://safe.hsag.com/.
  - Files should be submitted in the following path: *Oregon EQRO/OHA/MHP/From OHA.*
  - The exact field names and types for the requested data elements are **required** to facilitate HSAG's processing of the submitted files.
- Please include a "control total" file for the requested data files, following the specifications detailed below.

Member Enrollment Data

HSAG requests a data file listing the enrollment spans for all members enrolled with OHP FFS as of **March 31, 2026**.

File Extract Specifications

Table B-4 identifies the specific field qualifications required for the OHP FFS member enrollment file.

Table B-4—Member Enrollment File Specifications

Requirement	Description
Member Enrollment Segment	• Include all OHP FFS members meeting the following enrollment criteria: – Enrollment Start Date ≤ 03/31/2026 AND – Enrollment End Date ≥ 03/31/2026 OR Enrollment End Date is not populated (*if missing values indicate a member is still enrolled with OHP FFS when the data are extracted*) • Please include all enrollment segments meeting the above criteria. As such, one member may have multiple records in the enrollment file.
File Format	Files may be submitted in any of the following file formats: • ASCII text file in a pipe (|) delimited format • SAS®[7] format • Other file types, if coordinated with HSAG

Minimum Required Data Elements

Table B-5 identifies the minimum data elements requested for the OHP FFS member enrollment file. In general, HSAG needs to know the OHP member was enrolled as of May 1, 2026, and when the enrollment segment began and ended. Please only include the enrollment span covering May 1, 2026.

Table B-5—Required Data Elements for Member Enrollment File

Field Name	Description	Type	Notes
MemID	Member's Medicaid identification number	Character	None
Plan	Primary payer in which a member was enrolled	Character	Value = OHP FFS
StartDate	Date on which member's enrollment began	YYYYMMDD	None
EndDate	Date on which member's enrollment ended	YYYYMMDD	If the member is still enrolled, the value should be blank.

OHP FFS Member Demographic Data

HSAG requests a data file listing the OHP FFS member's demographic information as of **March 31, 2026**, for all members included in the extracted member enrollment data (i.e., data defined in Table B-4). HSAG will use this information to geocode the member's residential address for use in geographic

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analyses. Additionally, HSAG requests the member's date of birth, gender, and date of death, to identify the appropriate members serviced by OHP FFS providers from each provider category.

File Extract Specifications

Table B-6 identifies the specific field qualifications required for the member demographic file.

Table B-6—Member Demographic File Specifications

Requirement	Specification
Member	Include all members in the extracted OHP FFS member enrollment data specified in Table B-4
File Format	Files may be submitted in any of the following file formats: • ASCII text file in a pipe (|) delimited format • SAS®[8] format • Other file types; if coordinated with HSAG

Minimum Required Data Elements

Table B-7 identifies the minimum data elements requested for the OHP FFS member demographic file.

Table B-7—Required Data Elements for Member Demographic File

Field Name	Required Element	Type	Notes
MemID	Member's Medicaid identification number	Character	None
FName	Member's first name	Character	None
MI	Member's middle initial	Character	If not available, please leave blank.
LName	Member's last name	Character	None
DOB	Member's date of birth	YYYYMMDD	None
DOD	Member's date of death	YYYYMMDD	If the member is still alive, the value should be blank.
Gender	Member's gender	Character	If using coded values (e.g., "M" or "F"), please include descriptions for the coded values in the "control total" document.
Address1	The first street address line for member's residential address	Character	None

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Field Name	Required Element	Type	Notes
Address2	The second street address line for member's residential address	Character	None
City	The city for member's residential address	Character	None
State	The two-character state abbreviation code for member's residential address	Character	Example: "OR"
Zip	The five-digit zip code for member's residential address	Character	None
County	The full name of the county in which the member's residential address is located	Character	Example: "CLACKAMAS"
FIPS Code	The five-digit FIPS code associated with the county and state in which the member's residential address is located	Numeric	Example: A member living in Coos County, OR will have a data value of "41011"

Appendix C. OHP FFS Appointment Availability Questionnaire

Appointment Availability	
Does OHP FFS have policies, procedures, and/or processes for monitoring appointment availability for OHP FFS members? ☐ Yes ☐ No → Enter explanation.	
Please describe OHP FFS' methodology for monitoring appointment availability by addressing each of the elements below. Please include the appropriate documentation (i.e., policies, procedures, flow charts, data layouts, reports, etc.) that address the following elements.	
Data Source(s): Enter description.	
Documents submitted as evidence:	
Data Elements (e.g., average number of hours/days to next appointment, percent non-compliant with standards): Enter description.	
Documents submitted as evidence:	
Methodology and performance measure specifications: Enter description.	
Documents submitted as evidence:	
Process for integrating data, analyzing data, and validating results: Enter description.	
Documents submitted as evidence:	
Process for reporting and monitoring results: Enter description.	
Documents submitted as evidence:	
Process for following up on non-compliant providers and/or network deficiencies: Enter description.	
Documents submitted as evidence:	
Please provide copies of appointment availability reporting and monitoring for 2025, including evidence of decision making in response to results.	
Documents submitted as evidence:	