Oregon Health Authority

2025 Mental Health Parity Evaluation Protocol

March 2025

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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) needs. The required analysis of MH benefits is governed by federal regulations. 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 are 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—such as copays).
- Quantitative treatment limitations (QTLs—such as day and visit limits).
- Non-quantitative treatment limitations (NQTLs—such as prior authorization [PA] and provider network admission requirements).

Additional MHP regulations require that criteria for medical necessity determinations for MH/SUD benefits must 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 and require an updated analysis. 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. The remainder of this document describes the protocol for conducting the CY 2025 MHP evaluation and general guidelines for CCO and OHP FFS participation.

Table 1-1—List of CCOs and OHP FFS

MCE Name	CCO Short Name
Coordinated Care Organizations (CCOs)	
Advanced Health	AH
AllCare CCO, Inc.	AllCare
Cascade Health Alliance, LLC	CHA
Columbia Pacific CCO, LLC	CPCCO
Eastern Oregon CCO	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–Lane County	PCS-LN
PacificSource Community Solutions–Marion Polk	PCS-MP
Trillium Community Health Plan, Inc.–Tri-County	TCHP-TC
Trillium Community Health Plan, Inc.–Southwest	TCHP-SW
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:

- Conduct a review of the CCOs' treatment limitations on MH/SUD benefits to ensure they are comparable to and applied no more stringently than limitations applied to M/S benefits.
- Evaluate claims, UM data, and provider enrollment data to assess the impact of MH/SUD and M/S operations on claims and utilization decisions.
- Complete an evaluation of the adequacy of the provider network and timeliness of access to MH/SUD treatment and services.

- Identify each CCO's performance strengths, opportunities for improvement, and areas requiring corrective action.
- Gather information and perspective regarding findings from the documentation review, data analysis, and compliance determinations during meetings with community partners (CPs).
- Identify potential areas of interest from CPs to inform the scope of future targeted analyses for the MHP activity.
- Prepare a comprehensive report inclusive of all 2025 MHP activity findings and input from CPs for OHA to submit to the Oregon Legislative Assembly as required by HB 3046.

To accomplish its objective, and based on the results of collaborative planning with OHA, HSAG developed a treatment limitation attestation tool and supplemental questionnaire, and data submission templates to assess and document parity across M/S and MH/SUD benefits for participating CCOs and OHP FFS.

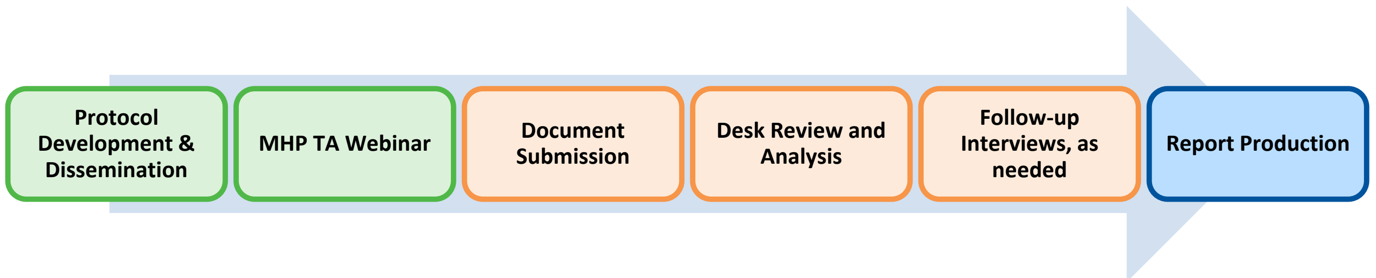
Introduction

OHA requires its CCOs and OHP FFS to undergo an annual MHP evaluation to ensure continued compliance with federal and State MHP requirements that includes a review of treatment limitations used by the organizations to manage MH/SUD and M/S benefits to ensure compliance with MHP requirements; 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*. The 2025 MHP evaluation is designed to assess and document parity across MH/SUD and M/S benefits for participating CCOs and OHP FFS, as well as highlight the capacity and availability of MH/SUD services to Medicaid members.

Technical Methods of Data Collection

The key 2025 MHP Analysis activities are illustrated in Figure 2-1 and described below.

Figure 2-1—2025 MHP Analysis Activities



1. **Protocol Development and Dissemination:** HSAG developed the 2025 MHP Evaluation Protocol to describe the scope and methodology for conducting the MHP analysis and provide guidance to OHA, the CCOs, and OHP FFS on their participation. The tools utilized for the analysis, identified below, were included with the protocol, and were 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*.[2-1]

- **2025 MHP Treatment Limitation Attestation Tool**—A standardized questionnaire used by the CCOs and OHP FFS to certify continued compliance with MHP requirements; collects information on the changes to the organization and its policies, procedures, and/or practices that could impact parity in the administration of MH/SUD and M/S benefits.
- **2025 MHP Treatment Limitation Supplemental Questionnaire—**A questionnaire used by the CCOs and OHP FFS to collect information on the policies, procedures, and/or practices that impact MH/SUD and M/S parity for implemented treatment limitations receiving a rating of *Partially Compliant* or *Not Compliant* in 2024; collects supplemental documentation and information to demonstrate compliance with parity requirements.
- **2025 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 credentialing data; and member-level detail files.
- **2025 OHP FFS Grievance Template—**A Microsoft Excel-based template used by OHP FFS to report grievance data.
- **2025 OHP FFS Appointment Availability Questionnaire—**A questionnaire used by OHP FFS to describe its methodology for monitoring appointment availability.

2. **MHP Technical Assistance (TA) Webinar:** HSAG will host a technical assistance (TA) webinar on **March 12, 2025.** The webinar will provide an overview of MHP regulations; details of the 2025 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 and OHA will produce, and update throughout the study, a Questions & Answers 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 Attestation Tool,* the *MHP Treatment Limitation Supplemental Questionnaire,* as applicable*,* and submit all applicable supporting documentation, as well as submit its claims, UM, and credentialing data through the *MHP Data Submission Template*. All requested data must be submitted on or before **June 2, 2025**.
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, including 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) files 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

[2-1] 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 6, 2025.

network reporting. When necessary, HSAG will follow up with the CCOs, OHP FFS, or OHA to obtain missing documentation, or receive clarification on submissions.

1. **Report Production:** HSAG will compile all information obtained from the desk review and data analysis to derive MHP findings for each CCO and OHP FFS. Per HB 3046, HSAG will summarize the results of its review and present the 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, 2025**.
5. **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 major data sources HSAG will use to determine each CCO's and OHP FFS's performance in complying with parity requirements 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 Attestation Tool*, including narrative responses to all applicable questions and supplemental documentation, submitted for HSAG's desk review.	January 1, 2024 – December 31, 2024
Completed *MHP Treatment Limitation Supplemental Questionnaire* (as applicable), including narrative responses and supplemental documentation to demonstrate compliance with parity requirements, submitted for HSAG's desk review.	January 1, 2024 – December 31, 2024
Completed *MHP Data Submission Template*, including: • Membership counts. • Aggregated paid and denied claims counts for in- and out-of-network providers. • Aggregated UM data including prior authorization, denial, and appeals counts. • Member-level records associated with utilization decisions. • Provider enrollment and termination counts.	January 1, 2024 – December 31, 2024

Data Obtained	Time Period to Which the Data Applied
• Member-level records associated with provider enrollment and termination decisions.	
OHP FFS member-level records of all grievances.	January 1, 2024 – December 31, 2024
CCO and OHP FFS grievance logs.[2-2]	January 1, 2024 – December 31, 2024
CCO provider network data based on bi-annual *DSN Provider Capacity* data submitted to, and provided by, OHA to HSAG.[2-3]	As of March 31, 2025
CCO member enrollment and demographic data provided by OHA to HSAG.[2-3]	As of May 1, 2025
OHA's *Quarter 1 (Q1) 2025 DSN Provider Capacity Report: Analysis and Review* results for network capacity, accessibility, and network adequacy (NA). Note: For CCOs only.	January 1, 2024 – December 31, 2024
OHP FFS provider network data based on an inventory of MH/SUD individual and facility/clinic/business/healthcare service providers (see Appendix B).	As of May 1, 2025
OHP FFS member enrollment and demographic data (see Appendix B).	As of May 1, 2025
Appointment availability results and updated monitoring methodology. • For CCOs – results from the *CY 2024 Revealed Shopper Survey Report.* • For OHP FFS – responses to appointment availability questions outlined in the OHP FFS Appointment Availability Questionnaire (see Appendix C).	January 1, 2024 – December 31, 2024
Information obtained through follow-up interviews, as needed.	July 31, 2025 – August 29, 2025

Data Aggregation and Analysis

HSAG will generate both qualitative and quantitative results based on submitted documentation to assess parity during the 2025 MHP Evaluation.

[2-2] For CCOs, OHA will provide HSAG with data obtained from the CCOs' quarterly grievance system reporting to support the assessment of access-related grievances for MH/SUD; no additional data submissions will be required. Since OHP FFS grievance data is not currently available, additional guidance on the collection and submission of access-related grievance data is presented in the OHP FFS Grievance Template.
[2-3] CCO provider and member data files are prepared and submitted to HSAG in support of the 2025 Network Adequacy Validation activity conducted by HSAG. These data sources will be used to conduct supplemental, urbanicity-based reviews of members' access to providers.

MHP Treatment Limitation Review

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

- Whether the CCO or OHP FFS reported and documented changes in its existing processes, policies, or procedures that support the administration of MH/SUD and M/S covered benefits.
- The extent to which changes, if documented, were compliant with federal and State parity requirements.

HSAG will use the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant,* as defined in

Table 2-2, to indicate the degree to which changes identified by CCOs and OHP FFS's remained compliant with parity requirements or if the changes affected the comparability and stringency of processes, strategies, or evidentiary standards used in administering MH/SUD and M/S benefits. A designation of *Not Applicable (NA)* will be used when a CCO or OHP FFS was *Partially Compliant* or *Not Compliant* with an element in 2024, or if *Compliant*, indicated no change was made to organizational processes during the period covered by HSAG's review.

For its review of the *MHP Treatment Limitation Supplemental Questionnaire*, HSAG will assess each CCO's and OHP FFS's responses across the following evaluation domains:

- Whether the CCO or OHP FFS described and provided documentation to address the *Partially Compliant* or *Not Compliant* rating in 2024, and
- The degree to which implemented treatment limitations demonstrated:
  - 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 also 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. Both scoring methodologies are in alignment with CMS' *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*.[2-4] HSAG will review all supportive documentation provided as well as information available from the prior MHP analyses, where appropriate.

[2-4] 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 were *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 were: • *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 were 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 of the attestation and questionnaire elements identified, HSAG will calculate a total compliance score for each applicable attestation and questionnaire 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 policies and procedures on the management of MH/SUD and M/S benefits, HSAG will analyze data collected between January 1, 2024, and December 31, 2024, across three key domains. The analysis will include aggregate counts for claims/encounters and UM decisions for MH/SUD and M/S services as well as MH/SUD provider enrollment data and identification of members represented within the MH, SUD, and M/S claims. 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 statewide, and for OHP FFS. CCO data collected to support the Administrative Data Profiles included services covered through four OHP benefit packages (i.e., CCOA, CCOB, CCOE, and CCOB).[2-5]

Although descriptive, the administrative 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

[2-5] 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).

will evaluate the extent to which key claims/encounter and UM 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 indicate the degree to which CCO's and OHP FFS's 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 2025 MHP Evaluation will assess the adequacy of the CCOs' and OHP FFS' MH/SUD provider networks by evaluating several interrelated measures of members' access to MH an 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 bi-annual *DSN Provider Capacity Reports* and OHP FFS' MHP submission (see Appendix B for guidance), HSAG will aggregate the data and report two core metrics:

- Provider Counts—The number and percentage of MH and SUD providers by adult and pediatric population.
- Provider-to-Enrollee Ratios—the ratio of MH and SUD providers to adult and pediatric 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 methadone (MTD) facility within acceptable travel times and distances to the nearest provider. A threshold of 95 percent of adult and pediatric members with acceptable travel times and distances will be used to identify CCOs' and OHP FFS' compliance with adult, pediatric, and facility providers, inclusive of all applicable urbanicities. Table 2-4 outlines the acceptable travel times and distances to the nearest provider by 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 provider specialties and facility types included in each provider tier.

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

Tier 1	**Individual Provider:** MH Provider (MH) and SUD Provider (SUD)
Tier 2	**Individual Provider:** Psychiatry (PSY) **Facility Provider:** Methadone Clinic (MTD)

Table 2-6 presents NA indicators and standards included in the 2025 MHP Evaluation.

Table 2-6—Network Adequacy Standards

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

In addition to evaluating compliance with Oregon NA standards by member population (i.e., adult and pediatric members) and facility, HSAG will conduct a supplemental analysis of members' access to MH and SUD providers by urbanicity. HSAG will use OHA's *Quarter 1 (Q1) 2025 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 2025, HSAG will incorporate results from OHA's *CY 2024 Revealed Shopper Survey Report* highlighting appointment availability for CCO members for substance use disorder (SUD) outpatient provider locations. The findings from this survey assessed the accuracy of provider directory data (e.g., location, service offerings) and ability of new and existing OHP members to obtain both routine and urgent appointments within established time frames. HSAG's evaluation will also include a review of OHP FFS' submission of the *OHP FFS Appointment Availability Questionnaire* to understand how the organization monitored the availability of appointments to MH/SUD and M/S services and providers. HSAG will assess the scope and consistency of OHP FFS' methodology and approach to monitoring appointment availability across MH/SUD and M/S services.

Access-related Grievances

HSAG will review and assess the percentage of access-related MH and SUD grievances to identify potential areas of concern with the availability of MH and SUD providers within each CCO's and OHP FFS' network. Although descriptive, the review of access-related grievances will be used to observe patterns that may be associated with the adequacy of MH/SUD and M/S provider networks. Additionally, to assess parity, HSAG will evaluate the extent to which the grievance metrics differ between MH/SUD and M/S services. HSAG will use deviation ratings of *None, Moderate,* and *Substantial,* as defined in Table 2-7, to indicate the degree to which CCO's and OHP FFS's reported profile metrics differed across MH/SUD and M/S services.

Table 2-7—Deviation Rating Definitions for Access-related Grievances

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

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 will be composed of 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 2025 MHP Evaluation report.

Reporting

Once findings are formulated and scoring is applied (where applicable), HSAG will finalize its review and prepare preliminary statewide findings and present the information to OHA and the MHP CP groups. OHA will then, in collaboration with its CP groups, make final determinations regarding each CCO's and OHP FFS's 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, 2025. CCO- and OHP FFS-specific results will be incorporated as an appendix 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 2025, 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.

HSAG HEALTH SERVICES ADVISORY GROUP

3. Data Collection Tools and Submission

MHP Treatment Limitation Attestation Tool

The *2025 MHP Treatment Limitation Attestation Tool* is a required, fillable Word document that allows CCOs and OHP FFS to attest to the absence of organizational changes to existing processes, policies, or procedures that were previously confirmed to support parity of mental health and substance use disorder (MH/SUD) and medical and surgical (M/S) benefits, or provide information on changes to its operations that may impact parity (e.g., procedural requirements, practices, workflows, etc.).

All responses, data, and information provided for the review should be associated with the following measurement period: January 1, 2024 – December 31, 2024. This template will be sent to all participating CCOs and OHP FFS via email, as well as posted to OHA's CCO Contract Forms Page (i.e., https://www.oregon.gov/oha/hsd/ohp/pages/cco-contract-forms.aspx).

MHP Treatment Limitation Supplemental Questionnaire

The *2025 MHP Treatment Limitation Supplemental Questionnaire* is a required, fillable Word document that allows CCOs and OHP FFS to address *Partially Compliant* and *Not Compliant* findings related to the implementation of treatment limitations reported in the 2024 *MHP Evaluation Summary Report.* The questionnaire requires CCOs and OHP FFS to describe actions taken to resolve findings and recommendations, including the submission of documentation on implemented treatment limitations that was previously missing, omitted, or incomplete needed to demonstrate compliance with parity requirements. For each *Partially Compliant* or *Not Compliant* NQTL reported, the CCO and OHP FFS will provide appropriate documentation that address the following questions:

1. Why the NQTL was assigned, including what evidence supports the rationale for use of the NQTL?
2. What procedures/processes/requirements are used to apply the NQTL by benefit and service type (e.g., time frames, evidentiary standards/documentation requirements, reviewer qualifications, monitoring/oversight of processes, etc.)?
3. How frequently/strictly the NQTL is applied (e.g., frequency NQTL applied, penalties for NQTL, etc.)?
4. What evidence supports the rationale for how frequently/strictly the NQTL is applied?

Unless otherwise requested, data and information provided for the review should be associated with the following measurement period: January 1, 2024 – December 31, 2024. This template will be posted to the MHP folder on HSAG's secure file transfer protocol (FTP) site, SAFE, for each CCO and OHP FFS, as applicable.

MHP Data Submission Template

For the 2025 MHP Evaluation, CCOs and OHP FFS will be required to complete and submit the *MHP Data Submission Template*. This Microsoft Excel file will be used to collect the following data from each participating organization. In total, there are ten Excel tabs that apply to both CCOs and OHP FFS, and one Excel workbook that only applies to OHP FFS. Data collected through this document includes:

- Membership counts.
- Aggregate paid and denied claims counts for in- and out-of-network providers.
- Aggregated UM data including prior authorization, denial, and appeals counts.
- Member-level records associated with utilization decisions.
- Provider enrollment, credentialing, and termination counts.
- Provider-level records associated with provider enrollment, credentialing, and termination decisions.

All responses, data and information provided for the review should be associated with the following measurement period: January 1, 2024 – December 31, 2024. This template will be sent to all participating CCOs and OHP FFS via email, as well as posted to OHA's CCO Contract Forms Page (i.e., https://www.oregon.gov/oha/hsd/ohp/pages/cco-contract-forms.aspx).

OHP FFS Supplemental Data Requirements

Since OHP FFS does not participate in EQR activities, additional data will be required to support the 2025 MHP Evaluation beyond the *MHP Treatment Limitation Attestation Tool, the MHP Treatment Limitation Supplemental Questionnaire,* and the *MHP Data Submission Template*. Guidance for the extraction and submission of this data are provided in Appendix B and Appendix C of the 2025 MHP Protocol. The additional data sources include:

- OHP FFS Provider network data (see Appendix B)
- OHP FFS Member enrollment and demographic data (see Appendix B)
- OHP FFS Appointment Availability Questionnaire (see Appendix C)
- OHP FFS Member-level records of all grievances (OHP FFS Grievance Template)

HSAG FTP Site

All completed documents and supplemental documentation will be submitted to HSAG's secure FTP site accessed via the following web address: *https://safe.hsag.com/home*. Key individuals from each organization should already have access to the FTP site. However, please contact Emily Taylor, Project Coordinator at etyalor@hsag.com, or 602-301-2492 with questions about SAFE access.

Summary of All Documentation to Be Submitted

All documentation should be posted to HSAG's secure FTP site no later than **June 2, 2025**. At a minimum, CCOs and OHP FFS should upload the following documents:

- The completed *2025 **MHP Treatment Limitation Attestation Tool*** with supporting documentation as necessary to support continued compliance, or reported changes that could impact parity for MH/SUD and M/S benefits.
- The completed *2025 **MHP Treatment Limitation Supplemental Questionnaire***, when applicable, with narrative responses to demonstrate compliance with parity requirements.
- The completed *2025 **MHP Data Submission Template***.
- OHP FFS only – OHP FFS Appointment Availability Questionnaire
- OHP FFS only – Provider network data
- OHP FFS only – Member enrollment and demographic data
- OHP FFS only – Member-level records of all grievances

When submitting documentation and data to HSAG's SAFE site, please be sure to upload documents to the appropriate folder and notify HSAG when your submission is complete. When uploading documents, please be sure to limit the length of the filename of uploaded documents.

Appendix A. MHP Timeline

Table A-1 outlines the CY 2025 MHP activities and pertinent dates.

Table A-1—CY 2025 MHP Timeline

Task	Date
HSAG posts MHP materials to CCOs and OHP FFS	03/04/25
HSAG conducts 2025 MHP Technical Assistance webinar with CCOs/OHP FFS	03/12/25
OHA conducts Community Partner (CP) focus sessions	Spring 2025
CCOs/OHP FFS submit completed documentation to HSAG, including the: • MHP Treatment Limitation Attestation Tool • MHP Treatment Limitation Supplemental Questionnaire, as applicable • MHP Data Submission Template • OHP FFS – Appointment Availability Questionnaire • OHP FFS – Provider network data • OHP FFS – Member enrollment and demographic data • OHP FFS – Member-level records of all grievances	06/02/25
OHA compiles and submits formal feedback to HSAG from MHP CPs	06/13/25
HSAG performs desk review of CCO and OHP FFS documentation; prepares administrative profiles, and conducts NA evaluations	06/23/25 – 08/29/25
HSAG conducts follow-up interviews, as needed.	07/31/25 – 08/29/25
HSAG presents preliminary findings to CPs	10/06/25 – 11/07/25
HSAG prepares draft report and CCO/OHP FFS individual results appendices	09/02/25 – 11/10/25
HSAG submits MHP Evaluation Draft Report to OHA and individual results appendices to CCOs and OHP FFS	11/12/25
Receive feedback from OHA, CCOs, and OHP FFS	11/26/25
Incorporate feedback and prepare revised MHP Evaluation Final Report; submit to OHA	12/01/25 – 12/17/25
OHA publishes final 2025 MHP Evaluation Report; submits to the OR Legislature	12/31/25

Appendix B. OHP FFS Supplemental Data Guidance

In addition to the *MHP Treatment Limitation Attestation Tool, MHP Treatment Limitation Supplemental Questionnaire,* and *MHP Data Submission Template*, OHP FFS is required to submit four 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 member-level records of all grievances

OHP FFS Provider Network Data Requirements

To align with CCO provider capacity data, the following guidance is based on OHA's CY 2025 CCO DSN Provider Capacity Report instructions.[B-1] 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 during CY 2024, and was active as of May 1, 2025. 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 May 1, 2025. • Include all individual provider locations and specialties reported via relevant taxonomy codes. 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 May 1, 2025. • 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.

[1] The *DSN Provider Capacity Report Template and Instructions, CY 2025* is located on the CCO Contract Forms webpage: https://www.oregon.gov/oha/hsd/ohp/pages/cco-contract-forms.aspx. Accessed on: January 6, 2025.

Requirement	Specification
Extraction Date	• Extract data as of May 1, 2025. • All active and contracted MH and SUD providers based on the MH/SUD claims identified, summarized, and reported on the *Claims – Summary Count* tab (i.e., 2-ClmSum) on the *MHP Data Submission Template*. Please note this includes providers associated with final, fully adjudicated claims (paid and denied) as of **May 1, 2025**, with dates of service between **January 1, 2024, through December 31**, **2024**.
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 as 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

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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
SoloProv_Ind	Individual Provider's Solo Indicator	**Description:** *This data field indicates whether the Individual Provider is solo/sole proprietor.* **Format/Value***:* 1-digit alphabetic character / "Y" = Solo Provider, "N" = Not a Solo Provider	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.*** ***For providers with SoloProv_Ind=Y, report the non-individual provider (type 2) NPI associated with the solo practice. If the solo provider does not have an associated non-individual provider (type 2) NPI, report the individual provider (type 1) NPI in this field.*** **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. For providers with SoloProv_Ind=Y, the GrpName should be the name of the solo provider's business entity. If there is no separate business entity name, the full name of the provider should be entered.*** **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.* ***Note: For providers with SoloProv_Ind=Y, the GrpDMAP_ID can be the same as what is reported in the DMAP_ID column, however must match what is reported on the Facility section of the report.*** **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

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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. This includes the GrpNPI reported for Solo Providers. 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/Health care 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.* ***Note: For providers with SoloProv_Ind=Y on the individual section of the report, the FacilityName should be the name of the solo provider's business entity. If there is no separate business entity name, the full name of the provider should be entered.*** **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 Service Provider's Zip Code	**Description:** *This data field must be populated with the Facility/Clinic, or Business/Healthcare Service Provider's site location (ZIP).* **Format/Value:** 5- or 9-digit numeric value (e.g., 97301)/ valid ZIP Code	Yes

Data Field Name	Date Field Definition	Data Field Description	Required
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 **May 1, 2025**. The child welfare population should be excluded from this data file.

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 ≤ 05/01/2025 AND − Enrollment End Date ≥ 05/01/2025 OR Enrollment End Date is not populated if missing values indicate a member is still enrolled with OHP FFS when the data are extracted • Include members identified and listed on the Claims – Member-Level Detail tab (3-ClmMLD) in the *MHP Data Submission Template*. • 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®[2] format • Other file types as 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, 2025, and when the enrollment segment began and ended. Please only include the enrollment span covering May 1, 2025.

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 **May 1, 2025**, for all members included in the extracted member enrollment data (i.e., data defined in Table B-4). HSAG

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will use this information to geocode the member's residential address for use in geographic 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®[3] format • Other file types as 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

[3] SAS and all other SAS Institute Inc. product or service names are registered trademarks or trademarks of SAS Institute Inc. in the USA and other countries. ® indicates USA registration.

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 2024, including evidence of decision making in response to results.	
Documents submitted as evidence:	