**Oregon 2021 Mental Health Parity (MHP) Attestation Form**

**[Organization Name]**

## Attestation Overview and Instructions

The *2021 MHP Attestation Form* is a required attestation that allows coordinated care organizations (CCOs) and Oregon Health Plan (OHP) Fee-For-Service (FFS) to attest to continued parity of mental health (MH)/substance use disorder (SUD) and medical/surgical (M/S) benefits or provide information on changes to operations that may impact parity (e.g., changes to delegation arrangements or utilization management [UM] operations). In addition, the form allows an opportunity for the organization to document adjustments made in support of providing enhanced quality services for MH/SUD benefits for the purposes of sharing best practices across CCOs and OHP FFS. **Unless otherwise requested, information provided in this attestation should be associated with the specified reporting period (September 2, 2020 through May 31, 2021).**

## MHP Parity Questions

For Sections A through E, please either indicate “No” or provide a descriptive summary response. For questions that include a descriptive summary response from the organization, please attach supporting documentation to the attestation for review by HSAG.

### Section A: General Questions

**A-1.** Were any changes or additions made to delegated administrative functions to a new or an existing subcontractor (e.g., UM, provider admission, etc.)?

**A-2.** Were any changes made to the sources of medical guidelines or evidence used by the organization (e.g., HERC, ASAM, MCG, InterQual)?

### Section B: Utilization Management (IP, OP, and Rx)

**B-1.** Were any changes made to payment arrangements with some/all providers (e.g., FFS to sub-capitation, per diem to diagnostic-related grouping, reduction in payment levels to specific provider types or for specific benefits)?

B-2. Were any changes made to the organization’s prior authorization list(s) for MH/SUD or M/S benefits?

B-3. Were any changes made to the organization’s timelines for prior authorization requests for MH/SUD or M/S benefits?

B-4. Were any changes made to documentation requirements for UM requests for MH/SUD or M/S benefits (e.g., evidence of medical necessity, documentation submission requirements)?

B-5. Were any changes made to the qualifications for reviewers that can authorize or deny requests in organization’s policies and procedures rolled out to staff? How do staff access them?

B-6. Were any changes made to the method for monitoring consistency of medical necessity criteria application for MH/SUD or M/S benefits (e.g., standards for consistency of medical necessity criteria and inter-rater reliability processes)?

B-7. Were any changes or modifications made to penalties for failure to request/receive prior authorization for MH/SUD or M/S benefits (e.g., payment reductions and exceptions or waivers of penalties)?

B-8. Were any changes made to the frequency, time frames, or conditions of utilization review for MH/SUD or M/S benefits (e.g., RR or CR time frames or conditions)?

### Section C: Provider Admission Criteria (CCOs Only)

C-1. Were any changes made to network status from open (accepting new provider applications) to closed (not accepting new provider applications for certain provider types) or from closed to open?

C-2. Were any provider admission requirements (e.g., special training, education, experience) added, removed, or changed, including as a result of State licensing changes, for any MH/SUD or M/S providers?

C-3. Were any MH/SUD or M/S provider types that are eligible for credentialing/reimbursement for services removed from the organization’s network?

### Section D: Out-of-Network (OON)/Out-of-State (OOS) Limits

D-1. Were any processes changed for accessing OON/OOS coverage for MH/SUD or M/S benefits?

D-2. Were any standards changed for providing OON/OOS coverage for MH/SUD or M/S benefits?

## Enhanced Quality Services MH/SUD Information

E-1. Were any changes made to the organization’s processes that positively impact the delivery of MH/SUD services for Medicaid members?

## Organization Attestation Statement

Please review and select the following attestation statement that applies to the organization’s completed attestation responses. A qualified representative from the organization must be listed by name and working title, identifying the individual that completed the attestation form on behalf of the organization.

🞎 The organization attests that no changes have been made to the organization’s delegation arrangements; UM processes for IP, OP, or Rx; provider admission processes; or OON/OOS processes that would impact MHP during the reporting period of September 1, 2020 through May 31, 2021.

🞎 The organization attests that changes identified in this attestation have been made to the organization’s delegation arrangements; UM processes for IP, OP, or Rx; provider admission processes; or OON/OOS processes that may impact MHP during the reporting period of September 1, 2020 through May 31, 2021

This attestation was completed and submitted by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on \_\_\_\_\_\_\_\_\_\_\_\_, \_\_, 2021.