Oregon Health Authority

2023 Mental Health Parity Evaluation Protocol

March 2023

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) 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, 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.

Description of the Mental Health Parity Evaluation

OHA requires its CCOs and OHP FFS to undergo an annual MHP evaluation to ensure continued compliance with federal and state MHP requirements. In 2020, HSAG conducted a comprehensive evaluation of each CCO's and OHP FFS's benefit structures and processes to ensure that existing benefits and NQTLs remained compliant with MHP regulations. In 2021, HSAG conducted a targeted MHP

analysis focusing on adherence to utilization management for M/S and MH/SUD benefits and services. In 2022, HSAG conducted a review of each CCO's and OHP FFS's attestation to ensure continued compliance with parity requirements for MH/SUD and M/S benefits as well as completed a comprehensive review of claims and utilization management data. Additionally, the CY 2022 MHP evaluation included the development of parity-based network measures to support new reporting requirements outlined in HB 3046. This year, the analysis will include 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; a file review targeting service authorization denials and appeals to ensure accurate implementation of policies and procedures; and an evaluation of the adequacy of the provider network and timeliness of access to MH/SUD treatment and services.

MHP Approach

HSAG will conduct the MHP evaluation in alignment with guidance outlined in the toolkit provided by 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*[1-1]. HSAG will:

- Conduct a review of treatment limitations of OHA's 16 CCOs and OHP FFS on MH/SUD benefits to ensure they are comparable to and applied no more stringently than limitations applied to M/S benefits.
- Evaluate claims, utilization management data, and provider enrollment data.
- Conduct a review of a sample of CCO and OHP FFS service authorization denials and appeals encompassing both MH/SUD and M/S denials.
- Complete an evaluation of the adequacy of the provider network and timeliness of access to MH/SUD treatment and services.
- Prepare a statewide, aggregate report of findings, including individual results with respect to each CCO's and OHP FFS's performance, strengths, and opportunities for improvement or requiring corrective action.

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 2023 MHP evaluation and general guidelines for CCO and OHP FFS participation.

[1-1] The CMS *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs* and additional CMS resources related to MHP can be accessed at: https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/parity/index.html. Accessed on: January 27, 2023.

Table 1-1—List of CCOs and OHP FFS

MCE Name	Acronym
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	Health Share
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-Lane
PacificSource Community Solutions–Marion Polk	PCS-MP
Trillium Community Health Plan, Inc.–North	TCHP-North
Trillium Community Health Plan, Inc.–South	TCHP-South
Umpqua Health Alliance, LLC	UHA
Yamhill Community Care Organization	YCCO
Oregon Health Plan Fee-for-Service	OHP FFS

2. Methodology

Introduction

The following section describes the way HSAG will conduct the MHP analysis for the Oregon Medicaid managed care program and addresses the following objectives:

- Assessment of parity between treatment limitations applied to MH/SUD and M/S benefits.
- MHP evaluation activities and technical methods of data collection.
- Description of data obtained.
- Data aggregation and analysis.

HSAG will follow standardized processes in conducting the review of each CCO's and OHP FFS's performance.

Objective of Conducting the Mental Health Parity Evaluation

The primary objective of HSAG's review is to provide meaningful information to OHA, the CCOs, and OHP FFS regarding compliance with relevant State and federal requirements. HSAG will:

- Collaborate with OHA to determine the scope of the evaluation as well as the data collection methods, analytic and scoring methodology, and reporting requirements.
- Collect and review data and supporting documentation to support the evaluation.
- Aggregate and analyze the data and information collected.
- Prepare the findings report.

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

Scope of the 2023 MHP Analysis

In 2023, the MHP evaluation will include four components—i.e., comprehensive review of treatment limitations; administrative data profile; a file review of CCO and OHP FFS service authorization denials and appeals; and an assessment of the adequacy of the provider network and timeliness of access to MH/SUD treatment and services. Table 2-1 describes the performance areas included in this year's review (CY 2023).

Table 2-1—CY 2023 MHP Evaluation Category and Description

Evaluation Category	Description
Treatment Limitation Review	Requires the CCOs and OHP FFS to submit documentation to demonstrate compliance with MHP requirements including: • Description of the treatment limitations used to manage MH/SUD and M/S benefits, including the application of financial requirements, dollar limits, QTLs, and/or NQTLs for MH/SUD benefits. • Attestation that any financial requirements, dollar limits, and QTLs are compliant with State and federal MHP requirements. • Documentation supporting the implementation of NQTLs for MH/SUD and M/S benefits, including: – The rationale for use of the NQTL. – Processes and strategies used in applying the NQTL both as written and in operation. – Evidentiary standards used to determine NQTLs and determine medical necessity. – The frequency and stringency used to apply NQTLs. • Information on the dissemination of medical necessity criteria used to make MH/SUD benefit determinations to providers and, upon request, members and potential members.
Administrative Data Profile	Requires the CCOs and OHP FFS to submit summary statistics and member level detailed records (MLDs) associated with claims processing, utilization management (UM) decisions, and provider enrollment decisions during CY 2022. The assessment will include: • The number and percent of inpatient (IP) and outpatient (OP) claims: – Paid and denied for MH/SUD and M/S services. – Paid for MH/SUD and M/S services by in- and out-of-network providers. – A list of unique members associated with reported MH/SUD claims in CY 2022. • The number and percent of IP, OP, and pharmacy (Rx): – MH/SUD and M/S prior authorization requests. – MH/SUD and M/S prior authorization denials. – MH/SUD and M/S prior authorization requests for services below the funding line of the priority list. – MH/SUD and M/S appeals and outcome—i.e., upheld or overturned. – MH/SUD and M/S appeals resulting in a hearing and outcome—upheld or overturned. • Aggregated enrollment and credentialing data including the number and percent of: – MH/SUD and M/S enrolled providers.

Evaluation Category	Description
	– MH/SUD and M/S providers terminated or not recredentialed. – MH/SUD and M/S requests for enrollment/credentialing/recredentialing. – MH/SUD and M/S enrollment/credentialing/recredentialing decisions—i.e., approved or denied.
File Review	Requires the CCOs and OHP FFS to submit clinical/administrative records for service authorizations resulting in a Notice of Adverse Benefit Determination (NOABD) and member appeals. The assessment will include: • Assessing the compliance and consistency of the CCOs' and OHP FFS' implementation of policies and procedures across MH/SUD and M/S benefits • Assessing the timeliness of service authorization denials and member appeal decisions.
Adequacy of MH/SUD Provider Networks	Requires the CCOs and OHP FFS to submit data to evaluate the adequacy of the MH/SUD provider network, including grievance data, individual- and facility-level provider data, and methods for monitoring appointment availability. The assessment will include: • Documentation of appointment availability monitoring • Number and percent of access-related grievances for MH and SUD services. • Number of MH and SUD providers. • Provider-to-Enrollee[1] ratios for MH and SUD providers. • Average drive time and distance to the nearest MH and SUD provider, including the percentage of members[2-1] with access to MH/SUD providers within state-defined time and distance standards.

OHA and its community partners (CP), the CCOs, and OHP FFS will use the information and findings resulting from HSAG's review to:

- Evaluate the parity of MH/SUD and M/S services furnished to members.
- Identify, implement, and monitor interventions to improve MHP, where appropriate.

Mental Health Parity Activities and Technical Methods of Data Collection

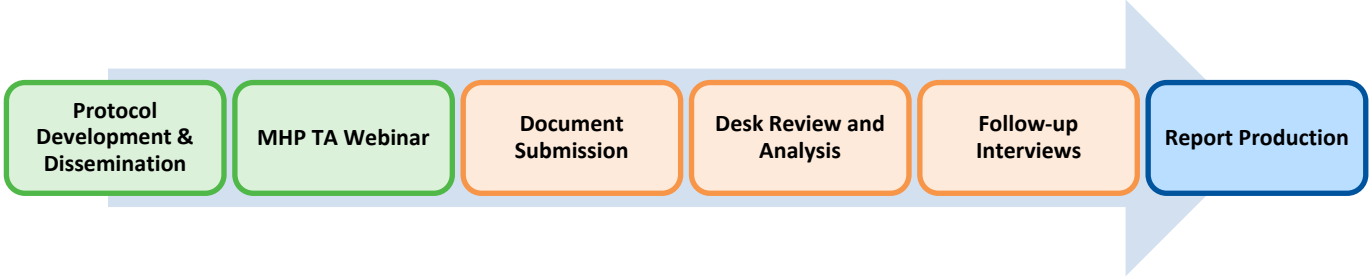
Before beginning the MHP evaluation, HSAG will develop data collection tools to document its review. The tools will be based on applicable federal and State regulations and laws, as well as the requirements

[2-1] Member-level data collected in the MHP Data Submission Template will used to ratio and time/distance analyses to members with a claim for MH/SUD services in CY 2022.

set forth in the contract between OHA and the CCOs. HSAG will follow the guidelines outlined in the toolkit provided by 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*.[2-2]

The key 2023 MHP Analysis activities are illustrated in Figure 2-1 and described below.

Figure 2-1—2023 MHP Analysis Activities



1. **Protocol Development and Dissemination:** HSAG has developed the 2023 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. HSAG also developed data collection tools to support information gathering on the treatment limitations used by each CCO and OHP FFS in the management of MH/SUD and M/S services, as well as the submission of claims, UM, and credentialing data.
   - **2023 MHP Treatment Limitation Review Tool**—Standardized questionnaire CCOs and OHP FFS use to submit documentation demonstrating compliance with MHP treatment limitations; collects information on the policies, procedures, and/or practices that impact MH/SUD and M/S parity.
   - **2023 MHP Data Submission Template**—Excel-based template CCOs and OHP FFS use to report data on inpatient, outpatient, and prescription drug claims and UM data, MH/SUD and M/S provider credentialing data, and member level detail files. The template is also used to collect grievance, appeals, and additional service authorization denial data for OHP FFS.
2. **MHP Technical Assistance (TA) Webinar:** HSAG will host a TA webinar on **March 17, 2023**, for CCOs and OHP FFS to review the MHP evaluation timeline, required documentation and submission guidelines, analysis, and reporting processes, and allow an opportunity for questions and answers.

[2-2] The CMS *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs* and additional CMS resources related to MHP can be accessed at: https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/parity/index.html. Accessed on: February 28, 2023.

3. **Document Submission:** The CCOs and OHP FFS will complete the *MHP Treatment Limitation Review Tool* 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 1, 2023**.[2-3]
4. **Desk Review and Analysis:** HSAG will conduct a desk review of each organization's documentation and data to evaluate parity between MH/SUD and M/S services and benefits. The desk review enables HSAG reviewers to increase their knowledge and understanding of each CCOs' and OHP FFS's operations, identify areas needing clarification, and begin compiling information needed to make a formal assessment. HSAG will perform an analysis of the claims, UM, and credentialing data to assess the impact of MH/SUD and M/S operations on claims and utilization decisions. Reported rates will be validated against MLD files and used to develop an administrative profile of each CCO and OHP FFS. This year, HSAG will perform a file review of MH/SUD and M/S service authorization denials and appeals to further understand UM decision details and their impact on parity. HSAG will also complete 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 MHP reporting.
5. **Follow-up Interviews:** HSAG will conduct follow-up interviews with organizations when desk review results or data analysis identified areas where additional information and/or clarification is required.
6. **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 community partners (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, 2023**.
7. **Corrective Action Plan and Implementation:** If a finding is documented for a CCO or OHP FFS, OHA will work with the CCOs and OHP FFS to address and resolve any findings identified during the 2022 MHP Evaluation.

[2-3] For CCOs, the clinical/administrative records required for the MHP file review will be submitted according to the CMR timeline on **March 6, 2023**; no MHP-specific submission is necessary. OHP FFS will submit its service authorization denial and appeal universe files to HSAG on, or before, **June 1, 2023,** from which HSAG will pull a sample of 10 cases, and 5 oversample, per file review type. Once the sample file is received, OHP FFS will have 30 days to submit the requested clinical/administrative records.

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, including, but not limited to:

- A completed *MHP Treatment Limitation Review Tool*, including identification of all NQTLs used by the organizations to manage MH/SUD and M/S benefits for IP, OP, Rx, and emergency care (EC) services and supplemental documentation.
- A completed *MHP Data Submission Template*, including:
  - Membership counts
  - Summary results for aggregated counts of claims, UM decisions, and provider enrollment and credentialing.
  - Detailed, member-level utilization data records.
- Clinical/administrative records for selected sample of service authorization denials and member appeals.[2-4]
- Documentation of the CCOs' and OHP FFS' appointment availability monitoring methodology and results.[2-5]
- CCO and OHP FFS grievance data.[2-6]
- MH/SUD provider capacity and member enrollment data.[2-7]

HSAG will obtain additional information for the MHP evaluation through interactions, discussions, and interviews with each CCO's and OHP FFS's key staff members, as necessary.

[2-4] For CCOs, HSAG will use file review data collected by HSAG for the 2023 Compliance Monitoring Review (CMR) activity; no additional data submission will be required. Since OHP FFS does not participate in the CMR activity, additional guidance on the collection and submission of service authorization data is presented in Appendix B. The OHP FFS program does not process appeals in the same manner as CCOs, instead, member requests to reconsider denials are managed through an informal conference prior to a state fair hearing. As such, member appeal records will not be reviewed for OHP FFS.
[2-5] For CCOs, HSAG will use responses from the 2023 DSN Narrative template to support the assessment of appointment availability monitoring; no additional data submission will be required. Since OHP FFS does not participate in the annual DSN evaluation, additional guidance on the collection appointment availability data is presented in Appendix B.
[2-6] 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 grievance data adequacy related data is presented in Appendix B.
[2-7] For CCOs, OHA will provide HSAG with provider data collected from the CCOs' quarterly DSN Provider Capacity reports to support the assessment of network adequacy measures; OHA will also provide HSAG with member enrollment and demographic data. As such, no additional data submissions will be required, except where noted in the 2023 MHP Data Submission Template. Since OHP FFS does not participate in the annual DSN evaluation, additional guidance on the collection and submission of grievance and network adequacy related data is presented in Appendix B.

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

Data Obtained	Time Period to Which the Data Applied
Responses submitted in organization's *MHP Treatment Limitation Review Tool* submitted for HSAG's desk review.	January 1, 2022 – December 31, 2022
Information obtained through follow-up interviews.	July 1, 2023 – August 31, 2023
Completed *Data Submission Template* submitted for HSAG's desk review, including: • Membership counts. • Aggregated paid and denied claims counts for in- and out-of-network providers. • Unique list of members associated with MH and SUD claims in CY 2022. • Aggregated UM data including prior authorization, denial, and appeals counts. • Member-level records associated with utilization decisions. • Provider enrollment and credentialing counts. • Member-level records associated with provider enrollment, credentialing, and termination decisions. • OHP FFS Only – member level records of all service authorization decisions resulting in an NOABD, excluding claim denials. • OHP FFS Only – member level records of all grievances.	January 1, 2022 – December 31, 2022
Clinical/administrative records associated with service authorization denials and member appeals.	January 1, 2022 – December 31, 2022
Appointment availability monitoring • For CCOs – responses to the *2023 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).	January 1, 2022 – December 31, 2022
CCO Grievance logs	January 1, 2022 – December 31, 2022

Data Obtained	Time Period to Which the Data Applied
CCO provider network data based on quarterly *DSN Provider Capacity* data submitted to, and provided by, OHA to HSAG.	January 1, 2022 – December 31, 2022
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, 2023
OHP FFS member enrollment and demographic data (see Appendix B).	As of May 1, 2023

Data Aggregation and Analysis

HSAG will generate both qualitative and quantitative results based on submitted documentation to assess parity during the 2023 MHP Evaluation.

MHP Treatment Limitation Review Tool Analysis

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 2-3, 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. A designation of not applicable (NA) will be used when a specific limitation classification on the review tool was inapplicable to a CCO or OHP FFS during the period covered by HSAG's review. This scoring methodology is in alignment with CMS' Parity Compliance Toolkit. HSAG will review all required documentation and any supportive documentation provided to further clarify identified limitations, as well as information available from the 2020, 2021, and 2022 MHP Analyses, as appropriate.

Table 2-3—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*.
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*.

From the ratings assigned to each of the limitations identified, HSAG will calculate a total compliance score for each applicable treatment limitation. 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.

The MHP scoring methodology is identified in Table 2-4.

Table 2-4—Example of Scoring Tool by Treatment Limitation Element

MHP Treatment Limitation Element	Compliance Determination	
	Rating	Score
Section 1: Financial Requirements		
Section 2: Aggregate Lifetime or Annual Dollar Limits		
Section 3: Quantitative Treatment Limits		
Section 4: Non-Quantitative Treatment Limits		
Section 5: Availability of Information		
Overall Compliance		

Administrative Data Profile

An administrative profile, or analysis, of each CCO's and OHP FFS's data is important to understanding the impact of CCO's and OHP FFS's policies and procedures on the management of MH/SUD and M/S benefits. HSAG will analyze data collected between January 1, 2022, and December 31, 2022, across three key domains. This data includes 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 representing 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 CCOs and OHP FFS, and statewide. 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. Additionally, to assess parity, HSAG 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 2-5, to indicate the degree to which CCO's and OHP FFS's reported profile metrics differed across MH/SUD and M/S services.

Table 2-5—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

As part of the 2023 MHP Evaluation, HSAG will assess the adequacy of the CCOs' and OHP FFS' MH/SUD provider by evaluating several interrelated measures of members' access to MH an SUD services.

Appointment Availability

HSAG will review the CCOs' responses to the 2023 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.

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 2-6, to indicate the degree to which CCO's and OHP FFS's reported profile metrics differed across MH/SUD and M/S services.

Table 2-6—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.

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 provider MH/SUD services to members. Using CCO data captured in OHA's quarterly 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
- Provider-to-Enrollee Ratios—the ratio of MH and SUD providers to members with at least one MH/SUD claim during the measurement year.

Time and Distance

As part of the evaluation of the adequacy of MH/SUD provider networks, HSAG will assess the geographic distribution of MH and SUD providers relative to member populations as represented by the percentage of members having access to a MH and SUD provider within the OHA-defined time and distance standards. These standards included the average travel time (in minutes) and driving distance (in miles) to the nearest three providers for each type of provider. To refine the time and distance measure, CCO and OHP FFS members will be limited to those report in the *MHP Data Submission Template* based on the MH/SUD claims identified in each organization's summary claim counts. Table 2-7 outlines OHA's time and distance standards.

Table 2-7—Time and Distance Standards

Geographic Classification	Definition	Time Standard	Distance Standard	Percentage of Overall Member Access Standard
Urban	A geographic area that is less than 10 map miles from a population center of 30,000 people or more.	30 Minutes	30 Miles	100%
Rural	A geographic area that is 10 or more map miles from a population center of 30,000 people or less.	60 Minutes	60 Miles	100%

HSAG will use Quest Analytics Suite software to calculate the duration of travel times and physical distances.

MHP Community Partner Input

In alignment with the requirements in HB 3046, OHA will continue meeting with three different community partner 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 community partner groups will be composed of OHP members, CCOs, and providers.

Discussions and feedback from the initial community partner meetings will be documented by OHA staff members and submitted to HSAG for review and inclusion in the 2023 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 community partner groups. OHA will then, in collaboration with its community partner 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, 2023. CCO- and OHP FFS-specific results will be incorporated as an addendum 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 2023, including the degree to which MCEs have effectively addressed recommendations made by the EQRO during the previous year's activities The ATR will be published on OHA's website.

3. Data Collection Tools and Submission

MHP Treatment Limitation Review Tool

The *2023 MHP Treatment Limitation Review Tool* is a required fillable Word document that allows CCOs and OHP FFS to identify all treatment limitations used by the organization to manage MH/SUD and M/S benefits for inpatient (IP), outpatient (OP), pharmacy (Rx), and emergency care (EC) services. Based on the findings from previous MHP Evaluations, the scope of data collected for financial requirements (FR), aggregate lifetime and annual dollar limits (AL/ADL), and quantitative treatment limitations (QTL) is limited. Each respective section (i.e., FR, AL/ADL, or QTL) will require documentation on (1) whether the treatment limitation is used by organization and applied to MH/SUD and/or M/S benefits, and (2) if used by the organization, whether the CCO and OHP FFS has assessed the application of treatment limitations for compliance with MHP regulatory standards.

Using the *MHP Treatment Limitation Review Tool*, CCOs and OHP FFS will identify all non-quantitative treatment limitations (NQTLs) used by your organization to manage MH/SUD and M/S benefits for IP, OP, Rx, and EC services. The most common NQTL types have been listed and arranged by category (i.e., medical management, provider network, and pharmacy management) within the tool. For each NQTL reported, the CCO must provide appropriate documentation (i.e., policies, procedures, processes, flow charts, etc.) 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 designated review period.

MHP Data Submission Template

For the 2023 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 nine Excel tabs that apply to both CCOs and OHP FFS, and two tabs that only apply to OHP FFS. Data collected through this document includes:

- Membership counts.
- Aggregate paid and denied claims counts for in- and out-of-network providers.

- Unique list of members associated with MH and SUD claims in CY 2022.
- Aggregated UM data including prior authorization, denial, and appeals counts.
- Member-level records associated with utilization decisions.
- Provider enrollment and credentialing counts.
- Member-level records associated with provider enrollment, credentialing, and termination decisions.
- OHP FFS Only – member level records of all service authorization decisions resulting in an NOABD, excluding claim denials.
- OHP FFS Only – member level records of all grievances.

Unless otherwise requested, data and information provided for the review should be associated with the following measurement period: January 1, 2022 – December 31, 2022. 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.

OHP FFS Supplemental Data Requirements

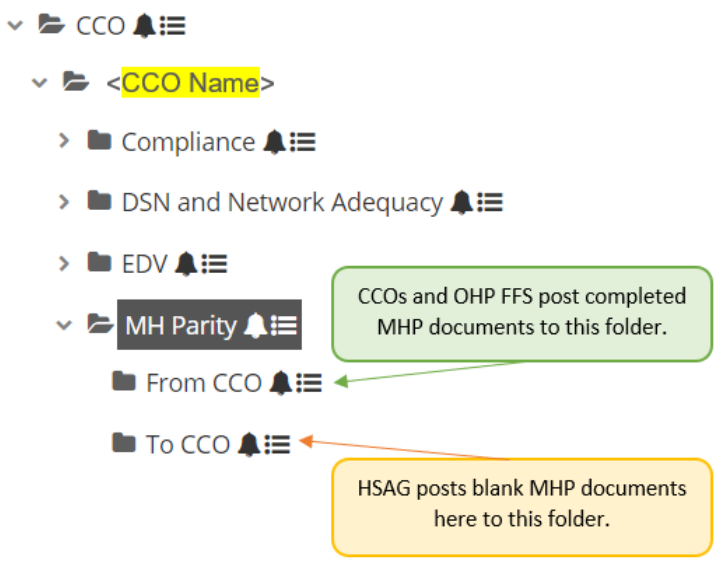
Since OHP FFS does not participate in EQR activities, additional data will be required to support the 2023 MHP Evaluation beyond the *MHP Treatment Limitation Review Tool* and *Data Submission Template*. Guidance for the extraction and submission of this data are provided in Appendix B and Appendix C of the 2023 MHP Protocol. The additional data sources include:

- OHP FFS Appointment Availability Questionnaire (see Appendix C)
- OHP FFS Provider network data (see Appendix B)
- OHP FFS member enrollment and demographic data (see Appendix B)

HSAG FTP Site

All completed documents and supplemental documentation 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 Stacy Wittkamper, Project Manager at swittkamper@hsag.com, or 602-801-6507 with questions about SAFE access. Figure 3-1 shows an example of the standard SAFE folder structure.

Figure 3-1—Sample Completed 2023 MHP Evaluation Tool



Summary of All Documentation to Be Submitted

All documentation should be posted to HSAG's secure FTP site no later than **June 1, 2023**. At a minimum, CCOs and OHP FFS should upload the following documents:

- The completed **2023 MHP Treatment Limitation Review Tool** with supporting documentation as necessary to support all NQTLs used by the organization to manage MH/SUD and M/S benefits for IP, OP, Rx, and EC services that may impact parity.
- The completed **2023 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

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 2023 MHP activities and pertinent dates.

Table A-1—CY 2023 MHP Timeline

Task	Date
HSAG posts MHP materials to CCOs and OHP FFS	03/01/23
CCOs submit CMR record review universe files to HSAG	03/06/23
HSAG conducts 2023 MHP Technical Assistance webinar with CCOs/OHP FFS	03/17/23
CCOs submit CMR record review files to HSAG	04/20/23
OHA conducts Community Partner focus sessions	*Spring 2023*
CCOs/OHP FFS submit completed documentation to HSAG, including the: MHP Treatment Limitation Review Tool MHP Data Submission Template OHP FFS Appointment Availability Questionnaire OHP FFS – Provider network data OHP FFS – Member enrollment and demographic data	06/01/23
HSAG selects and posts OHP FFS service authorization file review sample to SAFE	06/16/23
OHP FFS submits service authorization records to HSAG	07/21/23
OHA compiles and submits formal feedback to HSAG from MHP Community Partners	*06/16/23 – 06/23/23*
HSAG performs desk review of CCO and OHP FFS documentation	06/06/23 – 07/21/23
Conduct quantitative analysis of claims, coverage determinations, grievance/appeals, and provider enrollment	07/05/23 – 08/18/23
Conduct network adequacy evaluation	07/05/23 – 09/01/23
HSAG conducts follow-up interviews.	07/17/23 – 08/18/23
HSAG prepares preliminary findings	07/24/23 – 09/08/23
HSAG presents preliminary findings to Community Partners (CP)	09/18/23 – 09/29/23
OHA and CP finalize parity determinations; submit feedback to HSAG	10/02/23 – 10/22/23
HSAG prepares draft report and CCO/OHP FFS individual results appendices	09/05/23 – 10/30/23

Task	Date
HSAG submits MHP Analysis Draft Report to OHA and individual results appendices to CCOs and OHP FFS	10/31/23
Receive feedback from OHA, CCOs, and OHP FFS	11/15/23
Incorporate feedback and prepare revised MHP Analysis Final Report including 508 compliance; submit to OHA	11/16/23 – 12/02/23
OHA publishes final 2023 MHP Analysis Report; submits to the OR Legislature	12/31/23

Appendix B. OHP FFS Supplemental Data Guidance

In addition to *MHP Treatment Limitation Review Tool* and *MHP Data Submission Template*, OHP FFS is required to submit two 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 Provider Network Data Requirements

To align with CCO provider capacity data, the following guidance is based on OHA's CY 2023 Quarterly CCO DSN Provider Capacity Report specifications.[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 2022, and was active as of May 1, 2023. 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, 2023. • 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, 2023. • 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 providers.

[1] The *DSN Provider Capacity Report Template and Instructions, CY 2023* is located on the CCO Contract Forms webpage: https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx. Accessed on: January 27, 2023.

Requirement	Specification
Extraction Date	• Extract data as of May 1, 2023. • 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 final, paid MH/SUD claims processed as of May 1, 2023. – Paid, partially paid, and denied inpatient and outpatient claims.
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
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
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

Data Field Name	Date Field Definition	Data Field Description	Required
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
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
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

Data Field Name	Date Field Definition	Data Field Description	Required
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
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.*** **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

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
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 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 in a CCO as of June 30, 2022. 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 CCO 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 ≤ 05/01/2023 AND – Enrollment End Date ≥ 05/01/2023 OR Enrollment End Date is not populated if missing values indicate a member is still enrolled with the CCO 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.

Requirement	Description
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, 2023, and when the enrollment segment began and ended. Please only include the enrollment span covering May 1, 2023.

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

Field Name	Description	Type	Notes
MemID	Member's Medicaid identification number	Character	None
Plan	CCO in which a member was enrolled	Character	Values should align with CCO name acronyms shown on page 1 (e.g., AH, JCC, etc.)
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.

CCO Member Demographic Data

HSAG requests a data file listing the OHP FFS member's demographic information as of May 1, 2023, 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 geoaccess analyses. Additionally, HSAG requests the member's date of birth, gender, and date of death, to identify the appropriate members serviced by CCO providers from each provider category.

File Extract Specifications

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

[2] 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.

Table B-6—Member Demographic File Specifications

Requirement	Specification
Member	Include all members in the extracted CCO 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 CCO 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	None
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
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

[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
County	The full name of the county in which the member's residential address is located	Character	Example: "CLACKAMAS"
Urbanicity	The urbanicity of the member's residential location	Character	Example: "Urban"
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 2022, including evidence of decision making in response to results.	
Documents submitted as evidence:	