Oregon Health Authority

2024 Mental Health Parity Evaluation Summary Report

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HSAG HEALTH SERVICES ADVISORY GROUP

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1. Introduction

Background

Mental Health Parity (MHP) regulations are intended to ensure that coverage and access to services for the treatment of mental health (MH) and substance use disorder (SUD) conditions are provided in parity with treatments provided for medical and surgical (M/S) conditions. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) governs how MH/SUD treatments delivered by managed care organizations and limitations on MH/SUD benefits must be comparable to and applied no more stringently than the limitations applied to M/S benefits. Provisions of the MHPAEA became applicable to Oregon Health Plan (OHP) in October 2017 when the Medicaid Parity Final Rule (Title 42 of the Code of Federal Regulations [42 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 federal and State requirements, the Oregon Health Authority (OHA) contracted with its external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG), 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.

The 2024 analysis included a review of treatment limitations used by the CCOs and OHP FFS to manage the administration of MH/SUD and M/S benefits, a review of claims and utilization management (UM) data to identify key patterns and outcomes associated with the administration of covered benefits, an evaluation of the adequacy of the provider network and timeliness of access to MH/SUD treatment and services, and the results of OHA's targeted analysis of the utilization and timeliness of payment of peer support services (PSS) by and across CCOs and OHP FFS. The 2024

MHP Analysis and report were designed to assess and document parity across MH/SUD and M/S benefits for participating CCOs and OHP FFS.

Table 1-1 describes the organizations evaluated in the 2024 MHP Analysis and the associated organization abbreviations.

Table 1-1—List of Organization Names and Abbreviations

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

Objectives

The primary objectives of the MHP activity were 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 and OHP FFS' 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 CPs.
- Identify potential areas of interest from CPs to inform the scope of the 2025 MHP activity.
- Prepare a comprehensive report inclusive of all 2024 MHP activity findings and input from CPs for OHA to submit to the Oregon Legislative Assembly as required by HB 3046.

2. Process and Methodology

The 2024 MHP Evaluation assessed the extent to which coverage and access to services for the treatment of MH/SUD conditions were provided in parity with treatments provided for M/S conditions. The evaluation included a review of reported and documented changes to organizational policies and procedures governing the implementation of treatment limitations applied to MH/SUD and M/S services, as well as the actions taken by the CCOs and OHP FFS to resolve findings and recommendations to demonstrate compliance with parity requirements. Differences in how limits were applied to MH/SUD services as compared to M/S services were evaluated for continued compliance with MHP regulations to ensure evidence-based, quality MH/SUD care.

Technical Methods of Data Collection

The 2024 MHP activities are described below.

1. **Protocol Development and Dissemination:** HSAG developed the 2024 MHP Evaluation Protocol, which presented details and guidance to OHA, the CCOs, and the OHP FFS on the process for conducting the 2024 MHP activity. 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*.[1]
    - **2024 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.
    - **2024 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 2023; collects supplemental documentation and information to demonstrate compliance with parity requirements.
    - **2024 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. The template is also used to collect grievance data for OHP FFS.

[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: Oct 31, 2024.

2. **MHP Technical Assistance Webinar:** HSAG conducted a webinar with the CCOs and OHP FFS on March 14, 2024. The webinar provided an overview of MHP regulations; details of the 2024 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 produced a Frequently Asked Questions document to provide clarification to the CCOs and OHP FFS on any questions received during and after the webinar.
3. **Documentation Submission:** The CCOs and OHP FFS were required to submit the *MHP Treatment Limitation Attestation Tool*, the *MHP Treatment Limitation Supplemental Questionnaire*, as applicable, and all relevant supporting documentation, as well as submit claims, UM, and credentialing data through the *MHP Data Submission Template*. All requested data was due for submission on or before June 3, 2024.
4. **Desk Review and Analysis:** HSAG conducted a desk review of each CCO's and OHP FFS' submitted documentation and data to evaluate parity between MH/SUD and M/S services and benefits. HSAG performed 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 were validated against member level detail (MLD) files and used to develop an administrative profile of each CCO and OHP FFS. HSAG also performed 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 incorporated a multi-dimensional approach using a series of measures to support network reporting. Finally, in 2024, HSAG incorporated results from OHA's targeted evaluation assessing utilization of PSS by and across the CCOs and OHP FFS, as well as an analysis of the timeliness of payment for these services. When necessary, HSAG followed up with the CCOs, OHP FFS, or OHA to obtain missing documentation, or receive clarification on submissions.
5. **Report Production:** HSAG compiled the preliminary results from all information obtained for each CCO and OHP FFS. Per HB 3046, HSAG summarized the results of its review and presented the findings to OHA and its CPs to solicit input on the assessment of the CCOs' and OHP FFS' compliance with the requirement for parity between MH/SUD and M/S covered benefits, identifying areas in which MHP was not achieved and corrective actions were required to ensure future parity. HSAG received feedback from OHA and its CPs and drafted a final MHP Evaluation report for submission to OHA and the Oregon Legislature, no later than December 31, 2024.
6. **Corrective Action Plan and Implementation:** When 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 CCOs' and OHP FFS' compliance with the federal, State, and contract requirements for parity between the MH/SUD and M/S covered benefits, HSAG obtained information from multiple documents and sources completed and submitted by each organization, including, but not limited to:

- A completed *MHP Treatment Limitation Attestation Tool*, including narrative responses to all applicable questions and supplemental documentation.
- A completed *MHP Treatment Limitation Supplemental Questionnaire*, as applicable, including narrative responses and supplemental documentation to demonstrate compliance with parity requirements.
- A completed *MHP Data Submission Template*, including:
  - Membership counts.
  - Summary results for aggregated counts of claims/encounters, UM decisions, and provider enrollment/credentialing and terminations.
  - Detailed, member-level utilization decision data.
  - Detailed, provider-level enrollment/credentialing and termination decision data.
- MH/SUD provider capacity and member enrollment data.
- Appointment availability results and updated monitoring methodology.
  - For CCOs—results from the *CY 2023 Revealed Behavioral Health Telephone Survey Report*.
  - For OHP FFS—responses to appointment availability questions outlined in the *OHP FFS Appointment Availability Questionnaire*.
- CCO and OHP FFS grievance data.
- Results from OHA's analysis of the CCOs' and OHP FFS' PSS utilization and timeliness of payment data.

HSAG obtained additional information for the MHP Evaluation through interactions, discussions, and interviews with the CCO's and OHP FFS' key staff members, as necessary. Furthermore, OHA convened meetings with three groups of CPs (i.e., consumers, CCOs, and providers) to solicit community input on the MHP Evaluation and future studies. Feedback from these meetings was submitted to HSAG to integrate in this report.

How Data Were Aggregated and Analyzed

HSAG generated both qualitative and quantitative results based on submitted documentation in order to assess parity in the 2024 MHP Evaluation.

MHP Treatment Limitation Review

For its review of the *MHP Treatment Limitation Attestation Tool*, HSAG assessed each CCO's and OHP FFS' 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 used the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant*, as defined in Table 2-1, to indicate the degree to which changes identified by the CCOs and OHP FFS 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*) was used when a CCO or OHP FFS was *Partially Compliant* or *Not Compliant* with an element in 2023 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 assessed each CCO's and OHP FFS' 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 2023.
- 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 used the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant,* as defined in Table 2-1, to indicate the degree to which each CCO's and OHP FFS' performance were 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 aligned with CMS' *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance*

Programs.[2] HSAG reviewed all submitted documentation to further clarify identified limitations, as well as information available from prior MHP analyses, as appropriate.

Table 2-1—Rating Definitions for MHP Compliance Determinations

Rating	Definition
Compliant	Indicates that the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency*.
Partially Compliant	Indicates that the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was: • *Comparable* but were applied with different *stringency, or* • Not *comparable* but were applied with equivalent *stringency*. OR • Documentation was incomplete (i.e., one or more evaluation elements were not addressed), but organizational structure was identified.
Not Compliant	Indicates that the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was not *comparable* and applied with different *stringency*. If documentation and evidence were 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 calculated a total compliance score for each applicable attestation and questionnaire element. HSAG calculated the total score for each organization by totaling the number of *Compliant* (1 point) elements, the number of *Partially Compliant* (0.5 points) elements, and the number of *Not Compliant* (0 points) elements. Elements *Not Applicable* to the organization are scored *NA* and not included in the total score.

Administrative Data Profile

To further understand the impact of CCO and OHP FFS policies and procedures on the management of MH/SUD and M/S benefits, HSAG analyzed CCO and OHP FFS data collected between January 1, 2023, and December 31, 2023, across three key domains. The data included 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 reviewed all submitted data for consistency and conducted a comparative analysis to identify trends between MH/SUD and M/S services, between CCOs and OHP FFS, and statewide. Data collected to

[2] Ibid.

support the Administrative Data Profiles included services covered through four OHP benefit packages (i.e., CCOA, CCOB, CCOE, and CCOB).[3]

Although descriptive, the Administrative Data Profile was used to observe key patterns and outcomes associated with the administration of MH/SUD and M/S covered benefits. To further assess parity, HSAG evaluated the extent to which key claims/encounter and UM metrics differed between MH/SUD and M/S services. HSAG used deviation ratings of *None*, *Moderate*, and *Substantial*, as defined in Table 2-2, to indicate the degree to which each CCO's and OHP FFS' reported profile metrics differed across MH/SUD and M/S services.

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

Deviation Rating	Definition
None	Difference between MH/SUD and M/S profile metric is **less than** 5 percentage points.
Moderate	Difference between MH/SUD and M/S profile metric is: • **greater than or equal** to 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 2024 MHP Evaluation assessed the adequacy of the CCOs' and OHP FFS' MH/SUD provider networks by evaluating several interrelated measures of members' access to MH and SUD services.

Provider Network Capacity

HSAG conducted a review of the CCOs' and OHP FFS' provider network data files and synthesized the results to understand the provider network infrastructure in place to provide MH and SUD services to members. Using CCO data captured in OHA's semiannual *Delivery System Network (DSN) Provider Capacity Reports* and OHP FFS' MHP submission, HSAG aggregated the data and reported two core metrics:

- Provider Counts—The number and percentage of MH and SUD providers.
- Provider-to-Member Ratios—the ratio of MH and SUD providers to members with at least one MH/SUD claim during the measurement year.

[3] 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).

Time and Distance

HSAG assessed the geographic distribution of MH and SUD providers relative to member populations as represented by the percentage of members having access to an MH or SUD provider within the acceptable travel times and distances defined by OHA. These requirements included the average travel time (in minutes) and driving distance (in miles) to the nearest provider for each provider type. To refine the time and distance measures, CCO and OHP FFS members were limited to members with an MH and/or SUD diagnosis as reported in the *2024 MHP Data Submission Template* based on submitted MH/SUD claims. A threshold of 95 percent of members within the acceptable travel times and distances was used to identify CCOs and OHP FFS with adequate access within given urbanicities.[4] Table 2-3 outlines the acceptable travel times and distances by provider type and urbanicity.[5]

Table 2-3—Time and Distance Standards by Provider Type and Urbanicity

Urbanicity Classification	Definition	Network Tier	Acceptable Time	Acceptable 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
Counties with Extreme Access Considerations (CEAC)	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

[4] Although OHA has established time and distance standards, CCO compliance is not assessed as part of this evaluation. OHA assesses CCO compliance to time and distance standards based on adult and pediatric provider types comprising three tiers; 95 percent or more pediatric and adult members must meet the acceptable travel times and distances to the nearest adult and pediatric provider, regardless of urbanicity.

[5] OHA's acceptable travel times and distances include a third tier (i.e., Tier 3) of specialty providers, including Allergy & Immunology, Dermatology, Endocrinology, Gastroenterology, Hematology, Nephrology, Otolaryngology, Pulmonology, Rheumatology, Skilled Nursing Facility, and Urology providers. Tier 3 is excluded from the 2024 MHP Evaluation since no MH or SUD provider types are included in that tier.

Table 2-4 presents the provider types and facility types by network tier included in the evaluation of the adequacy of MH/SUD provider networks.

Table 2-4—MH and SUD Provider and Facility Type by Network Tier

Network Tier	Provider Type	Facility Type
Tier 1	Mental Health Provider (MHP), Adult and Pediatric Substance Use Disorder Provider (SUD), Adult and Pediatric	N/A
Tier 2	Psychiatry (PSYC), Adult and Pediatric	Methadone Clinic (MTDC)

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

Appointment Availability

HSAG incorporated results from OHA's *CY 2023 Revealed Behavioral Health Telephone Survey Report* highlighting appointment availability for CCO members for OP behavioral health (BH) 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 members to obtain both urgent and non-urgent appointments within established time frames.

HSAG used the CCOs' Delivery System Network (DSN) provider capacity data file (Quarter 1 [Q1], 2023) submitted to OHA by May 15, 2023, to develop the random sample of OP BH locations to be surveyed. Upon receipt of the aggregated network provider data from OHA, HSAG reviewed key data fields to assess potential duplication and completeness. HSAG collaborated with OHA to determine geographic restrictions and used the criteria noted in Table 2-5 to identify OP MH providers for the CCOs.

Table 2-5—BH Provider Identification Criteria

Display Name	Taxonomy Code
Counselor	101Y00000X
Mental health counselor	101YM0800X
Professional counselor	101YP2500X
Marriage and family therapist	106H00000X
Psychoanalyst	102L00000X
Clinical social worker	1041C0700X
Adolescent and children mental health clinic/center	261QM0855X
Adult mental health clinic/center	261QM0850X
Mental health clinic/center (including community mental health center)	261QM0801X

Once a list of providers was identified, HSAG selected a random sample of MH services locations where providers were accepting new patients (deduplicated to reduce repeat phone calls), and interviewers were instructed not to schedule actual appointments. Interviewers contacted each telephone number ("case"), abstracting data into a web-based data collection tool.

Callers made two attempts to contact each survey case during standard business hours (i.e., 9 a.m.to 5 p.m. Pacific Daylight Time). If put on hold at any point during the call, the caller waited on hold for five minutes before ending the call. If a call attempt was answered by an answering service or voicemail during normal business hours, the caller made a second call attempt on a different day and at a different time of day. A survey case was considered nonresponsive for the following outcomes:

- Disconnected/invalid telephone number (e.g., the telephone number in the CCO's data file connected to a fax line or a message that the number was no longer in service).
- Telephone number connected to an individual or business unrelated to a medical practice or facility.
- The caller was unable to speak with office personnel during either call attempt (e.g., the call went to voicemail or an answering service that prevented the interviewer from speaking with office staff members).

HSAG's evaluation also included 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 qualitatively assessed 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 reviewed and assessed 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 was used to observe patterns that may be associated with the adequacy of MH/SUD and M/S provider networks. Additionally, to assess parity, HSAG evaluated the extent to which the grievance metrics differed between MH/SUD and M/S services. HSAG used deviation ratings of *None*, *Moderate*, and *Substantial*, as defined in Table 2-6, to indicate the degree to which the CCO's and OHP FFS' reported grievance 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 profile metric is **less than** 5 percentage points.
Moderate	Difference between MH/SUD and M/S profile metric is: • **greater than or equal** to 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.

Special Topic Evaluation—Peer Support Services

In 2023, OHA worked with the community partners (CPs) to identify and select a topic for a targeted evaluation of an MH/SUD parity-related area of interest and/or concern. Based on the results of OHA's ranked choice survey of CP members in November 2023, OHA determined that the 2024 MHP Evaluation special topic would target the utilization of PSS across the CCOs and OHP FFS as well as the timeliness of payment for the service.

As a baseline year, the primary objective of the special topic evaluation was to understand the utilization of PSS by members with MH and/or SUD diagnoses by addressing the following questions:

- Were there differences in rates of PSS utilization across counties and CCOs?
- Were there differences in the timeliness of payments for PSS across counties and CCOs?
- Were there differences in the percentages of paid MH and SUD PSS claims across counties and CCOs?

OHA extracted paid and denied claims in June 2024 for peer services (Healthcare Common Procedure Coding System [HCPCS] = H0038, or self-help/peer services per 15 minutes) with dates of service between January 1, 2023, and December 31, 2023, for members with a primary diagnosis of MH or SUD.[6] Data were extracted and aggregated, by county and organization (i.e., 16 CCOs and OHP FFS), to support the derivation of three metrics:

- Utilization of PSS per 1,000 member months (MM)
- Percentage of paid PSS claims
- Timeliness of payment for PSS claims

HSAG used the aggregate data to present findings and address the evaluation objectives. The results from this review establish a baseline measurement and will be used to direct future deep dive investigations.

MHP Community Partner Input

In alignment with the requirements in HB 3046, OHA initiated meetings with three 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 were composed of OHP members, CCOs, and providers and were initially convened in April of 2024. In the fall, OHA organized a new CP group that included members from OHA's BH Policy team and community advocates, including the National Alliance on Mental Illness (NAMI). The CP group participated in the fall meeting to review findings

[6] MH and SUD diagnoses were based on ICD-10 classifications: MH = F01-F09 and F20-F99 | SUD = F10-F19.

and discuss conclusions and will be included in future biannual meetings. These discussion-oriented meetings served three key objectives:

1. Inform CPs of the 2024 MHP Analysis and scope of review.
2. Solicit input on MHP areas of concern.
3. Receive feedback on current and future study objectives, future evaluation topics, and potential methods.

Discussions and feedback from the initial CP meetings were documented by OHA staff members and submitted to HSAG for review and inclusion in this report. A summary of these discussions is contained in Appendix R. MHP Community Partner Feedback.

Once findings were formulated and scoring was applied (where applicable), the review was finalized, and preliminary findings were presented to OHA and the CP groups. During these meetings, OHA and HSAG presented:

- Evaluation results from the 2024 MHP Evaluation, including a summary of findings from the Treatment Limitation Review, Administrative Data Profile, evaluation of the adequacy of the provider networks and timeliness of access to MH/SUD treatment and services, and OHA's targeted evaluation of PSS utilization and the timeliness of payment for these services.
- Conclusions drawn from the CCO and OHP FFS findings.
- Recommendations for methodology changes in future MHP evaluations.

Table 2-7 contains a list of CP groups and meeting dates in 2024. OHA coordinated meetings in fall 2024 to review preliminary findings and discuss special evaluation topics for inclusion in the 2025 MHP Evaluation. The CCO partners received preliminary copies of their MHP findings in November 2024, and were provided an opportunity to review the results and submit written feedback.

Table 2-7—MHP CP Groups and Meeting Dates

CP Group	Initial Meeting	Closing Meeting(s)
Consumers	04/10/2024	10/09/2024
CCOs	04/23/2024	11/07/2024
Providers	04/04/2024	10/09/2024
BH Policy Advocates	—	11/07/2024

Reporting

Once feedback from OHA and the CP groups was received, all analyses, conclusions, and recommendations were synthesized to produce a statewide draft report summarizing the findings and identifying strengths, opportunities for improvement, and required actions, as appropriate. OHA and the CCOs then had an opportunity to review the draft report and provide feedback. CCO- and OHP FFS-specific results are incorporated as appendices to the report.

3. Results

This section contains the results from the 2024 MHP Evaluation and includes the qualitative and quantitative findings associated with the *MHP Treatment Limitation Attestation Tool*, *MHP Treatment Limitation Supplemental Questionnaire*, *MHP Administrative Data Profile*, the assessment of the adequacy of the provider networks and timeliness of access to MH/SUD treatment and services, and OHA's targeted evaluation of PSS utilization and timeliness of payment for these services. Together, these analyses evaluated the extent to which there was parity in the administration of MH/SUD benefits and M/S benefits by the CCOs and OHP FFS.

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the CCOs and OHP FFS to manage the administration of MH/SUD and M/S covered benefits. Four types of treatment limitations were evaluated across IP, OP, Rx, and emergency care (EC) services:

- FRs—payments by members for services received that are in addition to payments made by the CCO (e.g., copayments and deductibles).
- AL/ADLs—dollar limits on the total amount of a specified benefit over a lifetime or on an annual basis.
- QTLs—limits[7] on the scope or duration of a benefit that are expressed numerically (e.g., days or visit limits).
- NQTLs—limits on the scope or duration of benefits, such as PA or network admission standards. NQTLs were separated into three main categories—i.e., Medical Management, Provider Network, and Pharmacy Management.

HSAG's evaluation of the CCOs' and OHP FFS' responses to the *MHP Treatment Limitation Attestation Tool*, along with supplemental documentation (e.g., policies, procedures, processes, and workflows), indicated whether changes to existing processes, policies, or procedures for managing MH/SUD and M/S benefits were compliant with MHP requirements. If a CCO or OHP FFS was compliant with MHP requirements previously, the organization either attested that no changes were implemented within the organization, or reported on any changes to its operations that may have affected parity. Based on the CCOs' and OHP FFS' responses, there were no changes to the use of FRs, AL/ADLs, and QTLs as these treatment limitations continued to be not applicable in alignment with the regulatory structure of the Oregon Medicaid program. The *MHP Treatment Limitation Supplemental Questionnaire* was utilized by organizations to address 2023 findings that were less than *Compliant*. Of the 10 organizations that received *Partially Compliant* and *Not Compliant* findings in 2023 related to NQTLs, eight were able to provide additional documentation to support parity and resolve findings. The

[7] Soft limits, or benefit limits that allow an individual to exceed numerical limits for MH/SUD or M/S benefits on the basis of medical necessity, are considered NQTLs.

two remaining organizations (HSO and OHP FFS) continued to demonstrate insufficient oversight of subcontractors and vendors to ensure parity in the administration of NQTLs for MH/SUD and M/S benefits. Three CCOs (TCHP-SW, TCHP-TC, and YCCO) attested to the absence of operational changes to existing processes, policies, or procedures that were previously found to support the parity of MH/SUD and M/S benefits. Overall, documentation demonstrated the CCOs maintained standardized processes to support the management of NQTLs across benefit types.

Detailed results and findings for individual CCOs and OHP FFS are available in Appendix A through Appendix Q.

Financial Requirements

Neither the CCOs nor OHP FFS reported changes to the use of FRs in the administration of MH/SUD or M/S benefits across IP, OP, Rx, or EC services.

Aggregate Lifetime and Annual Dollar Limits

Neither the CCOs nor OHP FFS reported changes to the use of AL or ADL in the administration of MH/SUD or M/S benefits across IP, OP, Rx, or EC services.

Quantitative Treatment Limitations

Nearly all CCOs reported no changes to the use of QTLs in the administration of MH/SUD or M/S benefits across IP, OP, Rx, or EC services. However, one CCO (IHN) reported implementing changes to its management of MH/SUD or M/S benefits using QTLs. Specifically, IHN reported it removed its PA requirement for the first 30 occupational/physical therapy/speech therapy visits, as well as 76 presumptive and 24 definitive urine drug tests. Upon review, HSAG confirmed IHN's QTLs represented soft limits and should have been categorized as NQTLs since IHN allowed members to receive additional services beyond the quantity limit based on an approved PA. As such, none of the CCOs or OHP FFS reported the use of QTLs in the administration of MH/SUD or M/S benefits across IP, OP, Rx, or EC services.

Non-Quantitative Treatment Limitations

Since the regulatory structure of Medicaid and OHP makes the implementation of FRs, AL/ADLs, and QTLs unlikely, NQTLs represent a key mechanism used by the CCOs and OHP FFS to manage and ensure members' health care is necessary and appropriate. To facilitate the review of the changes to NQTLs implemented by the CCOs and OHP FFS, the *MHP Treatment Limitation Attestation Tool* included questions pertaining to the CCOs' organizational structure and three domains—i.e., Medical Management, Provider Network, and Pharmacy Management. Overall, 10 of the 17 organizations noted changes in their organizational structures, of which, the most prevalent changes were related to subcontractors or the delegation of managed care functions to existing subcontractors, including updates to medical guidelines. However, none of the changes implemented by the CCOs and OHP FFS affected parity and highlighted continued compliance with MHP requirements.

To assist in HSAG's review of NQTLs receiving *Partially Compliant* or *Not Compliant* ratings in 2023, the *MHP Treatment Limitation Supplemental Questionnaire* required the organizations to describe actions taken to resolve findings and, when appropriate, provide documentation that addressed 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?

Table 3-1 highlights the overall ratings of compliance with parity requirements for the CCOs and OHP FFS for NQTLs, by domain and overall.

Table 3-1—Compliance With Parity Requirements by CCO/OHP FFS by NQTL Domain and Overall

Organization Name	Medical Management	Provider Network	Pharmacy Management	Overall Compliance Rating
AH	Compliant	Compliant	Compliant	**Compliant**
AllCare	Compliant	Compliant	Compliant	**Compliant**
CHA	Compliant	Compliant	Compliant	**Compliant**
CPCCO	Compliant	Compliant	Compliant	**Compliant**
EOCCO	Compliant	Compliant	Compliant	**Compliant**
HSO	Compliant	Compliant	Partially Compliant	**Partially Compliant**
IHN	Compliant	Compliant	Compliant	**Compliant**
JCC	Compliant	Compliant	Compliant	**Compliant**
PCS-CO	Compliant	Compliant	Compliant	**Compliant**
PCS-CG	Compliant	Compliant	Compliant	**Compliant**
PCS-LN	Compliant	Compliant	Compliant	**Compliant**
PCS-MP	Compliant	Compliant	Compliant	**Compliant**
TCHP-SW	Compliant	Compliant	Compliant	**Compliant**
TCHP-TC	Compliant	Compliant	Compliant	**Compliant**
UHA	Compliant	Compliant	Compliant	**Compliant**
YCCO	Compliant	Compliant	Compliant	**Compliant**
OHP FFS	Partially Compliant	Partially Compliant	Partially Compliant	**Partially Compliant**

Compliant—indicates the CCO/OHP FFS NQTL processes, strategies, evidentiary standards, and other factors were in alignment with parity requirements.
Partially Compliant—indicates the CCO/OHP FFS NQTL was either comparable or applied with similar stringency, but not both, or due to insufficient information or clear evidence of parity associated with implemented NQTLs.
Not Compliant—indicates the CCO/OHP FFS organizational structure did not meet comparability or stringency criteria, or no documentation was submitted to evaluate the consistency and stringency of NQTLs.

Medical Management

The most changes reported by the CCOs (i.e., AH, AllCare, CHA, IHN, and PCS) were related to Medical Management NQTLs which included UM processes (i.e., PA, concurrent review [CR], and retrospective review [RR]). These changes most often included removing PA requirements, implementing oversight processes, and aligning processes with State regulations or guidelines. Documentation continued to demonstrate compliance and confirm the CCOs have established standardized processes to support the implementation of MH/SUD and M/S benefits.

The CCOs (i.e., AH, AllCare, EOCCO, and HSO) that completed the *MHP Treatment Limitation Supplemental Questionnaire* to address 2023 Medical Management NQTL findings in 2023 provided sufficient documentation to demonstrate compliance with MHP requirements for the administration of MH/SUD and M/S benefits. However, OHP FFS continued to demonstrate a lack of oversight and monitoring of Medical Management NQTLs to ensure they are comparable and applied no more stringently for MH/SUD benefits compared to M/S benefits, resulting in a *Not Compliant* parity rating for UM processes (i.e., PA and CR). This finding was due largely to the lack of supporting documentation (e.g., policies, procedures, standard operating procedures, workflows) governing the work of OHP FFS subcontractors and vendors. OHP FFS received the rating of *Partially Compliant* for medical necessity criteria and practice guideline selection/criteria NQTLs, as documentation addressed M/S services only and was not sufficient to determine whether the processes, strategies, and evidentiary standards used in administering MH/SUD benefits were comparable to the processes, strategies, and evidentiary standards used in administering M/S benefits.

Provider Network

The CCOs reported the least number of changes for Provider Network NQTLs. Neither the CCOs nor OHP FFS reported changes to the use of geographic restrictions or limitations in the administration of MH/SUD or M/S benefits. One CCO (CHA) implemented changes to provider enrollment and credentialing that included eliminating the delegation of credentialing functions, and four CCOs (AH, CHA, CPCCO, and JCC) implemented changes to provider reimbursement rates that increased payment rates for BH services to align with OHA guidance and advance Medicaid program goals and priorities. None of the changes resulted in MH/SUD benefits being applied more restrictively than M/S benefits.

In general, the 2023 MHP Evaluation resulted in few *Partially Compliant* or *Not Compliant* ratings for Provider Network NQTLs (i.e., provider enrollment and credentialing, reimbursement rates, and geographic restrictions or limitations). HSO was able to resolve its finding by clarifying that its subcontractors did not use geographic network restrictions to manage MH/SUD and M/S benefits. OHP FFS also sufficiently addressed geographic limitations through its responses to the *MHP Treatment Limitation Supplemental Questionnaire*. Overall, OHP FFS applied the same rationale and processes in applying geographic limitations to the provision of MH/SUD and M/S benefits and demonstrated that evidentiary standards used in administering the NQTL were comparable across MH/SUD and M/S benefits. OHP FFS provided information on specific reimbursement rates developed and implemented for primary care providers (PCPs) and safety net clinics as they are paid using a Prospective Payment System (PPS), but documentation was limited to M/S services. Due to the absence of MH/SUD

information, a comprehensive assessment of parity could not be performed. For provider enrollment and credentialing processes, OHP FFS failed to provide sufficient documentation to demonstrate that its processes, strategies, evidentiary standards, and other factors used to enroll and credential providers were not applied more stringently for MH/SUD benefits compared to M/S benefits. Therefore, OHP FFS received a *Partially Compliant* rating for provider enrollment and credentialing.

Pharmacy Management

Three of the CCOs (i.e., AH, AllCare, and IHN) reported changes to PA processes for pharmacy services in the administration of MH/SUD and M/S services. These changes included the addition or removal of PA requirements based on the Prioritized List of Health Services and its corresponding treatment guidelines, Food and Drug Administration (FDA) indications, and nationally recognized medical standards. Two CCOs (AH and AllCare) noted changes in formulary design for prescription drugs that consisted of medications being added to the formulary and additional UM edits based on the Prioritized List of Health Services guideline changes. All implemented changes were based on applicable nationally recognized medical standards. AH also reported changes to step therapy and fail-first strategies that included the addition and elimination of requirements for certain medications according to applicable nationally recognized medical standards. None of the changes identified by the CCOs for the Pharmacy Management NQTLs affected parity; all organizations demonstrated continued parity between MH/SUD and M/S services.

Most 2023 MHP Evaluation findings for Pharmacy Management were related to formulary design. Overall, seven CCOs and OHP FFS described and provided the appropriate documentation to demonstrate compliance with MHP requirements and parity standards for formulary design. However, HSAG was unable to assess HSO for compliance with MHP requirements due to the lack of sufficient documentation from a subcontractor, resulting in a *Partially Compliant* rating. OHP FFS continued to receive a *Not Compliant* rating for pharmacy PA processes since its documentation did not demonstrate how PA for prescription drugs was implemented. Other 2023 Pharmacy Management NQTL findings for the CCOs and OHP FFS, including step therapy/fail-first strategies; methods for determining usual, customary, and reasonable charges; and quantity limits, were all sufficiently addressed by the CCOs and OHP FFS leading to *Compliant* ratings.

Availability of Information

In addition to ensuring the various financial and treatment limitations that affect the administration of MH/SUD and M/S benefits are applied with comparable frequency and rigor, the Medicaid/CHIP (Children's Health Insurance Program) parity rule also includes a requirement regarding the availability of information related to MH/SUD benefits. Specifically, the CCOs and OHP FFS must make the criteria for medical necessity determinations for MH/SUD benefits available to members, potential members, and affected providers, upon request. Table 3-2 shows the parity ratings for the CCOs and OHP FFS related to compliance with the availability of information requirements, and whether changes were made to the process, policies, or procedures since the 2023 MHP Evaluation.

Table 3-2—Overall Compliance With Availability of Information Requirements by Organization

Organization Name	Compliance Rating	Changes Made Since 2023
AH	Compliant	—
AllCare	Compliant	—
CHA	Compliant	—
CPCCO	Compliant	—
EOCCO	Compliant	—
HSO	Compliant	Yes
IHN	Compliant	—
JCC	Compliant	—
PCS-CO	Compliant	—
PCS-CG	Compliant	—
PCS-LN	Compliant	—
PCS-MP	Compliant	—
TCHP-SW	Compliant	—
TCHP-TC	Compliant	—
UHA	Compliant	—
YCCO	Compliant	—
OHP FFS	Partially Compliant	Yes

"—" indicates the CCO reported it did not implement changes to the way it makes medical necessity criteria available to members.

Overall, the CCOs continued to demonstrate that medical necessity criteria information was made available to members, potential members, and network providers through a variety of formats, including member handbooks, provider manuals, CCO websites, and via notices to members when a service or reimbursement for an MH/SUD service was denied. A few organizations reported changes related to the dissemination of medical necessity determinations—i.e., HSO and OHP FFS. One HSO subcontractor reported the reorganization of its website to provide greater visibility and access to the criteria for medical necessity information for its providers. OHP FFS reported making the FFS member handbook available to members online. While the member handbook lists the services that require PA, it does not inform the member that OHP's covered benefits and treatments are based on a list of conditions and services defined by the Prioritized List of Health Services, which is maintained by the Health Evidence Review Commission (HERC). Since the OHP FFS member handbook did not inform members of the medical necessity criteria information, there is insufficient documentation to support the distribution of medical necessity criteria to members, resulting in a *Partially Compliant* finding. As noted in prior reports, several organizations continue to include links to the HERC Prioritized List of Health Services without interpretive guidelines or instructions, which could represent a barrier to members' understanding of these resources. While these findings did not result in a parity finding, the CCOs and OHP FFS should take steps to ensure that available information is readily accessible to members.

Administrative Data Profiles

The following Administrative Data Profile identified key patterns and outcomes associated with the administration of MH/SUD and M/S covered benefits across three domains:

- Claims, including IP and OP services[8]
- UM, including IP, OP, and Rx coverage determinations
- Provider enrollment

Each of the following subsections examines the extent to which performance metrics differed for MH/SUD and M/S services in order to identify potential areas of parity concerns. To facilitate the presentation of results, the differences noted between MH/SUD and M/S performance metrics are displayed as an absolute value, or difference.[9] As such, the larger the number in the figure, the greater the difference between the MH/SUD and M/S performance metrics. Detailed results and findings for individual CCOs and OHP FFS are available in Appendix A through Appendix Q.

Claims

To conduct the claims analysis, the CCOs and OHP FFS submitted claims counts that encompassed all covered services (except non-emergency medical transportation [NEMT] and Rx[10]) by claim type (i.e., IP and OP) and provider network status (i.e., in-network [IN] and out-of-network [OON]) at the header and detail claim level. Since claims are paid at the detail (service) line level, aggregate header counts were categorized as paid, partially paid, and denied. Claims were defined as *partially paid* if at least one detail claim line was denied; claims that included all paid detail lines or all denied detail lines should be classified as paid claims and denied claims, respectively. The total number of IP and OP claims was evaluated at the header level and reported as the total number paid (i.e., paid and partially paid claims) and denied overall, and by network status. The aggregate counts from the CCOs and OHP FFS were then used to generate the percentage of claims paid by benefit type; the difference between the percentage of paid claims for MH/SUD versus M/S services was then evaluated as the core metric for evaluating parity. The absolute difference was used to classify the deviation in the rates of claims paid between MH/SUD and M/S services to determine if the difference was negligible (less than 5 percentage points), moderate (greater than or equal to 5 percentage points, but less than 10 percentage points), or substantial (greater than or equal to 10 percentage points).

Although data were not available to determine the types of services that were paid versus denied, moderate and substantial differences in rates identify areas where operational policies and procedures

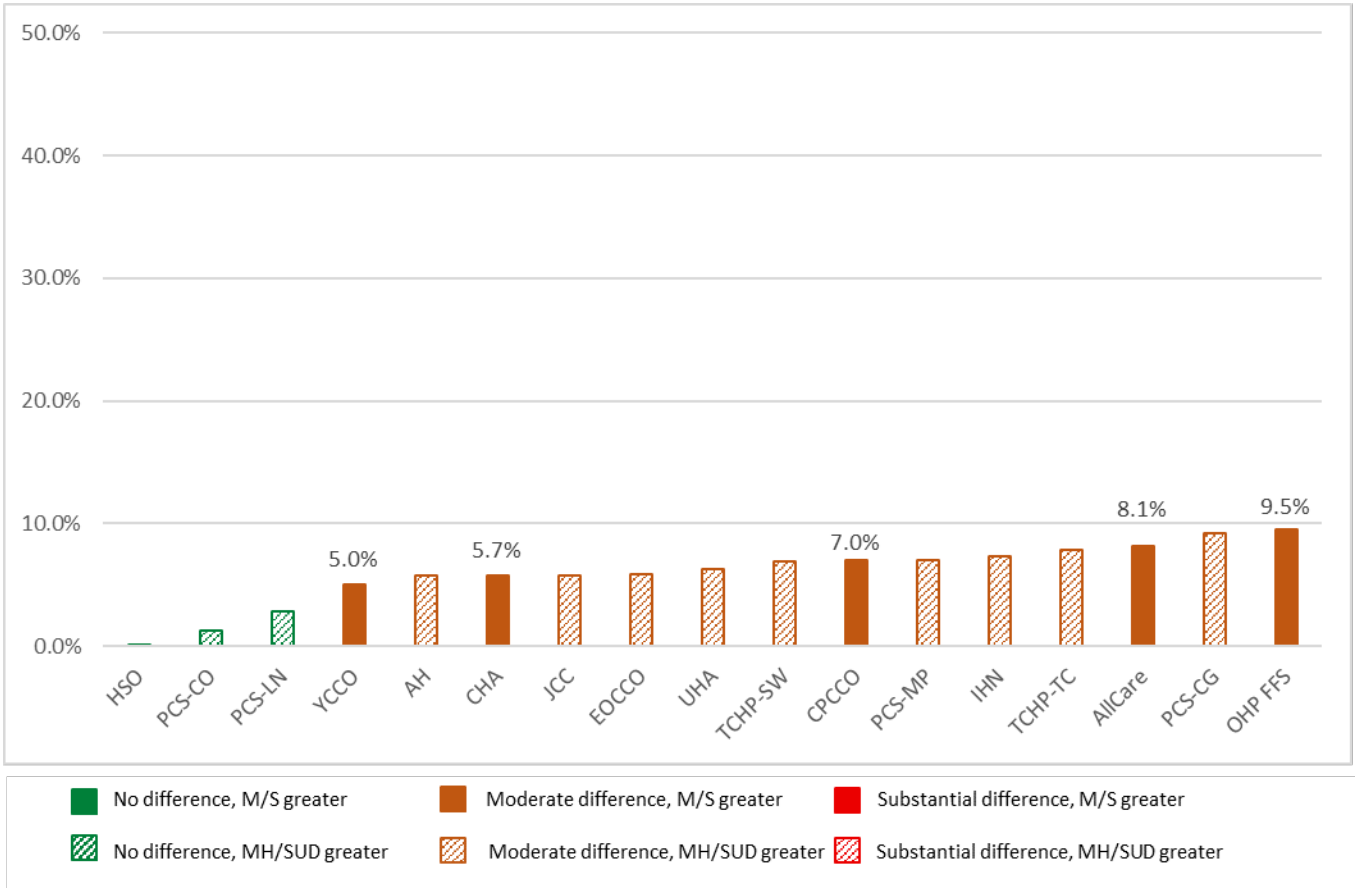
[8] Claims data included dental claims but excluded NEMT and Rx claims.
[9] The *absolute value* is the actual magnitude of a numerical value or measurement. As such, the *absolute difference* represents the difference, taken without regard to sign, between the values of two variables.
[10] NEMT and Rx claims were excluded from the analysis due to a general diagnosis code used for NEMT and the absence of a diagnosis code on incoming Rx claims. As a result, the CCOs and OHP FFS were unable to distinguish and classify individual claims as MH/SUD or M/S.

(i.e., claims submission requirements, authorization determinations, claims processing, provider billing, etc.) highlight instances where MH/SUD and M/S outcomes were different and warrant further review, especially when the differences were outliers compared to other CCOs and the CCO aggregate. In addition to assessing the absolute difference in the percentage of paid claims, the analysis indicated whether the difference reflected greater rates of payment for MH/SUD services over M/S services.

Inpatient Claims

Figure 3-1 shows the absolute difference in the percentage of paid MH/SUD and M/S IP claims for all CCOs and OHP FFS.

Figure 3-1—Absolute Difference in the Percentage of Paid Inpatient Claims



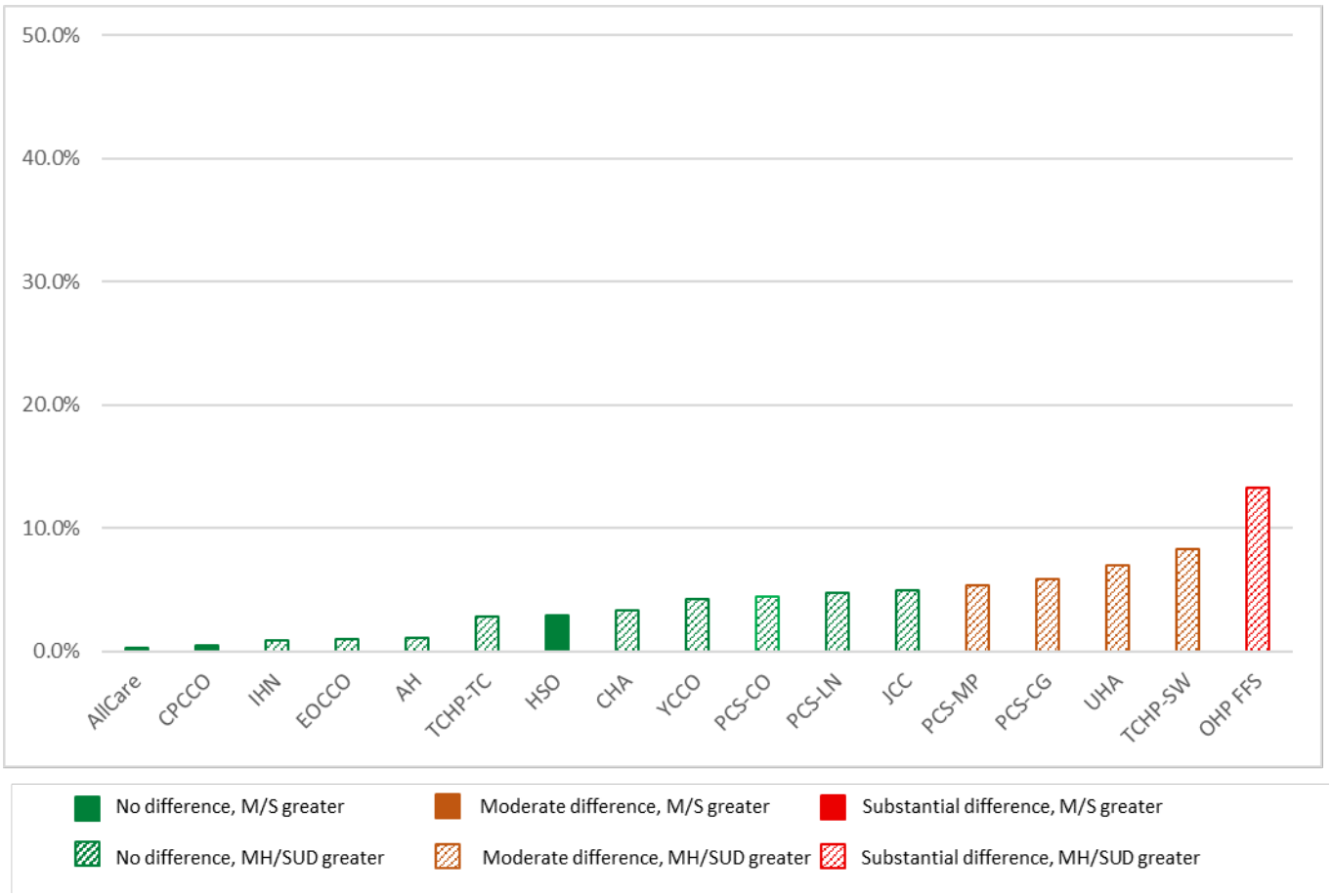
Overall, the difference in the statewide CCO percentage of paid IP claims for MH/SUD services (86.8 percent) and M/S services (84.3 percent) was negligible (2.5 percentage points), with individual CCO differences ranging from 0.1 percentage point (HSO) to 9.2 percentage points (PCS-CG), and OHP FFS being the highest at 9.5 percentage points. Thirteen CCOs and OHP FFS (i.e., YCCO, AH, CHA, JCC, EOCCO, UHA, TCHP-SW, CPCCO, PCS-MP, IHN, TCHP-TC, AllCare, and PCS-CG) exhibited a moderate difference in the percentage of paid IP claims, although only YCCO, CHA, CPCCO, AllCare, and OHP FFS showed higher percentages of paid M/S IP claims. However, a comparison

across header and detail claims showed that when separating MH/SUD and M/S services by line item, payment differences exhibited a higher percentage of paid claims for MH/SUD detail lines; reversing trends identified at the header level. The remaining three CCOs had less than a 5-percentage-point difference in paid IP claims rates. Compared to prior years, a greater number of CCOs exhibited moderate differences in paid IP claims; this is down from three MCEs (i.e., two CCOs and OHP FFS) reported in the 2023 MHP Evaluation.

Outpatient Claims

Figure 3-2 shows the absolute difference in the percentage of paid MH/SUD and M/S OP claims for all CCOs and OHP FFS.

Figure 3-2—Absolute Difference in the Percentage of Paid Outpatient Claims



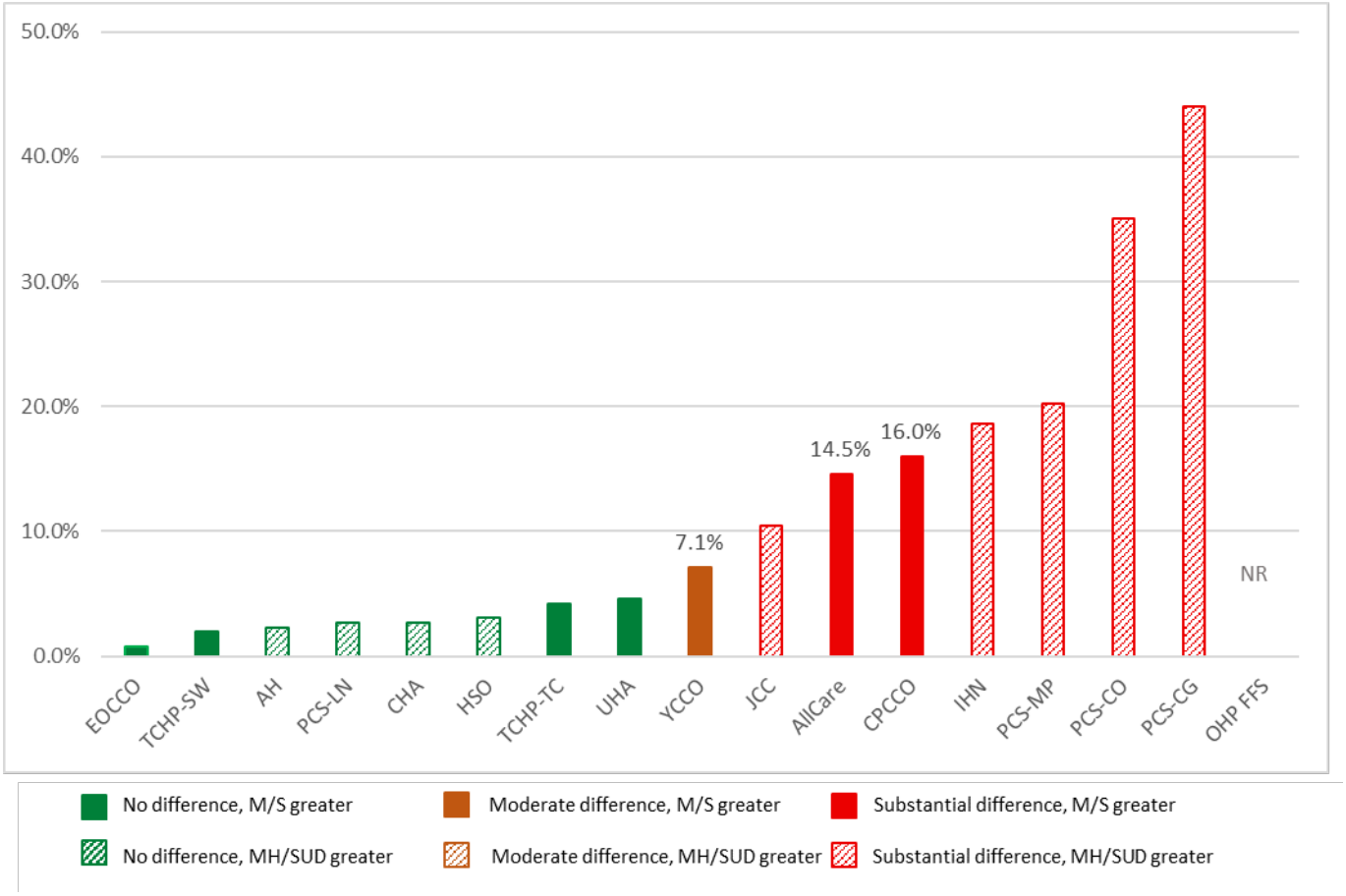
Similar to IP claims, the difference in the statewide CCO percentage of paid OP claims for MH/SUD services (91.5 percent) and M/S services (88.3 percent) was negligible at 3.2 percentage points, with individual CCO differences ranging from 0.3 percentage points (AllCare) to 8.3 percentage points (TCHP-SW), and OHP FFS being the highest at 13.3 percentage points. Only OHP FFS exhibited a substantial difference in the percentage of paid OP claims (13.3 percentage points). Among the remaining CCOs, only four exhibited a moderate difference in the percentage of OP paid claims (PCS-

MP, PCS-CG, UHA, and TCHP-SW); however, the percentage of OP paid claims was higher for MH/SUD services in all cases. The remaining 12 CCOs had less than a 5-percentage-point difference in paid OP claims rates.

Out-of-Network Paid Claims

Figure 3-3 shows the absolute difference in the percentage of paid MH/SUD and M/S IP claims for OON providers for all CCOs.[11]

Figure 3-3—Absolute Difference in the Percentage of Inpatient Paid Claims for Out-of-Network Providers



NR (Not Reported) indicates OHP FFS was unable to provide claims data stratified by IN and OON providers; therefore, OHP FFS was excluded from this analysis.

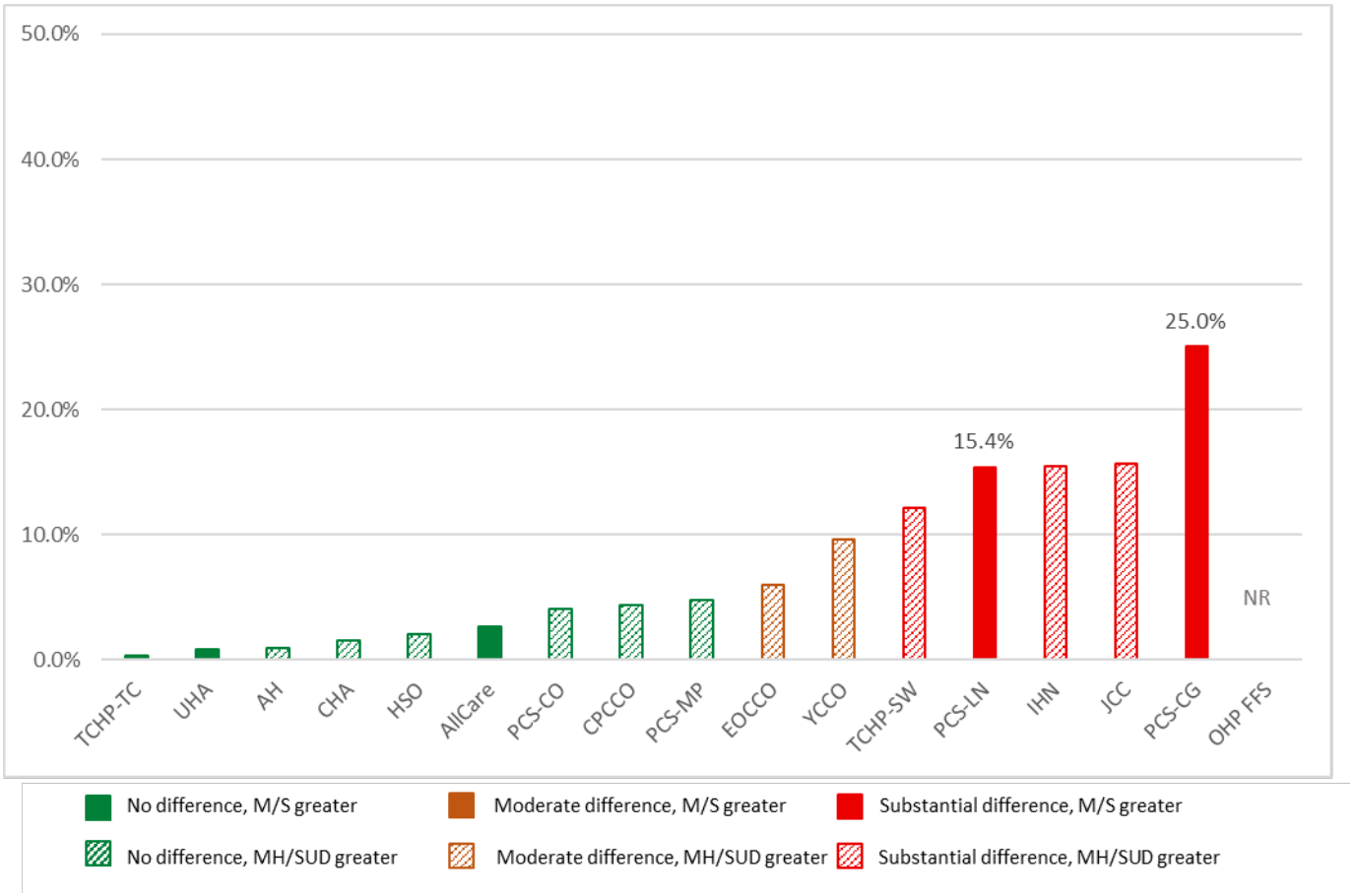
While the difference in the statewide CCO percentage of paid OON IP claims for MH/SUD services (71.6 percent) and M/S services (66.0 percent) was moderate at 5.6 percentage points, variation across the CCOs and OHP FFS was considerably greater with differences ranging from 0.8 percentage points (EOCCO) to 44.0 percentage points (PCS-CG). Of the 16 CCOs, eight exhibited moderate or substantial

[11] Due to the structure of its program, OHP FFS does not distinguish between IN and OON providers; any provider enrolled with Oregon Medicaid is classified as "IN." As such, OHP FFS is listed as "NR" for this measure.

differences in the percentage of paid OON IP claims for MH/SUD and M/S services. However, only two of the CCOs (AllCare [14.5 percentage points] and CPCCO [16.0 percentage points]) showed substantial differences, wherein the percentage of paid claims was substantially lower for OON MH/SUD IP claims.[12] Compared to the 2023 MHP Evaluation, the results showed an increase in the number of CCOs with negligible difference (i.e., five CCOs to eight CCOs) and a slight decrease in the number of plans with substantial differences in the percentage of paid claims.

Figure 3-4 shows the absolute difference in the percentage of paid MH/SUD and M/S OP claims for OON providers for all CCOs.[13]

Figure 3-4—Absolute Difference in the Percentage of Outpatient Paid Claims for Out-of-Network Providers



[12] During its review of the draft report, CPCCO identified a data quality issue related to its IP claims summary count submission. The CCO confirmed it included institutional claims from a CMS Coordination of Benefits Agreement (COBA) contractor which should have been excluded from the analysis. These claims were rebilled and paid by the CCO and included as IN professional MH/SUD claims. Although the CCO resubmitted revised claims data counts, the information was not received in time for inclusion in the report. However, preliminary review suggests that the difference in the percentage of paid MH/SUD and M/S IP claims was negligible.

[13] Due to the structure of its program, OHP FFS does not distinguish between IN and OON providers; any provider enrolled with Oregon Medicaid is classified as "IN." As such, OHP FFS is listed as "NR" for this measure.

NR (Not Reported) indicates OHP FFS was unable to provide claims data stratified by IN and OON providers; therefore, OHP FFS was excluded from this analysis.

Unlike paid OON IP claims, the difference in the statewide CCO percentage of paid OON OP claims for MH/SUD (74.4 percent) and M/S (72.4 percent) services were negligible at just 2.0 percentage points. However, individual CCO performance showed considerable differences with results ranging from 0.3 percentage points (TCHP-TC) to 25.0 percentage points (PCS-CG). Of the 16 CCOs, seven exhibited moderate or substantial differences in the percentage of paid OON OP claims between MH/SUD and M/S services. Two of the CCOs (PCS-LN [15.4 percentage points] and PCS-CG [25.0 percentage points]) showed substantial differences in which the percentage of paid OON OP claims for M/S was greater. In general, results improved somewhat from the 2023 MHP Evaluation, with the number of CCOs showing substantial differences in higher rates of paid M/S OON OP claims decreasing from four CCOs to two CCOs. Additionally, while TCHP-SW, IHN, and JCC continued to show substantial differences between the rate of paid claims for MH/SUD and M/S services, the differences were in favor of MH/SUD services.

Utilization Management

To conduct the UM analysis, the CCOs and OHP FFS submitted authorization, coverage determination, and appeals and administrative hearing counts that encompassed all covered services by service type (i.e., IP, OP, and Rx). The total number of PA requests and denials was identified, reported, and stratified by M/S and MH/SUD services. The CCOs and OHP FFS also provided aggregate counts on the number of authorization denials that were subsequently appealed and the associated outcome (i.e., upheld or overturned), as well as information regarding subsequent requests for administrative hearings. Both sets of results were stratified based on whether the denial was related to M/S or MH/SUD services. The aggregate counts from the CCOs and OHP FFS were then used to generate the percentage of denied authorizations by benefit type; the difference between the percentage of denied authorizations for MH/SUD versus M/S services was then evaluated as the core metric for evaluating parity. The absolute difference was used to classify the deviation in denial rates between MH/SUD and M/S services to determine if the difference was negligible (less than 5 percentage points), moderate (greater than and equal to 5 percentage points, but less than 10 percent), or substantial (greater than or equal to 10 percentage points). Aggregate data on appeals and administrative hearings are not presented in the main report since the overall number of appeals and administrative hearings was too small to produce reliable statistics; however, individual results for the CCOs and OHP FFS are presented in the Appendix A through Appendix Q. As such, the results in this section will focus on comparison of authorization denials. In addition to assessing the absolute difference in the percentage of authorization denials, the analysis indicates whether the difference identified greater denial rates for MH/SUD services over M/S services.

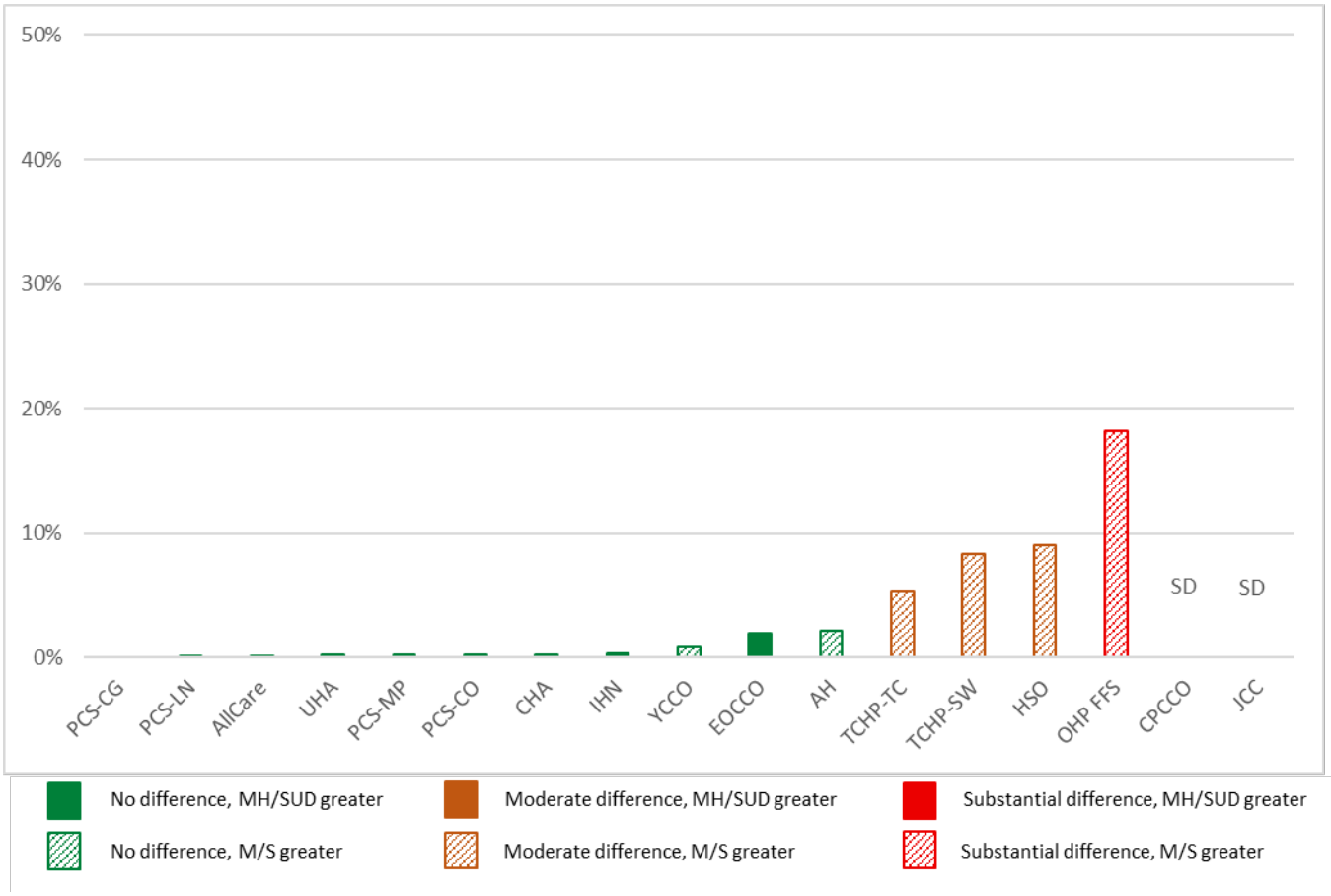
Member-level data were also captured for all PA denials. These data were reviewed to provide context for identifying potential factors contributing to moderate and substantial differences in aggregate denial rates. Results from this analysis are presented at the end of this section.

The following figures display the results of the comparisons in the percentage of IP, OP, and Rx denials for MH/SUD and M/S PA requests for all CCOs and OHP FFS. The larger the number, the greater the difference between the percentage of PA denials between MH/SUD and paid M/S. Green bars indicate a deviation rating of *None*, while the orange and red bars indicate a rating of *Moderate* and *Substantial*, respectively. Solid bars, along with the absolute percentage-point difference, indicate that a higher percentage of MH/SUD PA requests were denied compared to M/S PA requests.

Inpatient Authorization Denials

Figure 3-5 shows the absolute difference in the percentage of denied MH/SUD and M/S IP PA requests for all CCOs and OHP FFS.

Figure 3-5—Absolute Difference in the Percentage of Inpatient PA Denials



SD (Small Denominator) indicates reported data are valid, but the denominator is too small to support reporting.
Note: OHP FFS data should be viewed with caution as nearly one-third (29.9 percent) of all IP PA requests could not be defined as MH/SUD or M/S due to system limitations and the lack of ongoing monitoring of PA decisions.

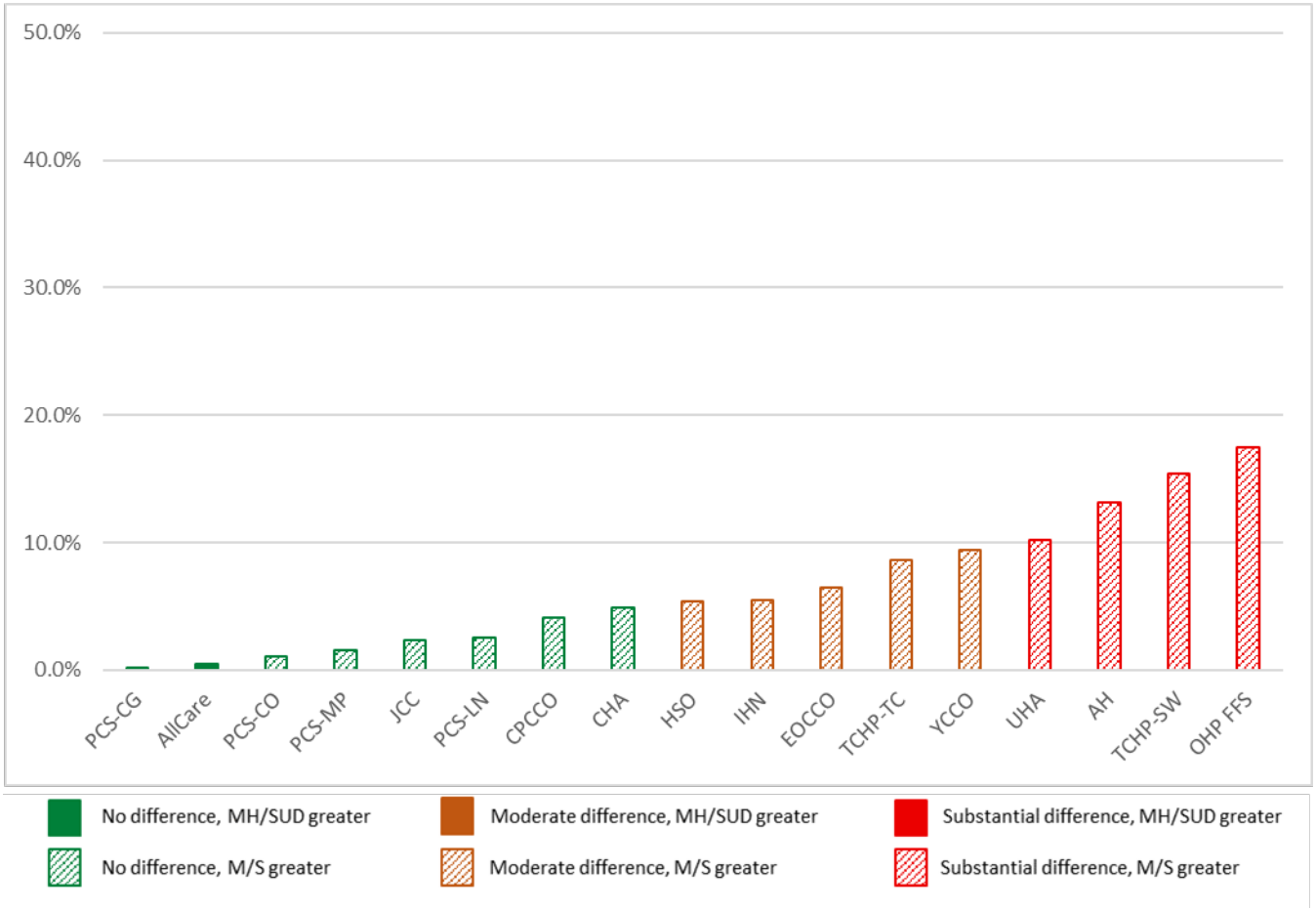
Overall, the difference in the statewide CCO percentage of denied IP PA requests for MH/SUD services (1.4 percent) and M/S services (4.6 percent) was negligible at 3.2 percentage points, with individual CCO differences ranging from 0.0 percentage points (PCS-CG and PCS-LN) to 9.0 percentage points

(HSO), and OHP FFS being the highest (18.2 percentage points). Three CCOs and OHP FFS exhibited moderate or substantial differences in the percentage of denied IP PA requests; however, the rate of denial was lower for MH/SUD IP PA requests compared to M/S requests. Eleven CCOs had less than a 5-percentage-point difference in IP PA denial rates. Overall, there was considerably less variation among the CCOs compared to prior year reporting. Furthermore, compared to OP and Rx PAs, there were considerably fewer IP PAs (i.e., 8.3 percent versus 74.5 percent and 17.2 percent, respectively). Two CCOs (JCC and CPCCO) denial rates could not be reported as a result of too few IP PA requests (less than 10).

Outpatient Authorization Denials

Figure 3-6 shows the absolute difference in the percentage of denied MH/SUD and M/S OP PA requests for all CCOs and OHP FFS.

Figure 3-6—Absolute Difference in the Percentage of Outpatient PA Denials



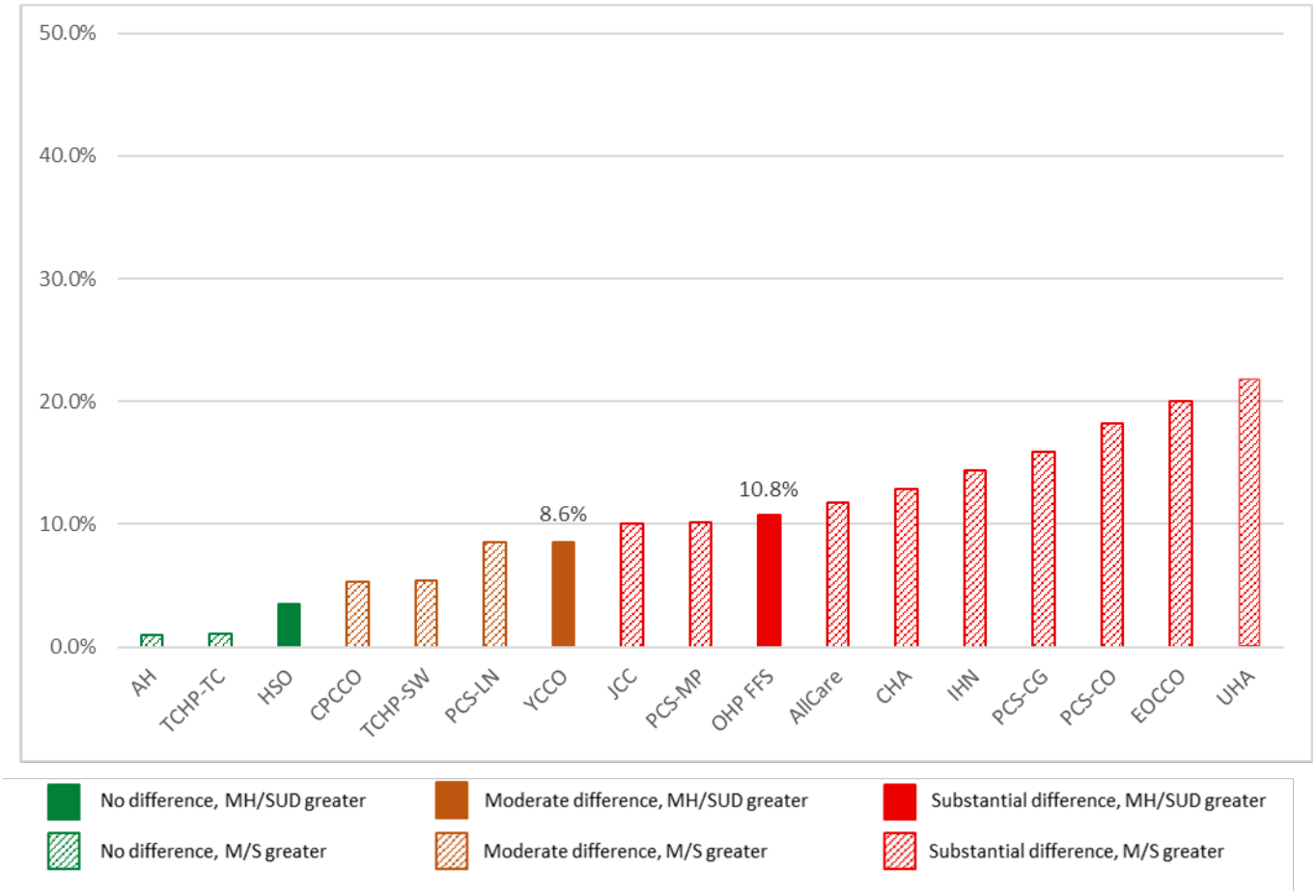
Note: OHP FFS data should be viewed with caution as more than half (54.0 percent) of all OP PA requests could not be defined as MH/SUD or M/S due to system limitations and the lack of ongoing monitoring of PA decisions.

Overall, the difference in the statewide CCO percentage of denied OP PA requests for MH/SUD services (5.1 percent) and M/S services (10.4 percent) was moderate at 5.3 percentage points, with individual differences ranging from 0.2 percentage point (PCS-CG) to 15.4 percentage points (TCHP-SW). Three CCOs (UHA [10.2 percentage points], AH [13.1 percentage points], TCHP-SW [15.4 percentage points]), and OHP FFS showed substantial differences in the percentage of denied OP PA requests; however, in all cases, the rate of denial was lower for MH/SUD OP PA requests than M/S OP PA requests. These results reflect a similar pattern of denials when compared to the 2023 MHP Evaluation findings.

Pharmacy Authorization Denials

Figure 3-7 shows the absolute difference in the percentage of denied MH/SUD and M/S Rx PA requests for all CCOs and OHP FFS.

Figure 3-7—Absolute Difference in the Percentage of Pharmacy PA Denials



Overall, the difference in the statewide CCO percentage of denied Rx PA requests for MH/SUD services (45.3 percent) and M/S services (51.2 percent) was moderate at 5.9 percentage points, with individual CCO differences ranging from 0.9 percentage point (AH) to 21.9 percentage points (UHA). OHP FFS showed a moderate difference of 10.8 percentage points with MH/SUD Rx PA requests (31.2 percent) being denied at a higher rate than M/S Rx PA requests (20.4 percent). YCCO exhibited moderate differences in denial rates (8.6 percentage points), with MH/SUD Rx PA denials being higher than M/S Rx PA denials. Three CCOs had less than a 5-percentage-point difference in Rx PA denial rates (AH, TCHP-TC, and HSO). Similar to OP PA denials, these results reflect a similar pattern of denials when compared to the 2023 MHP Evaluation findings.

Member-Level Denial Reasons

To facilitate comparisons across the nonstandard categorizations of denials used by individual CCOs and OHP FFS, denial reasons were qualitatively and thematically organized to allow for aggregation and comparison. When more than one denial reason was documented by a CCO or OHP FFS, the primary

denial reason was categorized. Following this process, denial reasons were grouped into six key categories:

- Does Not Meet Criteria—requested service does not meet clinical treatment guidelines for medical necessity or appropriateness
- Not a Covered Benefit—variety of noncoverage denials (e.g., noncovered services, benefit exclusions)
- Service is *Below the Line*—service requested was below the line on the OHP Prioritized List[14]
- Treatment Limitations—UM controls implemented by health plans to manage member health care (i.e., provider network, visit limits, drug utilization procedures)
- Out-of-Network Provider—service requested is delivered by a provider outside the network
- Administrative Denial—denial due to administrative issues associated with the PA request (e.g., insufficient documentation, member eligibility)
- Unknown—documentation insufficient to categorize

Table 3-3 shows the statewide aggregate percentage of denial reasons by benefit (i.e., MH/SUD and M/S) for IP, OP, and Rx PA requests. Results are sorted in descending order from the most to least frequent denial reason.

Table 3-3—Statewide PA Denial Reasons by Service Type and Benefit

Denial Reason	Total	Inpatient		Outpatient		Pharmacy	
		MH/SUD	M/S	MH/SUD	M/S	MH/SUD	M/S
Does Not Meet Criteria	45.0%	78.1%	85.8%	43.9%	45.7%	63.7%	39.6%
Not a Covered Benefit	21.8%	11.3%	7.0%	8.1%	30.5%	7.7%	16.1%
Service is *Below the Line*	13.1%	0.0%	1.2%	0.3%	12.9%	3.1%	15.8%
Treatment Limitation	12.2%	0.0%	0.2%	0.4%	1.2%	23.3%	23.0%
Out-of-Network Provider	3.9%	1.5%	1.2%	40.3%	6.8%	0.0%	0.1%
Administrative Denial	3.5%	6.9%	3.2%	6.1%	2.1%	2.2%	5.1%
Unknown	0.5%	2.2%	1.4%	0.9%	0.8%	0.0%	0.3%

Overall, across all CCOs and regardless of benefit, nearly half of all PA requests were denied for services determined to not be medically necessary (45.0 percent), followed by PA requests denied because the service was not a covered benefit (21.8 percent). Together, these two categories accounted for the majority of all PA denials (66.8 percent) as well as individually across IP (92.4 percent), OP (75.3 percent), and Rx (57.8 percent) services. The next most frequent denial reason for a PA request was related to services below the line (13.1 percent) and UM controls implemented by the CCOs and OHP FFS (Treatment Limitation = 12.2 percent). Overall, less than 10 percent of the denial reasons were related to OON providers (3.9 percent), administrative denials (3.5 percent), or unknown reasons

[14] Oregon Health Authority. Prioritized List of Health Services. Available at: https://www.oregon.gov/oha/hsd/ohp/pages/prioritized-list.aspx. Accessed on: Oct 31, 2024.

(0.5 percent). Although denial reasons were generally consistent across the CCOs and OHP FFS, several differences were identified when examining denials by service type and benefit, including the following:

- While denials for IP PA requests failing to meet criteria was the most prevalent reason for both MH/SUD and M/S services, the rate of denials among MH/SUD-related services was about 7 percentage points lower than that of M/S services (i.e., 78.1 percent versus 85.8 percent).
- OP PA requests for MH/SUD and M/S services were denied most frequently for requests not meeting criteria (43.9 percent and 45.7 percent, respectively). However, while OP PA denials related to services not being a covered benefit were the next most frequent denial reasons for M/S (30.5 percent), it only accounted for 8.1 percent of MH/SUD OP PA denials. Among MH/SUD OP PA denials, the next most frequent denial reasons were related to *Service is Below the Line* (0.3 percent), *Treatment Limitation* (0.4 percent), *Out-of-Network Providers* (40.3 percent), and *Administrative Denial* (6.1 percent) accounting for 56.1 percent of all denials.
- Unlike IP and OP PA requests, UM controls implemented by the CCOs and OHP FFS for Rx PA requests were the second most prevalent reason for a denial (MH/SUD [23.3 percent] and M/S [23.0 percent]).

Appeals and Hearings

In addition to evaluating UM service denials, HSAG also reviewed appeals and administrative hearings decisions. However, due to the small number of appeals and hearings at the organization level, formal analyses were not performed. Overall, less than 10 percent of all denials resulted in an appeal with the percentage of appeals by benefit type ranging from 3.9 percent for IP appeals, 7.8 percent for Rx appeals, and 8.1 percent for OP appeals. On average, MH/SUD appeals account for 10 percent of the appeals in 2023; however, a review of the percentage of overturned appeal decisions showed some differences. While MH/SUD appeals were overturned less frequently than M/S appeals (27.6 percent versus 43.0 percent, respectively), the outcomes show that more than a quarter of all MH/SUD decisions are overturned on appeals. For IP and Rx appeals, the percentage of overturned MH/SUD appeals was substantially higher for MH/SUD IP appeals (42.8 percentage points) and negligibly higher for MH/SUD Rx appeals (2.7 percentage points). While these results should be viewed with caution given the small number of appeals, the relatively high percentage of overturned denial decisions suggest potential barriers to care that may impact the timeliness of MH/SUD services to members. No data are presented on administrative hearings as only 1.5 percent, or a total of 153 hearings, were requested across all organizations in 2023.

Provider Enrollment

In order to assess parity related to management of provider networks, the CCOs and OHP FFS submitted the average monthly count of MH/SUD and M/S providers along with the total number of provider applications or renewals received, approved and denied, as well as the number of providers terminated in calendar year (CY) 2023. All counts were stratified by benefit type to facilitate comparisons. These data points were collected to offer information on parity of provider credentialing practices between MH/SUD and M/S. The aggregate counts from the CCOs and OHP FFS were then used to generate the

percentage of providers terminated and approved[15] by benefit type; the difference between the percentage of providers terminated and approved MH/SUD and M/S providers was then evaluated as the core metric for evaluating parity. The absolute difference was used to classify the deviation in termination and approval rates between MH/SUD and M/S providers to determine if the difference was negligible (less than 5 percentage points), moderate (greater than or equal to 5 percentage points, but less than 10 percentage points), or substantial (greater than or equal to 10 percentage points). In addition to assessing the absolute difference in the percentage of terminated and approved providers, the analysis indicated whether the difference identified greater rates of termination/approval for MH/SUD providers versus M/S providers.

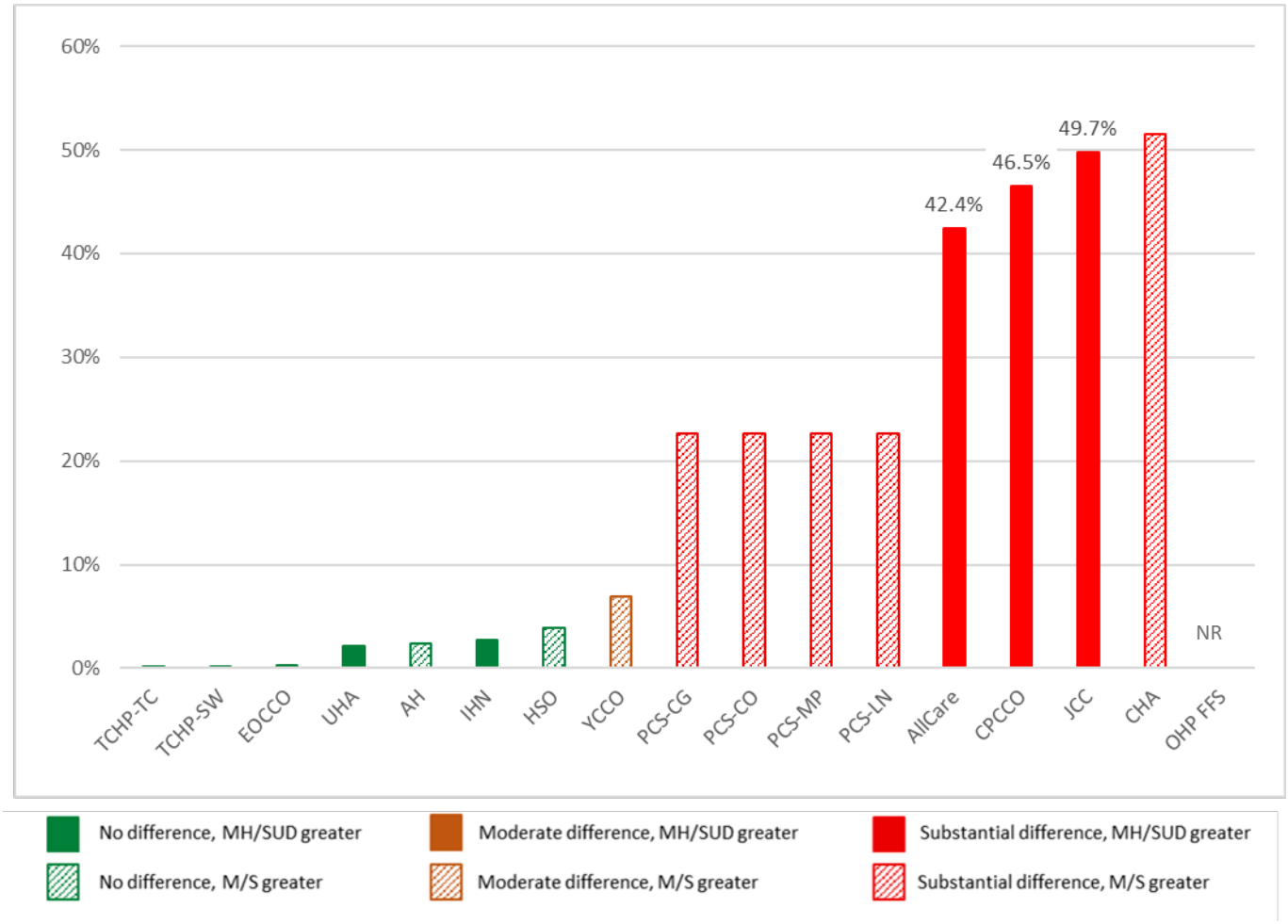
The following figures display the results of the comparisons in the percentage of terminated and approved applications for MH/SUD and M/S providers for all CCOs and OHP FFS, where available.

Provider Terminations

Figure 3-8 shows the absolute difference in the percentage of terminated MH/SUD and M/S providers for all CCOs. The larger the number, the greater the difference between the percentage of MH/SUD and M/S provider terminations. Green bars indicate a deviation rating of *None*, while the orange and red bars indicate a *Moderate* or *Substantial* difference, respectively. Solid bars, along with the absolute percentage-point difference, indicate that a higher percentage of MH/SUD providers were terminated compared to M/S providers.

[15] Due to limitations associated with the structure and availability of provider data within OHP FFS' information systems, OHP FFS is unable to accurately track MH/SUD and M/S providers and cannot distinguish new enrollment and reenrollment applications for providers or provider terminations based on specialty type (i.e., MH/SUD versus M/S). Further, MH/SUD and M/S counts are estimated since exact delineation of provider type is not currently possible within these data systems. As such, while OHP FFS is included in the termination analysis, results are not available on approval or terminations rates and excluded from these results.

Figure 3-8—Absolute Difference in the Percentage of Providers Terminated



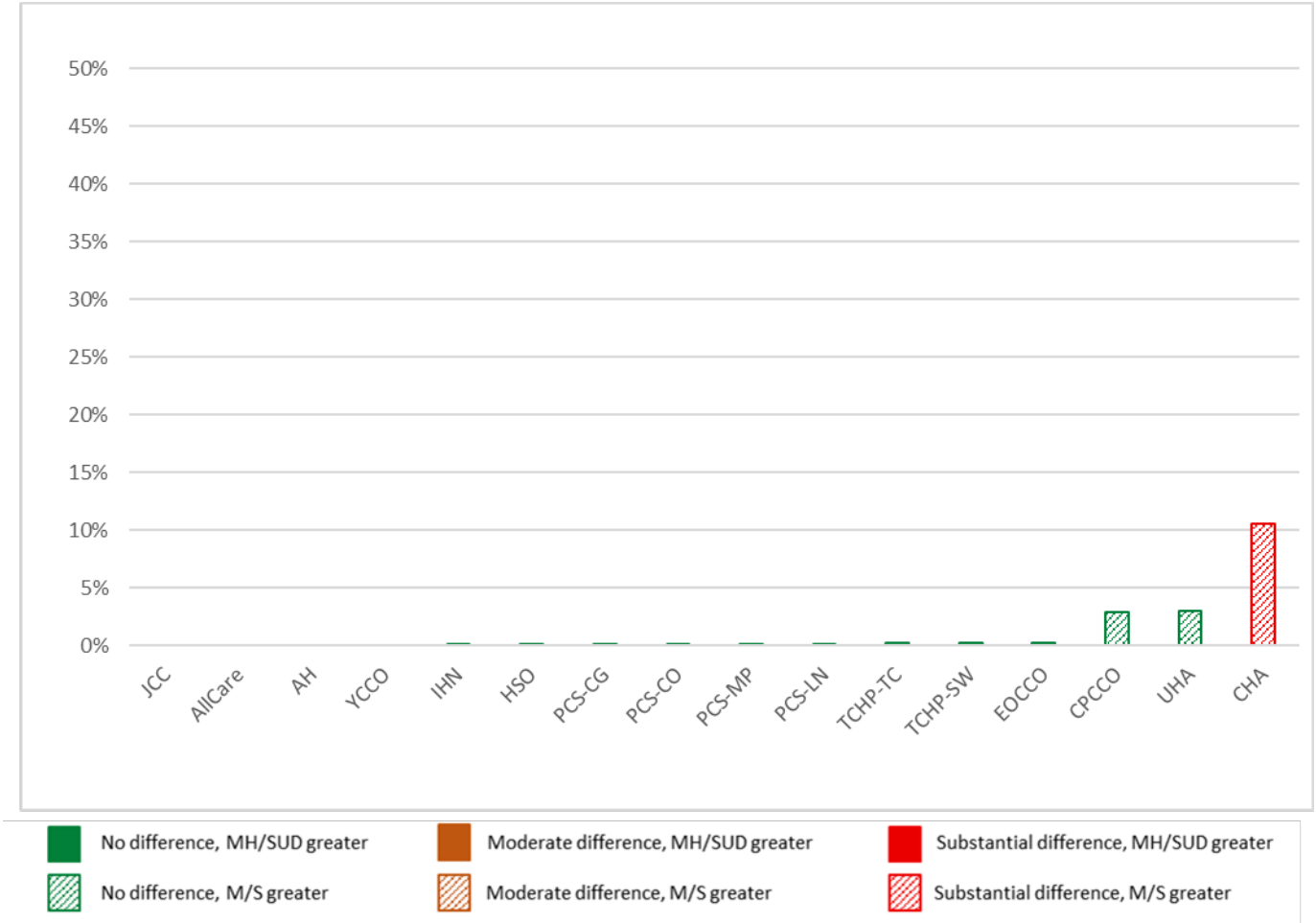
NR (Not Reported) indicates data were not reported because the organization was unable to distinguish the number of MH/SUD and M/S terminations, applications, and providers up for recredentialing.

Overall, the absolute difference in the statewide CCO percentage of terminated providers for MH/SUD (5.6 percent) and M/S (15.3 percent) was moderate at 9.7 percentage points, with individual CCO differences ranging from 0.1 percentage points (TCHP-SW and TCHP-TC, each) to 51.5 percentage points (CHA). One CCO (YCCO) exhibited a moderate difference in the percentage of MH/SUD and M/S provider terminations where M/S termination rates were greater than MH/SUD termination rates. Eight CCOs exhibited substantial differences with three CCOs (AllCare, CPCCO, and JCC) exhibiting a substantially larger percentage of MH/SUD providers being terminated compared to M/S providers. The remaining CCOs (TCHP-TC, TCHP-SW, EOCCO, UHA, AH, IHN, and HSO) exhibited little to no difference in the percentage of MH/SUD and M/S providers terminated or not recredentialed in CY 2023. OHP FFS was excluded from the analysis since it was unable to provide data to assess parity. OHP FFS results were not reported due to system limitations and the lack of ongoing monitoring provider terminations and application approvals.

Provider Approvals

Figure 3-9 shows the absolute difference in the percentage of approved provider applications for MH/SUD and M/S providers for all CCOs. The larger the number, the greater the difference between the percentage of approvals between MH/SUD and M/S provider applications. Green bars indicate a deviation rating of *None*, while the orange and red bars indicate a *Moderate* or *Substantial* difference, respectively. Solid bars, along with the absolute percentage-point difference, indicate that a higher percentage of M/S provider applications were approved compared to MH/SUD provider applications.

Figure 3-9—Absolute Difference in the Percentage of Provider Applications Approved



Overall, the difference in the statewide CCO percentage of provider applications approved for MH/SUD providers (99.6 percent) and M/S providers (99.2 percent) was negligible at 0.4 percentage points, with individual CCO differences ranging from 0.0 percentage points (JCC, AllCare, AH, and YCCO, each) to 10.5 percentage points (CHA). Only one CCO exhibited a substantial difference in the percentage of MH/SUD and M/S provider applications approved in CY 2023 (CHA); however, MH/SUD approval rates were greater than M/S approval rates.

Adequacy of MH/SUD Provider Networks

In addition to assessing the outcomes of organizational policies and procedures via a review of claims and UM, HB 3046 also requires an annual assessment of the adequacy of the provider network and timeliness of access to MH/SUD treatment and services as prescribed by the authority by rule. HSAG assessed the adequacy of the CCOs' and OHP FFS' MH/SUD provider networks by evaluating several interrelated measures of members' access to MH and SUD services.

Provider Network Capacity

To address provider network capacity, HSAG conducted a review of the CCOs' and OHP FFS' provider network data files and synthesized the results to understand the provider network infrastructure in place to provide MH/SUD services to members. Using CCO data captured in OHA's semiannual *DSN Provider Capacity Reports* and OHP FFS' MHP submission, HSAG aggregated the data and reported two core metrics:

- **Provider Counts**—The number and percentage of MH and SUD providers, as well as changes over time to determine the stability of each network.
- **Provider-to-Member Ratios**—The ratio of MH and SUD providers to members with at least one MH/SUD claim during the measurement year.

Provider Counts

Table 3-4 shows the total number of providers in network (i.e., Total) and total number and percentage of MH providers contracted with each CCO (i.e., MH [#] and MH [%], respectively). The table also indicates, for each CCO, whether the change from Q1 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of MH providers. The data represent a calendar difference of one year. Although a comparative review of the distribution of providers showed substantial changes in some cases, caution should be used when interpreting network stability due to differences in reporting across calendar years, in accordance with OHA reporting requirements.

Table 3-4—Number and Percentage of MH Providers by Quarter

Organization Name	Q1 2023			Q1 2024			Difference	
	Total	MH (#)	MH (%)	Total	MH (#)	MH (%)	#	% Change
AH	501	182	36.3%	611	250	40.9%	68	37.4% ▲
AllCare	1,501	488	32.5%	1,451	501	34.5%	13	2.7%
CHA	410	123	30.0%	369	120	32.5%	-3	-2.4%
CPCCO	8,559	1,987	23.2%	9,180	2,467	26.9%	480	24.2% ▲
EOCCO	6,803	1,100	16.2%	6,473	1,246	19.2%	146	13.3% ▲

Organization Name	Q1 2023			Q1 2024			Difference	
	Total	MH (#)	MH (%)	Total	MH (#)	MH (%)	#	% Change
HSO	10,833	2,012	18.6%	11,535	2,964	25.7%	952	47.3% ▲
IHN	5,306	1,217	22.9%	5,260	1,265	24.0%	48	3.9%
JCC	8,684	2,108	24.3%	9,458	2,661	28.1%	553	26.2% ▲
PCS-CO	9,322	3,682	39.5%	9,460	4,079	43.1%	397	10.8% ▲
PCS-CG	9,159	3,681	40.2%	9,306	4,079	43.8%	398	10.8% ▲
PCS-LN	9,472	3,681	38.9%	9,577	4,079	42.6%	398	10.8% ▲
PCS-MP	9,480	3,684	38.9%	9,646	4,082	42.3%	398	10.8% ▲
TCHP-SW	4,452	1,739	39.1%	5,188	2,519	48.6%	780	44.9% ▲
TCHP-TC	5,241	1,660	31.7%	6,840	1,933	28.3%	273	16.4% ▲
UHA	586	139	23.7%	1,173	209	17.8%	70	50.4% ▲
YCCO	5,650	2,013	35.6%	6,835	2,292	33.5%	279	13.9% ▲
OHP FFS	NR	6,933	—	NR	5,919	—	-1,014	-14.6% ▼

"—" indicates rate could not be calculated.

NR (Not Reported) indicates data were not reported because the organization's data do not collect information on total membership since the FFS network is not the same structure as the CCOs' network. Provider counts are based on the number of enrolled providers active during the review period (i.e., MH claim in 2023).

Overall, the MH provider network increased substantially both in comparison to other provider types and in raw numbers. Several factors likely contributed to this growth, including efforts by OHA and the CCOs to distribute targeted BH payments, expanded CCO contracting efforts, and data improvements from OHA and the CCOs. However, caution should be used when interpreting the results, as some CCOs report provider network capacity data at an enterprise level, which may increase the overall number of providers regardless of local availability to Medicaid members. Additional observations include:

- Of the 16 CCO networks, 13 showed substantial changes between 2023 and 2024. Of the CCOs with substantial changes, six CCOs showed more than a 20-percentage-point change, with three (HSO, TCHP-SW, and UHA) of those six showing a 40-percentage-point change.
- Raw counts of additional MH providers among the 15 CCOs that increased their networks ranged from as low as 13 to as high as 952, with a median increase of 397 providers.
- OHP FFS was unable to report changes in the stability of its MH network.

Table 3-5 shows the total number of providers in network (i.e., Total) and total number and percentage of SUD providers contracted with each CCO (i.e., SUD [#] and SUD [%], respectively). The table also indicates, for each CCO, whether the change from Q1 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of SUD providers. The data

represent a calendar difference of one year. Although a comparative review of the distribution of providers showed substantial changes in some cases, caution should be used when interpreting network stability due to differences in reporting across calendar years, in accordance with OHA reporting requirements.

Table 3-5—Number and Percentage of SUD Providers by Quarter

Organization Name	Q1 2023			Q1 2024			Difference	
	Total	SUD (#)	SUD (%)	Total	SUD (#)	SUD (%)	#	% Change
AH	501	56	11.2%	611	74	12.1%	18	32.1% ▲
AllCare	1,501	144	9.6%	1,451	121	8.3%	-23	-16.0% ▼
CHA	410	69	16.8%	369	49	13.3%	-20	-29.0% ▼
CPCCO	8,559	528	6.2%	9,180	511	5.6%	-17	-3.2%
EOCCO	6,803	292	4.3%	6,473	409	6.3%	117	40.1% ▲
HSO	10,833	582	5.4%	11,535	558	4.8%	-24	-4.1%
IHN	5,306	411	7.7%	5,260	464	8.8%	53	12.9% ▲
JCC	8,684	534	6.1%	9,458	536	5.7%	2	0.4%
PCS-CO	9,322	550	5.9%	9,460	578	6.1%	28	5.1%
PCS-CG	9,159	550	6.0%	9,306	578	6.2%	28	5.1%
PCS-LN	9,472	550	5.8%	9,577	578	6.0%	28	5.1%
PCS-MP	9,480	550	5.8%	9,646	578	6.0%	28	5.1%
TCHP-SW	4,452	414	9.3%	5,188	455	8.8%	41	9.9%
TCHP-TC	5,241	292	5.6%	6,840	358	5.2%	66	22.6% ▲
UHA	586	100	17.1%	1,173	150	12.8%	50	50.0% ▲
YCCO	5,650	417	7.4%	6,835	352	5.1%	-65	-15.6% ▼
OHP FFS	NR	1,013	—	NR	1,160	—	147	14.5% ▲

"—" indicates rate could not be calculated.

NR (Not Reported) indicates data were not reported because the organization's data do not collect information on total membership since the FFS network is not the same structure as the CCOs' network. Provider counts are based on the number of enrolled providers active during the review period (i.e., MH claim in 2023).

Overall, the SUD provider network showed moderate to substantial changes between 2023 and 2024. Network percentage increases were as high as 50 percent, while the counts of providers gained or lost were typically below 70 percent. These changes continue the trend from 2023 of a gradual increase in the size of the overall SUD provider network. Six of the seven CCOs showing moderate changes in counts reported providers at a network level (i.e., a combined pool) rather than restricting counts to those available within respective service regions, including for regions or CCOs separated by hundreds

of miles. These CCOs included CPCCO, JCC, PCS-CG, PCS-CO, PCS-LN, and PCS-MP. This type of reporting may mask potentially substantial changes in the local SUD provider network.

Provider-to-Member Ratios

Table 3-6 shows the unique counts of MH and SUD providers, the number of members identified as having an MH or SUD diagnosis,[16] and the ratio of providers to members within each CCO's network. The provider-to-member ratio was calculated by dividing the number of members with an MH or SUD diagnosis enrolled with a CCO by the number of MH or SUD providers in the CCO's network. This metric serves as a way to standardize estimations of a CCO's or OHP FFS' provider network as it adjusts for membership size. Since OHA did not have specific provider-to-member ratio standards for any provider type, the results below are presented for information only.

Table 3-6—Provider-to-Member Ratios by CCO and Provider Type

Organization Name	MH			SUD		
	Providers (N)	Members (N)	Ratio	Providers (N)	Members (N)	Ratio
AH	250	4,879	1:20	74	8,920	1:121
AllCare	501	10,707	1:22	121	3,792	1:32
CHA	120	6,984	1:59	49	2,729	1:56
CPCCO	2,467	7,089	1:3	511	2,069	1:5
EOCCO	1,246	14,016	1:12	409	3,431	1:9
HSO	2,964	87,555	1:30	558	20,718	1:38
IHN	1,265	57,195	1:46	464	44,281	1:96
JCC	2,661	13,368	1:6	536	1,899	1:4
PCS-CO	4,079	19,489	1:5	578	4,498	1:8
PCS-CG	4,079	3,403	1:1	578	861	1:2
PCS-LN	4,079	24,896	1:7	578	5,520	1:10
PCS-MP	4,082	28,143	1:7	578	6,973	1:13
TCHP-SW	2,519	6,866	1:3	455	2,151	1:5
TCHP-TC	1,933	5,497	1:3	358	1,745	1:5
UHA	209	8,783	1:43	150	2,961	1:20
YCCO	2,292	9,312	1:5	352	3,819	1:11
OHP FFS	5,919	24,563	1:5	1,160	4,736	1:5

[16] The member population used to determine provider-to-member ratios was restricted to members with at least one IP or OP claim with an MH or SUD diagnosis during CY 2023 to better reflect the population in need of MH and SUD providers.

Overall, provider-to-member ratios were low, indicating the CCOs and OHP FFS had a large number of providers contracted to perform MH and SUD services relative to members with an MH or SUD diagnosis. However, this does not mean that members had greater access to MH and SUD providers compared to other provider types (e.g., PCPs and specialists). While provider-to-member ratios are not indicative of network adequacy in and of themselves, they serve as useful general trend indicators that often help to identify potential network outliers and data issues.

Time and Distance

As part of its evaluation, HSAG reviewed the geographic distribution of MH and SUD providers relative to members with an MH or SUD diagnosis[17] to assess the percentage of members with access to an MH or SUD provider within the OHA-defined, acceptable travel times and distances. This review included the average travel time (in minutes) and driving distance (in miles) to the nearest provider by provider type, as well as to the subsequent second and third nearest provider to further assess the overall availability of MH and SUD providers.

Table 3-7 presents the average time and distance to the nearest three MH and SUD providers, by organization and geographic setting (i.e., large urban). If the average driving time or distance exceeded the acceptable travel time and distance requirements set forth by OHA, the result is shaded in red. CCOs that do not have a large urban setting within their service region are not listed within the table.

Table 3-7—Average Time and Distance to the Nearest Three MH and SUD Providers by CCO and Geography—Large Urban

Organization Name	MH						SUD					
	Time (Min)			Distance (Miles)			Time (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
HSO	0.7	0.9	1.0	1.2	1.4	1.6	1.5	1.8	1.9	2.4	2.9	3.1
TCHP-TC	0.8	0.9	1.0	1.3	1.5	1.7	1.6	1.8	1.8	2.7	3.0	3.0
YCCO	1.6	2.1	2.2	1.7	2.2	2.4	4.1	4.3	4.3	4.7	4.9	5.0
OHP FFS	0.7	0.9	1.0	1.1	1.4	1.6	1.2	1.5	1.6	2.0	2.4	2.6

Overall, the average drive times and distances to the nearest three MH and SUD providers for all CCOs and OHP FFS were within the acceptable travel times and distances set by OHA (i.e., 10 minutes/5 miles for large urban areas.)

Table 3-8 presents the average time and distance to the nearest three MH and SUD providers, by organization and geographic setting (i.e., urban). If the average driving time or distance exceeded the

[17] The member population used to determine time and distance was restricted to members with at least one IP or OP claim with an MH or SUD diagnosis during CY 2023 to better reflect the population in need of MH and SUD providers. These results differ from the 2024 DSN Evaluation as the results in that report reflect full CCO membership.

acceptable travel time and distance requirements set forth by OHA, the result is shaded in red. CCOs that do not have an urban setting within their service region are not listed within the table.

Table 3-8—Average Time and Distance to the Nearest Three MH and SUD Providers by CCO and Geography—Urban

Organization Name	MH						SUD					
	Time (Min)			Distance (Miles)			Time (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
AllCare	1.1	1.4	1.5	1.2	1.5	1.7	1.6	2.4	2.5	1.9	2.8	2.9
IHN	0.8	1.1	1.2	0.8	1.1	1.2	1.4	1.6	1.8	1.5	1.7	1.9
JCC	0.8	0.9	1.1	0.9	1.0	1.2	2.6	2.6	2.7	3.0	3.0	3.1
PCS-CO	0.6	0.8	0.9	0.6	0.8	0.9	1.4	1.8	2.0	1.4	1.9	2.2
PCS-LN	0.7	0.9	1.2	0.9	1.2	1.5	1.6	1.7	2.0	2.0	2.2	2.8
PCS-MP	0.8	0.9	1.1	0.9	1.1	1.4	1.4	1.7	1.8	1.8	2.2	2.3
TCHP-SW	1.0	1.2	1.2	1.3	1.7	1.7	1.8	2.1	2.1	2.4	2.9	2.9
YCCO	1.2	1.5	1.7	1.2	1.7	1.9	1.6	1.6	1.6	1.8	1.8	1.8
OHP FFS	1.0	1.3	1.4	1.2	1.5	1.7	1.7	2.0	2.2	2.1	2.5	2.7

Overall, the average drive times and distances to the nearest three MH and SUD providers for all CCOs and OHP FFS were within the acceptable travel times and distances set by OHA (i.e., 25 minutes/15 miles for urban areas.)

Table 3-9 presents the average time and distance to the nearest three MH and SUD providers, by organization and geographic setting (i.e., rural). If the average driving time or distance exceeded the acceptable travel time and distance requirements set forth by OHA, the result is shaded in red. All CCOs and OHP FFS include rural urbanicities within their service regions.

Table 3-9—Average Time and Distance to the Nearest Three MH and SUD Providers by CCO and Geography—Rural

Organization Name	MH						SUD					
	Time (Min)			Distance (Miles)			Time (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
AH	3.0	3.8	4.6	3.2	4.1	5.0	10.3	11.2	11.2	11.2	12.2	12.2
AllCare	4.2	4.3	4.4	4.6	4.6	4.7	5.1	5.5	6.2	5.5	6.0	6.8
CHA	4.4	4.5	5.2	4.8	4.9	5.6	4.7	4.8	5.5	5.0	5.2	6.0
CPCCO	3.0	3.7	5.1	3.2	4.0	5.6	6.7	6.7	6.9	7.3	7.3	7.5
EOCCO	2.9	3.8	3.9	3.1	4.1	4.2	3.7	3.9	6.7	4.0	4.2	7.2
HSO	3.2	4.6	4.9	3.4	5.0	5.3	13.3	13.9	14.0	15.3	16.0	16.0
IHN	1.9	2.5	3.0	2.1	2.6	3.2	5.8	10.3	10.4	6.3	11.2	11.3

Organization Name	MH						SUD					
	Time (Min)			Distance (Miles)			Time (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
JCC	3.4	4.1	4.3	3.7	4.5	4.6	15.9	15.9	16.0	18.1	18.2	18.2
PCS-CO	2.6	3.0	3.4	2.8	3.3	3.6	4.9	5.1	5.1	5.3	5.5	5.6
PCS-CG	2.8	3.3	3.5	3.1	3.6	3.7	10.0	10.0	10.0	10.9	10.9	10.9
PCS-LN	2.8	3.3	3.7	3.0	3.6	4.0	9.0	9.0	16.5	9.8	9.8	18.1
PCS-MP	1.7	2.1	2.4	1.8	2.2	2.6	2.9	7.8	9.9	3.1	8.6	11.1
TCHP-SW	3.0	3.7	3.9	3.3	4.0	4.3	11.7	12.0	19.0	12.8	13.1	20.7
TCHP-TC	6.1	6.2	6.2	6.6	6.7	6.7	14.1	15.0	15.1	15.8	17.0	17.1
UHA	3.5	5.4	5.5	3.8	5.8	6.0	6.9	7.3	8.8	7.5	7.9	9.6
YCCO	2.4	2.9	3.1	2.6	3.1	3.4	3.7	3.8	5.3	4.0	4.2	5.8
OHP FFS	4.3	5.0	5.9	4.6	5.5	6.4	7.7	9.3	11.0	8.4	10.1	12.1

Overall, OHP FFS and all CCOs except TCHP-SW exhibited average drive times and distances to the nearest three MH and SUD providers within the acceptable travel times and distances set by OHA (i.e., 30 minutes/20 miles for rural areas.) The average distance for TCHP-SW members to the third nearest SUD provider was 20.7 miles in rural areas. Although just over the OHA-defined travel times and distances, this average distance to the third nearest provider represented a moderate increase from the average reported distance to the nearest two providers (i.e., 12.8 miles and 13.1 miles, respectively).

Table 3-10 presents the average time and distance to the nearest three MH and SUD providers, by organization and geographic setting (i.e., CEAC). If the average driving time or distance exceeded the acceptable travel time and distance requirements set forth by OHA, the result is shaded in red. CCOs that do not have a CEAC setting within their service region are not listed within the table.

Table 3-10—Average Time and Distance to the Nearest Three MH and SUD Providers by CCO and Urbanicity—CEAC

Organization Name	MH						SUD					
	Time (Min)			Distance (Miles)			Time (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
EOCCO	6.6	7.9	8.2	7.2	8.6	8.9	7.3	7.7	7.8	8.0	8.3	8.4
PCS-CO	2.2	3.3	3.4	2.4	3.6	3.6	4.1	4.6	4.6	4.4	4.9	4.9
OHP FFS	5.7	7.1	8.4	6.1	7.7	9.1	8.4	9.4	14.4	9.1	10.2	15.6

Overall, the average drive times and distances to the nearest three MH and SUD providers for all CCOs and OHP FFS were within the acceptable travel times and distances set by OHA (i.e., 40 minutes/30 miles for CEAC areas.)

Table 3-11 presents the percentages of CCO members[18] with acceptable access (i.e., travel time or distance) to MH and SUD services, by CCO and geographic setting. The results are aggregated across all members and not stratified by adult and pediatric populations. CCOs that do not have one of the geographic settings within their service regions are listed as *NA* and shaded gray for those categories. Results showing less than 95 percent of members meeting the acceptable travel times and distances for each urbanicity are shaded red.[19]

Table 3-11—Time and Distance Results for Tier 1 Providers by CCO and Urbanicity

Organization Name	MH				SUD			
	Large Urban	Urban	Rural	CEAC	Large Urban	Urban	Rural	CEAC
AH	NA	NA	>99.9%	NA	NA	NA	92.2%	NA
AllCare	NA	100%	99.7%	NA	NA	100%	97.9%	NA
CHA	NA	NA	97.6%	NA	NA	NA	96.9%	NA
CPCCO	NA	NA	100%	NA	NA	NA	97.1%	NA
EOCCO	NA	NA	99.6%	96.7%	NA	NA	99.7%	96.8%
HSO	100%	NA	100%	NA	99.4%	NA	94.8%	NA
IHN	NA	100%	100%	NA	NA	100%	98.4%	NA
JCC	NA	100%	99.9%	NA	NA	100%	92.5%	NA
PCS-CO	NA	100%	99.7%	99.8%	NA	100%	98.5%	99.3%
PCS-CG	NA	NA	98.2%	NA	NA	NA	95.4%	NA
PCS-LN	NA	100%	100%	NA	NA	100%	91.2%	NA
PCS-MP	NA	100%	>99.9%	NA	NA	100%	99.6%	NA
TCHP-SW	NA	100%	99.5%	NA	NA	100%	92.0%	NA
TCHP-TC	99.8%	NA	99.2%	NA	98.3%	NA	93.8%	NA
UHA	NA	NA	99.8%	NA	NA	NA	97.6%	NA
YCCO	100%	100%	100%	NA	90.1%	100%	100%	NA
OHP FFS	100%	100%	98.6%	98.9%	99.8%	100%	95.4%	98.0%

While more than 95 percent of CCO and OHP FFS members, regardless of urbanicity, were within acceptable travel times and distances to the nearest MH providers, six CCOs with service areas comprising rural urbanicities had fewer than 95 percent of members within acceptable travel times and

[18] The member population used to determine time and distance was restricted to members with at least one IP or OP claim with an MH or SUD diagnosis during CY 2023 to better reflect the population in need of MH and SUD providers.

[19] Although OHA has established time and distance standards, CCO compliance is not assessed as part of this evaluation. OHA assesses CCO compliance to time and distance standards based on adult and pediatric provider types comprising three tiers; 95 percent or more pediatric and adult members must meet the acceptable travel times and distances to the nearest adult and pediatric provider, regardless of urbanicity.

distances to the nearest SUD provider (AH, HSO, JCC, PCS-LN, TCHP-SW, and TCHP-TC). However, all six CCOs showed that more than 90 percent of members were within acceptable rural access requirements. Additionally, one CCO (YCCO) had fewer than 95 percent of its members within acceptable time and distance requirements for SUD providers in a large urban geographic setting, although more than 90 percent of YCCO's members still had access within 5 miles or 10 minutes.

Appointment Availability

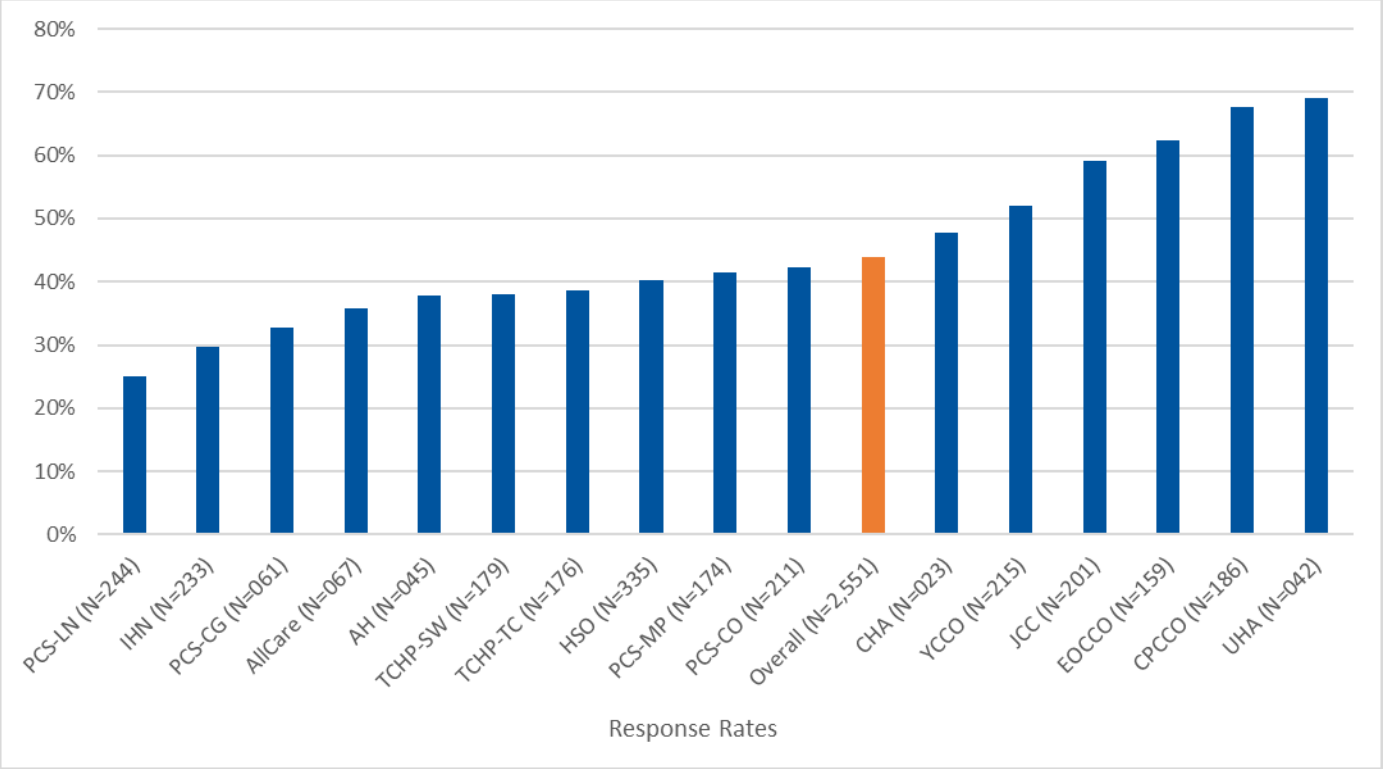
Even with adequate capacity and the appropriate distribution of services, assessing the timeliness of access to relevant services is critical to ensuring adequate access to care. *Appointment Availability* addresses how quickly OHP members are able to make an appointment and get in to see a provider. In 2023, HSAG conducted a revealed telephone survey of OP BH locations contracted with one or more CCOs. The purpose of the study was to assess the accuracy of OP MH provider data and collect appointment availability of OHP members for OP MH services. Specifically, the survey examined the ability of new and existing members to obtain both urgent and non-urgent appointments within established time frames.

Survey findings identified several opportunities for improving the quality of the CCOs' provider capacity data and addressing the availability of new and existing patient appointments for OHP members. The following are a subset of the results from the study.

Response Rates

Survey callers attempted to contact each survey case up to two times during standard business hours on different days and times of day; a case that could not be contacted was considered nonresponsive. Figure 3-10 illustrates the survey response rates by CCO. "N" represents the number of cases resulting in successful contact (cases reached), or the numerator, for the measure. The denominator includes all cases sampled.

Figure 3-10—Response Rates by CCO



Overall, the response rate was 43.9 percent with individual CCO response rates ranging from 25.0 percent (PCS-LN) to 69.0 percent (UHA). Of the 1,432 cases that could not be reached, nearly half of the unsuccessful calls (44.5 percent) were due to outreach callers reaching a voicemail, busy signal, continuous ringing, or the caller was placed on an extended hold time after two attempts. Bad phone number information (i.e., disconnected number, fax number, or reaching a nonmedical facility) accounted for 11.7 percent of the unsuccessful calls followed by office locations refusing to participate in the survey (4.1 percent). IHN, AH, and AllCare had the highest percentages of cases in which the service locations were unable to be reached (i.e., 60.5 percent, 57.8 percent, and 56.7 percent, respectively), while PCS-LN and PCS-CG had the highest percentages of cases with a bad phone number (i.e., 27.5 percent and 26.2 percent, respectively).

Provider Data Accuracy

Once contact with a provider office was made, callers verified provider information prior to requesting the availability of appointments. Errors associated with provider data resulted in decreased opportunities to secure an appointment, representing substantial barriers to obtaining an appointment. Table 3-12 shows the percentage of calls that were able to verify key provider data elements.

Table 3-12—Overall Provider Data Accuracy Results by CCO

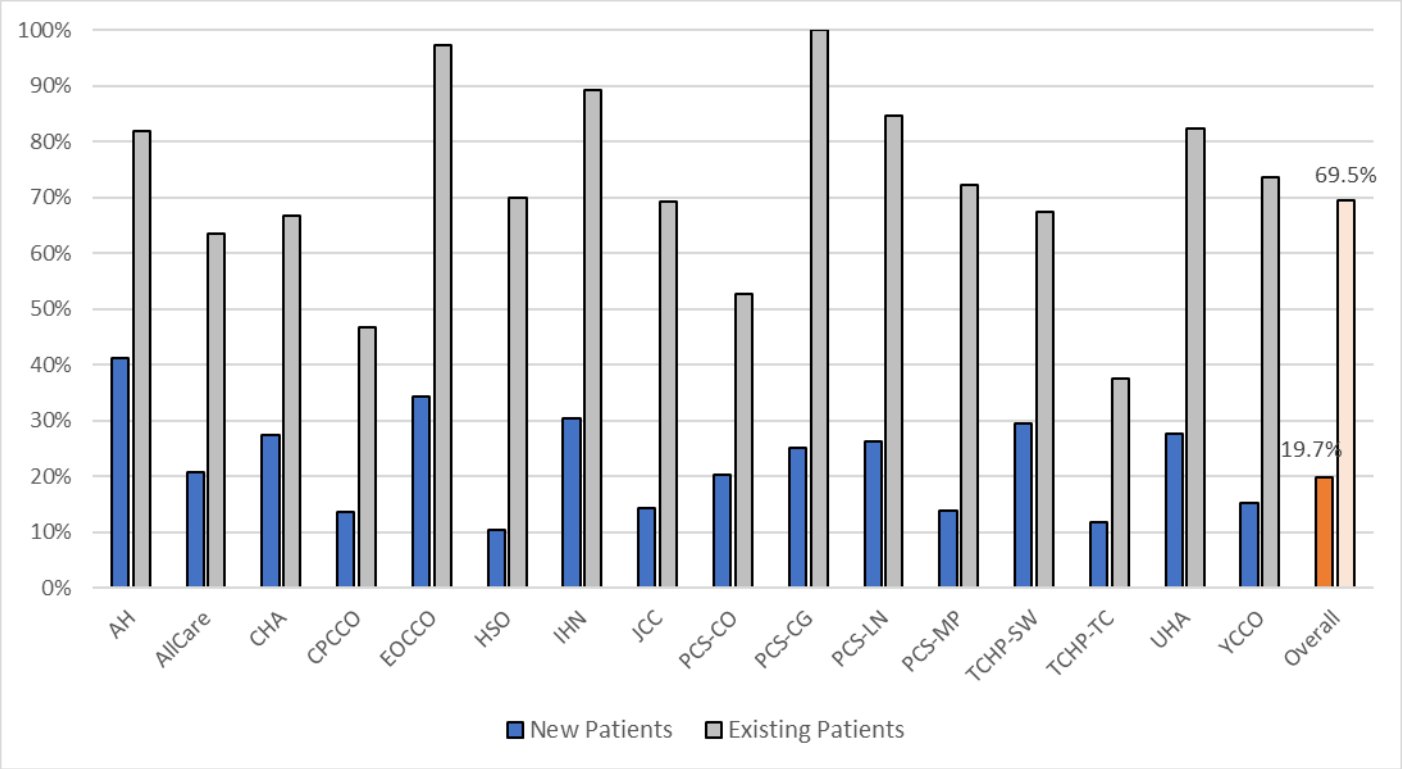
CCO	Correct Provider Location	Offering Requested Service	Accepts OHP	Accepts CCO	Accepting New Patients
AH	76.5%	64.7%	64.7%	64.7%	52.9%
AllCare	70.8%	54.2%	54.2%	45.8%	37.5%
CHA	81.8%	72.7%	72.7%	54.5%	45.5%
CPCCO	82.5%	64.3%	61.9%	37.3%	27.8%
EOCCO	77.8%	62.6%	57.6%	36.4%	35.4%
HSO	71.9%	37.0%	36.3%	22.2%	16.3%
IHN	79.7%	66.7%	59.4%	53.6%	50.7%
JCC	79.8%	62.2%	58.0%	21.8%	21.0%
PCS-CO	73.0%	69.7%	52.8%	42.7%	41.6%
PCS-CG	60.0%	45.0%	35.0%	25.0%	25.0%
PCS-LN	70.5%	42.6%	42.6%	42.6%	34.4%
PCS-MP	80.6%	51.4%	51.4%	50.0%	27.8%
TCHP-SW	83.8%	72.1%	70.6%	63.2%	58.8%
TCHP-TC	66.2%	60.3%	57.4%	47.1%	38.2%
UHA	86.2%	69.0%	65.5%	58.6%	58.6%
YCCO	79.5%	56.3%	52.7%	33.9%	32.1%
Overall	**76.9%**	**58.3%**	**54.3%**	**39.2%**	**33.7%**

Overall, only one-third of all outreach calls resulted in callers being able to request an appointment. While individual CCO performance showed considerable variation by provider data element, none of the CCOs exceeded a 60 percent level of accuracy, indicating substantial barriers to members' ability to schedule appointments. HSO exhibited the lowest percentages of verified locations offering the requested services (37.0 percent), accepting the CCO (22.2 percent), and accepting new patients (16.3 percent), while PCS-CG had the lowest percentage of office locations that verified the provider's location (60.0 percent) and accepting OHP (35.0 percent).

Appointment Availability

Figure 3-11 displays the number and percentage of survey respondents with a verified location offering the requested services that accepted OHP and the CCO, accepted new patients, and offered a new or existing patient appointment out of all respondents, including providers who refused to participate in the survey.

Figure 3-11—Overall Appointment Availability by CCO and Patient Status



Due to the quality of provider data and conditional requirements associated with scheduling appointments, only 19.7 percent and 69.5 percent resulted in an appointment date for new and existing patients, respectively. In addition to barriers created through inaccurate provider data, common reasons for not scheduling an appointment included the schedule or calendar being unavailable (27.1 percent), requiring pre-registration or personal information to schedule (23.2 percent), or other limitations (20.5 percent). HSO (10.4 percent) and TCHP-TC (37.5 percent) had the lowest rates of appointments offered for new and existing patients, respectively.

Appointment Wait Times

The CCOs must have policies and procedures in place to ensure the scheduling of MH appointments is reasonable. For routine MH services for non-priority populations, assessments should be scheduled and performed within seven calendar days of the request, with a second appointment occurring as clinically appropriate. For urgent MH appointments for all populations, appointments should be provided within 24 hours (or one calendar day) of the request. Table 3-13 shows the average wait time to routine and urgent appointments for new and existing patients as well as the percentage of appointments that were compliant with established wait time standards. Green shading indicates whether the average wait time met standards.

Table 3-13—Overall Appointment Availability for Providers Reached

CCO	Routine Appointments				Urgent Appointments			
	New Patients		Existing Patients		New Patients		Existing Patients	
	Avg Wait Time to Appt (Days)	Percent Compliant	Avg Wait Time to Appt (Days)	Percent Compliant	Avg Wait Time to Appt (Days)	Percent Compliant	Avg Wait Time to Appt (Days)	Percent Compliant
AH	21	28.6%	4	100%	11	14.3%	1	75.0%
AllCare	7	60.0%	4	100%	4	50.0%	2	57.1%
CHA	42	0.0%	26	66.7%	28	33.3%	19	50.0%
CPCCO	34	17.6%	12	54.5%	25	28.6%	11	38.9%
EOCCO	18	58.8%	11	85.7%	18	35.3%	10	60.0%
HSO	14	71.4%	7	95.0%	11	14.3%	2	66.7%
IHN	13	50.0%	3	100%	8	38.5%	1	83.3%
JCC	20	47.1%	9	72.2%	20	31.3%	7	55.6%
PCS-CO	13	77.8%	5	85.0%	13	16.7%	5	42.1%
PCS-CG	24	60.0%	0	100%	24	20.0%	2	80.0%
PCS-LN	19	56.3%	3	95.5%	13	12.5%	3	45.5%
PCS-MP	41	50.0%	8	76.9%	44	22.2%	4	56.5%
TCHP-SW	5	83.3%	5	96.6%	13	10.0%	1	75.0%
TCHP-TC	13	62.5%	8	81.8%	9	33.3%	2	70.0%
UHA	23	16.7%	6	100%	9	20.0%	2	50.0%
YCCO	13	50.0%	4	92.9%	13	30.0%	2	77.8%
Overall	**19**	**53.7%**	**7**	**87.6%**	**16**	**24.7%**	**4**	**62.0%**

The overall average wait time for non-urgent or routine MH visits was 19 calendar days for new patients and seven calendar days for existing patients. Of the cases reached for which a non-urgent or routine appointment was made, 53.7 percent and 87.6 percent of the appointments were compliant with appointment availability standards (i.e., seven calendar days) for new and established patients, respectively. The results suggest that while established patients are more likely to obtain an appointment within seven calendar days, just over half of new patients failed to get an appointment within seven calendar days.

The overall average wait times for urgent MH visits was 16 calendar days for new patients and four calendar days for existing patients. Of the cases reached for which an urgent appointment was made, 24.7 percent and 62.0 percent of the appointments were compliant with appointment availability standards (i.e., 24 hours) for new and established patients, respectively. The results suggest that while established patients are more likely to obtain an appointment within 24 hours, nearly one-third do not.

Since OHP FFS was not included in the 2023 BH Telephone Survey, HSAG collected and evaluated information on OHP FFS' processes for monitoring appointment availability based on its completion of an Appointment Availability Questionnaire. OHP FFS reported that it does not currently have any mechanisms in place to monitor appointment availability for MH/SUD or M/S providers and relied solely on grievance data and issues raised through OHA's Ombuds Program.

Access-Related Grievances

The 2024 MHP Evaluation also reviewed 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. Table 3-14 shows the percentage of access-related grievances compared to the overall number of grievances for MH and SUD services. At the time of this review, OHP FFS did not maintain a centralized repository of grievances, nor did it track and categorize the types of grievances received. As such, OHP FFS did not capture grievance data consistently across divisions such that information was reliably categorized, or easily extracted and monitored, and was not included in this analysis.

Table 3-14—Percentage of Access-Related MH/SUD Grievances

CCO	Total Grievances	MH/SUD		Access-Related MH/SUD Grievances	
		Number	Percent	Number	Percent
AH	568	10	1.8%	0	0.0%
AllCare	276	65	23.6%	11	16.9%
CHA	171	1	0.6%	0	0.0%
CPCCO	341	3	0.9%	1	33.3%
EOCCO	1,020	41	4.0%	10	24.4%
HSO	7,974	197	2.5%	28	14.2%
IHN	963	16	1.7%	1	6.3%
JCC	509	21	4.1%	2	9.5%
PCS-CO	820	15	1.8%	1	6.7%
PCS-CG	141	2	1.4%	2	100%
PCS-LN	2,565	26	1.0%	7	26.9%
PCS-MP	2,173	79	3.6%	10	12.7%
TCHP-SW	488	12	2.5%	3	25.0%
TCHP-TC	753	26	3.5%	2	7.7%
UHA	522	53	10.2%	35	66.0%
YCCO	203	4	2.0%	1	25.0%
CCO Aggregate	**19,487**	**571**	**2.9%**	**114**	**20.0%**

Overall, only 2.9 percent of all CCO grievances in 2023 were associated with MH/SUD services and benefits, represent a small increase since 2022 (2.2 percent). The percentage of MH/SUD-related grievances across individual CCOs ranged from 0.6 percent (CHA) to 23.6 percent (AllCare), with an average CCO rate of 4.1 percent. Results showed a consistent distribution of MH/SUD-related grievances except for AllCare and UHA, with most CCOs exhibiting less than 5 percent of all grievances related to MH/SUD services. While the percentage of access-related grievances associated with MH/SUD services was low for CCOs with a CCO aggregate rate of 20.0 percent, the range of access-related MH/SUD grievances across individual CCOs was substantially wider. For seven CCOs, the percentage of MH/SUD access-related grievances was greater than or equal to 20 percent, with one CCO (UHA) having two-thirds of its MH/SUD grievances being related to access. (Note that while PCS-CG showed 100 percent of its grievances were related to access, this accounted for only two total grievances.) Although these results suggest that access-related grievances are a focus of many MH/SUD grievances, the results should be interpreted with caution due to the overall low total numbers of MH/SUD grievances. Additionally, as reported by OHA's CP groups, MH/SUD members are less likely to submit a grievance, increasing the instability of this metric in understanding issues related to members' access to critical services.

Special Topic Evaluation—Peer Support Services

To conduct the PSS evaluation, OHA extracted data on OHP Medicaid beneficiaries with an MH and SUD diagnosis and claims for self-help/peer services for CY 2023. The data were then aggregated by CCO/OHP FFS and county to generate a series of counts and description statistics including:

- Total number of members with a primary MH or SUD diagnosis and associated MM
- Number of paid and denied PSS claims, where HCPCS = H0038
- Utilization of PSS per 1,000 MM
- The average, median, minimum, and maximum number of days between bill date and paid date
- The average, median, minimum, and maximum number of days between date of service (DOS) and paid date.

This information was then aggregated to generate baseline information on the extent to which PSS are used by members with MH and SUD diagnoses, differences in the percentage of paid vs. denied PSS claims, and median time between the date PSS services were rendered and the claim was paid. The analysis was stratified by organization (i.e., CCO and OHP FFS) and by county to better understand utilization patterns and reported individually for members with a primary diagnosis of MH and SUD. As utilization metrics are not inherently "good or bad," the baseline utilization and timeliness results presented in this section are for informational purposes only.

PSS Results by CCO and OHP FFS

Table 3-15 displays the PSS utilization results for claims with dates of service in 2023 among members with an MH diagnosis. As a baseline measurement year, results are presented for informational purposes only.

Table 3-15—Baseline PSS Evaluation Results for Members With MH Diagnosis

Organization Name	Number of PSS Claims	PSS/ 1,000 MM	Paid PSS Claims (Percent)	Median Days From DOS to Payment
AH	145	0.441	66.7%	35
AllCare	170	0.223	97.5%	91
CHA	484	1.559	88.8%	58
CPCCO	202	0.464	85.0%	110
EOCCO	689	0.781	99.0%	41
HSO	1,048	0.199	92.5%	42
IHN	149	0.151	76.6%	50
JCC	336	0.436	87.7%	90
PCS-CO	546	0.606	89.3%	48
PCS-CG	106	0.506	93.7%	27
PCS-LN	529	0.484	92.0%	25
PCS-MP	967	0.552	96.6%	27
TCHP-SW	210	0.487	87.3%	48
TCHP-TC	38	0.069	77.0%	35
UHA	133	0.295	89.5%	41
YCCO	239	0.555	96.6%	35
OHP FFS	833	0.489	80.5%	25

Overall, the median PSS utilization rate for members with an MH diagnosis was 0.484/1,000 MM with individual CCO and OHP FFS utilization rates ranging from 0.069/1,000 MM (TCHP-TC) to 1.559/1,000 MM (CHA), demonstrating considerable variation across organizations. CHA's use of PSS (1.559/1,000 MM) among its MH population was substantially higher than the next closest CCO (i.e., 0.781 [EOCCO]). Both of these CCOs' service regions are comprised largely of rural and CEAC geographic areas. In general, lower utilization of PSS services among members with an MH diagnosis was associated with the CCOs with urban and large urban areas.

Regarding the payment of PSS claims for members with an MH diagnosis, most CCOs and OHP exhibited a moderate to high rate of paid PSS claims with a median percentage of PSS claims paid of 89.3 percent. Individual CCO and OHP FFS rates ranged from 66.7 percent (AH) to 99.0 percent (EOCCO). Overall, 13 of the CCOs exhibited payment rates among PSS claims for members with an MH diagnosis that were greater than 80 percent with seven exhibiting payment rates greater than

90 percent. Conversely, AH (66.7 percent), IHN (76.6 percent), and TCHP-TC (77.0 percent) showed the lowest percentage of paid PSS claims.

Finally, 82.4 percent of PSS claims for members with an MH diagnosis with dates of service in 2023 were paid within 60 days of receipt, with most (58.8 percent) being paid between 31 to 60 days from date of service. On average, the CCOs and OHP FFS paid claims within 49 days of the date of service with minor variation exhibited in individual organization timeliness to payment (i.e., 25 days [PCS-LN and OHP FFS], each, to 110 days [CPCCO]). Additionally, there were three plans with median days to payment greater than 90 days (i.e., AllCare, JCC, and CPCCO).

Table 3-16 displays the PSS utilization results for claims with dates of service in 2023 among members with an SUD diagnosis. As a baseline measurement year, results are presented for informational purposes only.

Table 3-16—Baseline PSS Evaluation Results for Members With SUD Diagnosis

Organization Name	Number of PSS Claims	PSS/ 1,000 MM	Paid PSS Claims (Percent)	Median Days From DOS to Payment
AH	190	0.578	76.1%	35
AllCare	696	0.915	97.0%	43
CHA	200	0.644	84.9%	52
CPCCO	230	0.528	92.2%	50
EOCCO	667	0.756	91.4%	35
HSO	2,458	0.466	93.0%	40
IHN	746	0.758	94.7%	24
JCC	699	0.908	96.6%	36
PCS-CG	61	0.291	61.8%	29
PCS-CO	612	0.680	97.0%	21
PCS-LN	335	0.307	91.0%	30
PCS-MP	913	0.521	94.5%	22
TCHP-SW	187	0.434	85.3%	30
TCHP-TC	211	0.383	85.6%	31
UHA	327	0.724	94.8%	31
YCCO	163	0.379	92.5%	31
OHP FFS	1,577	0.925	64.1%	71

Overall, the median PSS utilization rate for members with an SUD diagnosis was somewhat higher (0.578/1,000 MM) compared to members with an MH diagnosis (i.e., 0.484/1,000 MM), with individual CCO and OHP FFS utilization rates ranging from 0.291/1,000 MM (PCS-CG) to 0.925/1,000 MM (OHP FFS), demonstrating less variation across organizations than among MH members receiving PSS.

Like members with an MH diagnosis, the percentage of paid PSS claims for CCOs and OHP FFS among members with an SUD diagnosis was moderate to high with a median percentage of PSS claims paid of 92.2 percent. Individual CCO and OHP FFS rates ranged from 61.8 percent (PCS-CG) to 97.0 percent (AllCare and PCS-CO). Overall, 14 of the CCOs exhibited payment rates among PSS claims for members with an SUD diagnosis that were greater than 80 percent, with 11 CCOs exhibiting payment rates greater than 90 percent. Conversely, PCS-CG (61.8 percent) and OHP FFS (64.1 percent) showed the lowest percentages of paid PSS claims for members with an SUD diagnosis.

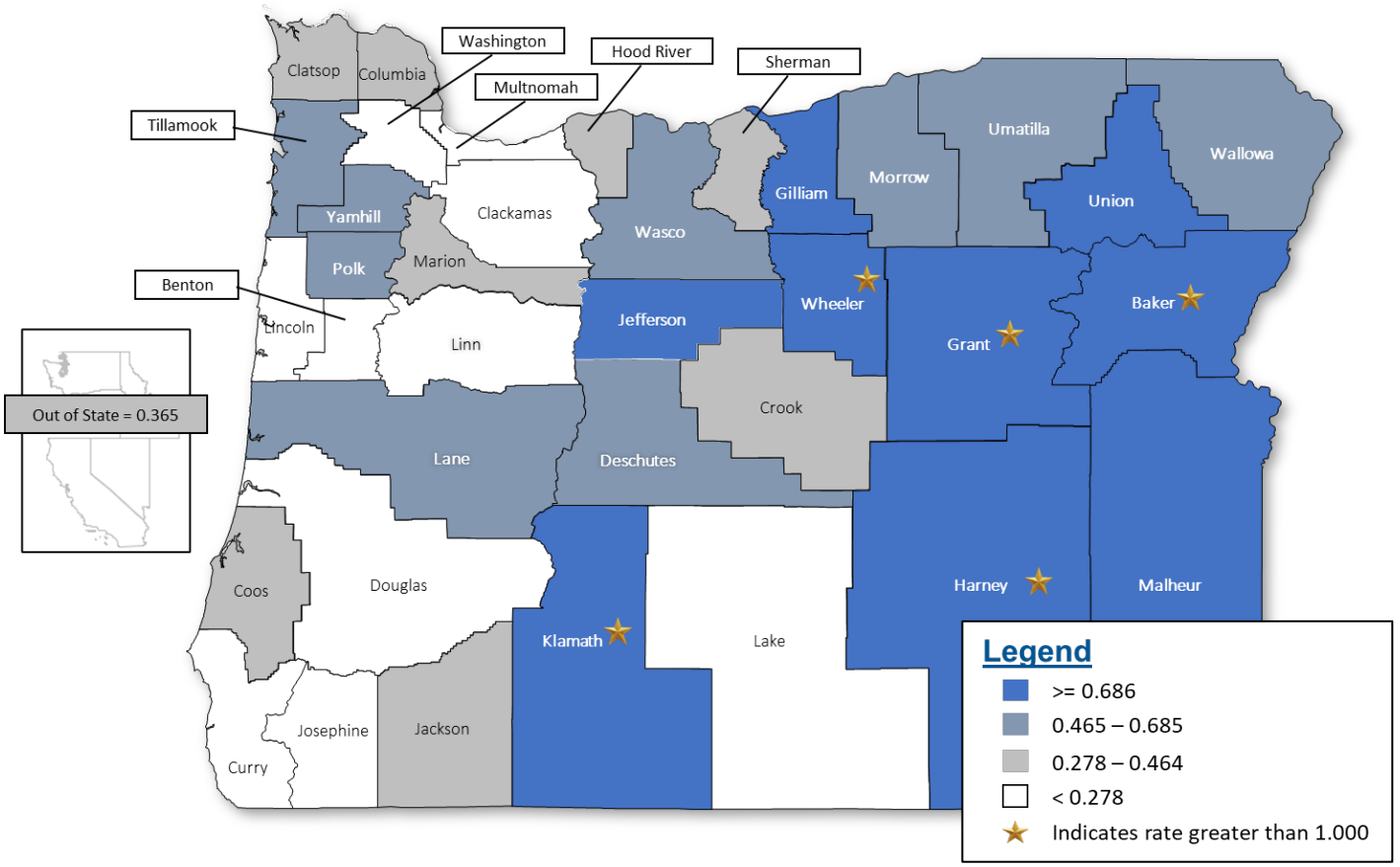
Finally, 94.1 percent of PSS claims for members with an SUD diagnosis with dates of service in 2023 were paid within 60 days receipt with most (58.8 percent) being paid between 31 to 60 days from date of service. On average, the CCOs and OHP FFS paid claims within 36 days of the date service with minor variation exhibited in individual organization timeliness to payment (i.e., 21 days [PCS-CO] to 71 days [OHP FFS], which was the only organization with a median payment date greater than 60 days).

PSS Results by County

Figure 3-12 and Figure 3-13 show PSS utilization rates for members with an MH diagnosis by county based on quartiles.[20] Detailed results related to county-specific utilization rates, percentage of paid PSS claims, and the timeliness of payment are presented in Appendix S and summarized below. Overall, PSS utilization results by county generally aligned with MH and SUD PSS utilization results by organization. Given the region-based structure of the Oregon CCO program, similarities in performance are expected.

[20] A *quartile* is a division of PSS utilization rates into four defined intervals (i.e., < 25th percentile, 25th–50th percentile, 50th–75th percentile, and > 75th percentile) based on the values of the data and how they compare to the entire set of PSS utilization rates.

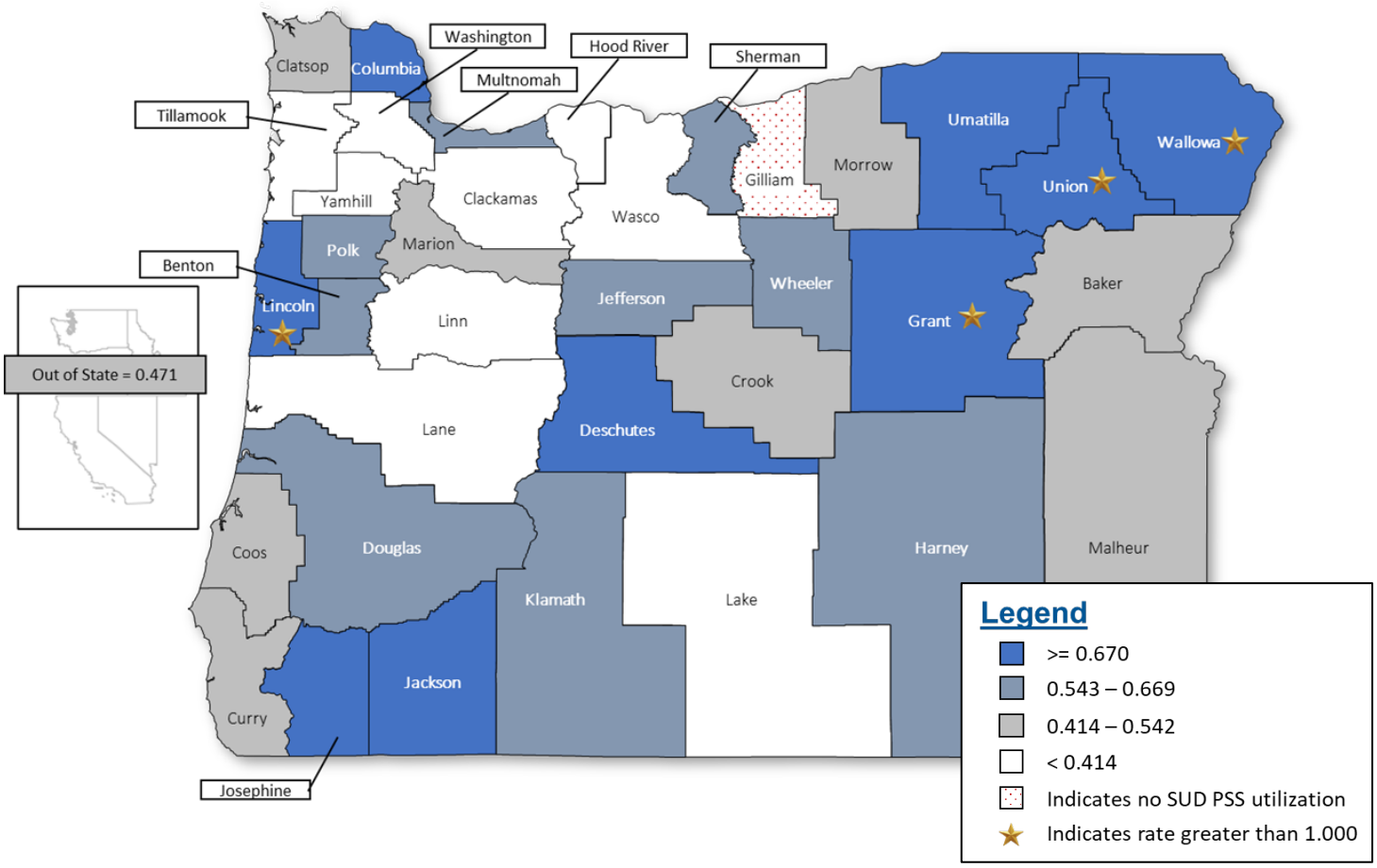
Figure 3-12—PSS Utilization by County for MH Members



General findings related to PSS utilization by members with an MH diagnosis include the following:

- The median county-based PSS utilization rate for members with an MH diagnosis was 0.464/1,000 MM, with individual county utilization rates ranging from 0.025/1,000 MM (Lake) to 1.842/1,000 MM (Grant) demonstrating considerable variation across counties.
- Counties with utilization rates above 1.000 included Baker (1.009), Harney (1.244), Wheeler (1.293), Klamath (1.371), and Grant (1.842), of which all represent counties with extreme access consideration, except for Klamath County, which is designated a rural urbanicity. In general, utilization was higher among less urban areas.
- On average, the percentage of paid PSS claims was 87.9 percent statewide with individual county rates ranging from 33.3 percent (Lake) and 100 percent (Gilliam and Sherman, each). Overall, 31 of 37 counties' payment rates among PSS claims for members with an MH diagnosis were greater than 80 percent, with 22 exhibiting payment rates greater than 90 percent.
- Overall, 89.2 percent of PSS claims for members with an MH diagnosis with dates of service in 2023 were paid within 60 days receipt with most (62.2 percent) being paid between 31 to 60 days from the date of service. On average, the CCOs and OHP FFS paid claims within 43 days of the date of service with minor variation exhibited in the timeliness of payment across counties (i.e., 18 days [Wallowa] to 120 days [Columbia], the only county with median days to payment greater than 90 days).

Figure 3-13—PSS Utilization by County for SUD Members



General findings related to PSS utilization by members with an SUD diagnosis include the following:

- The median county-based PSS utilization rate for members with an SUD diagnosis was 0.544/1,000 MM, with individual county utilization rates ranging from 0.151/1,000 MM (Tillamook) to 1.892/1,000 MM (Lincoln), demonstrating considerable variation across counties and somewhat higher utilization than members with an MH diagnosis.
- There were no PSS claims for members with SUD diagnosis reported in Gilliam County.
- Counties with utilization rates above 1.000 included Grant (1.147), Union (1.454), Wallowa (1.590), and Lincoln (1.892), of which all represent counties with extreme access consideration or designation as a rural urbanicity.
- On average, the percentage of paid PSS claims was 86.2 percent statewide, with individual county rates ranging from 62.5 percent (Columbia) and 100 percent (Wheeler). Overall, 26 of 36 counties' payment rates among PSS claims for members with an SUD diagnosis were greater than 80 percent, with 17 exhibiting payment rates greater than 90 percent.
- Overall, 86.2 percent of PSS claims for members with an SUD diagnosis and dates of service in 2023 were paid within 60 days receipt, with most (55.6 percent) being paid between 31 to 60 days

from the date of service. On average, the CCOs and OHP FFS paid claims within 50 days of the date service, with considerable variation exhibited in the timeliness of payment across counties (i.e., 21 days [Deschutes, Marion, and Wallowa] to 327 days [Sherman]). Three counties exhibited median days to payment considerably greater than 90 days—i.e., Jefferson (135 days), Columbia (147 days), and Sherman (327 days).

4. Discussion

Conclusions

The overall findings from the 2024 MHP Evaluation are presented below.

Treatment Limitation Review

Overall, neither the CCOs nor OHP FFS reported making any changes to, nor do the organizations apply FRs or AL/ADLs in the administration of, MH/SUD and M/S benefits for IP, OP, Rx, or EC services. Additionally, while one CCO reported using QTLs in its management of MH/SUD and M/S benefits, the QTLs were actually soft limits and should have been categorized as NQTLs since members can receive additional services based on medical necessity. These findings align with prior MHP evaluations and align with expectations based on the OHP regulatory structure.

The CCOs and OHP FFS reported a variety of changes in the organizational structures used to manage and ensure that health care services members received were necessary and appropriate. Many of the changes were associated with modifications to subcontractual relationships, including the delegation of managed care functions to existing subcontractors and updates to clinical guidelines. However, none of the changes identified by the CCOs and OHP FFS during the attestation review were found to negatively impact parity. The CCOs also reported several changes in the operational policies, procedures, and processes governing the administration of MH/SUD and M/S benefits. Among the most prevalent operational changes were to Medical Management NQTLs related to UM processes (i.e., PA, CR, and RR). Three CCOs attested to the absence of operational changes that were previously confirmed to support the parity of MH/SUD and M/S benefits. Overall, the evaluation of reported changes applied to NQTLs (i.e., Medical Management, Provider Network, and Pharmacy Management) by the CCOs continued to demonstrate parity across MH/SUD and M/S benefits; no CCO recommendations were identified based on the 2024 MHP attestation review.

Most of the organizations that received a *Partially Compliant* or *Not Compliant* finding in the 2023 MHP Evaluation Summary Report were able to provide additional documentation to demonstrate parity and resolve findings. However, two organizations were unable to show evidence of sufficient oversight of subcontractors or vendors to assess parity. As a result, both organizations received a less than *Compliant* rating. OHP FFS was the only organization to receive a *Partially Compliant* rating for more than one NQTL domain (i.e., Medical Management, Provider Network, and Pharmacy Management) and overall. This was largely due to the lack of supporting documentation (e.g., internal policies, procedures, processes, standard operating procedures, and workflows) to demonstrate how the treatment limitations were implemented and applied to MH/SUD and M/S benefits. As a result, OHP FFS was unable to demonstrate that NQTLs were comparable and not applied more stringently for MH/SUD benefits compared to M/S benefits. Additionally, OHP FFS did not provide necessary information related to its subcontractors or vendors, listed references to regulatory requirements (i.e., OARs) and coverage guidelines (i.e., the HERC Prioritized List of Health Services), and included links to OHP

webpages. While OHP FFS did provide some process flows, these documents represented step-by-step processing and failed to address the application to MH/SUD and M/S benefits; descriptions of the requirements; and evidence to support development of the NQTL. Overall, OHP FFS continues to demonstrate a lack of defined operational policies and procedures to support the implementation, management, and monitoring of NQTLs to ensure parity. Without appropriate documentation of operational processes for administering MH/SUD and M/S benefits, OHP FFS remains noncompliant with MHP requirements.

Administrative Data Profile

For the Administrative Data Profile, parity between MH/SUD and M/S benefit administration was evaluated across three domains: claims (i.e., paid IP and OP claims, including IN and OON providers); UM (i.e., IP, OP, and Rx PA denials); and provider enrollment (i.e., terminations and provider application approvals). Overall, CCO aggregate results across each domain continued to show minimal differences in the administration of MH/SUD and M/S benefits across the CCOs and OHP FFS, although considerable variation in CCO performance remains within each of the measures. As noted in earlier MHP evaluations, the data submitted by the CCOs and OHP FFS continue to raise concerns related to the quality and consistency of data and/or implementation of claims, UM, and provider enrollment processes. The presence of outlier counts, incomplete data, and inconsistent trends all suggest issues with data collection, extraction, and/or reporting which may mask or bias outcomes associated with the study, although this is not necessarily indicative of an impact on parity across benefit types. Identified differences in claims, UM, and provider enrollment outcome patterns suggest additional review by the CCOs and OHP FFS is needed.

Claims

Overall, the difference in the percentage of paid MH/SUD and M/S claims for the CCO aggregate across all claims (i.e., IP, OP, IN, and OON) was negligible, although individual CCOs and OHP FFS exhibited considerable variation in payment rates across all stratifications. When individual CCO and OHP FFS differences were moderate or substantial for paid IP and OP claims, the deviation was generally due to a higher percentage of paid MH/SUD claims versus paid M/S claims. When compared to 2023 findings, a greater number of CCOs exhibited moderate differences in the payment of MH/SUD IP claims compared to M/S IP claims (i.e., four CCOs in 2023 to 13 CCOs and OHP FFS). Of the CCOs and OHP FFS with moderate differences, four CCOs and OHP FFS reported higher rates of denied MH/SUD IP claims compared to M/S IP claims. These outcomes suggest the need for further investigation to determine whether UM or claim processes negatively impact MH/SUD claims. Differences among the CCOs' and OHP FFS' paid OP claims were generally less when compared to paid IP claims.

When restricting the analysis to paid OON IP and OP claims, at least half of the CCOs continued to exhibit moderate or substantial differences in the percentages of paid OON IP and OP claims; however, for all but two CCOs for IP and OP paid claims, the deviation was due to a higher percentage of paid MH/SUD claims compared to paid M/S claims. Although differences in the percentage of paid OON claims may be legitimate, they may also indicate procedural or network differences that highlight potential barriers to members' access to MH/SUD services. The CCOs should review OON claim

denials to understand factors affecting the lower percentage of paid MH/SUD IP and OP claims compared to M/S IP and OP claims, and assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside the CCO's network (e.g., appointment availability).

Utilization Management

Overall, differences in the percentage of denials for MH/SUD and M/S PA requests continued to vary across all service types (i.e., IP, OP, and Rx). While the percentage point differences in the CCO aggregate denial rates were negligible between MH/SUD and M/S IP services, the percentage point difference in the CCO aggregate OP and Rx denial rates was moderate (between 5 and 10 percentage points). However, when CCO and OHP FFS absolute differences in the percentage of PA denials were *moderate* or *substantial*, MH/SUD PA requests continued to be denied less frequently than M/S PA requests. Overall, both OP and Rx denials exhibited a large increase in the number of CCOs and OHP FFS for which the difference between MH/SUD and M/S PA denials was substantial. A review of denial reasons across benefit type and services revealed that most denials were related to services not meeting clinical criteria or for non-covered services. However, while patterns of denial reasons were relatively stable, OP PA denials demonstrated variations between MH/SUD and M/S services with a greater percentage of MH/SUD OP PA denials related to UM controls and treatment limitations, administrative denials, and OON providers, suggesting an area requiring greater review to ensure parity across MH/SUD and M/S services. Additionally, unlike IP and OP PA requests, UM controls implemented by the CCOs and OHP FFS for Rx PA requests were the second most prevalent reason for a denial.

While the review of UM data at the aggregate level was focused on PA denials due to the small number of appeals and hearings reported by individual CCOs and OHP FFS, a review of the percentage of overturned appeal decisions showed important differences. Although OP MH/SUD appeals were overturned less frequently than OP M/S appeals, the appeals outcomes showed that more than a quarter of all MH/SUD decisions were overturned on appeals. For IP and Rx appeals, the percentage of overturned MH/SUD appeals was substantially higher for IP MH/SUD appeals and negligibly higher for Rx MH/SUD appeals. While these results should be viewed with caution given the small number of appeals, the relatively high percentage of overturned denial decisions suggest potential barriers to care that may impact the timeliness of MH/SUD services to members.

Provider Enrollment

Overall, the CCOs and OHP FFS continued to demonstrate challenges with tracking and reporting provider enrollment and terminations; especially OHP FFS, which was unable for the third year to provide reliable data on MH/SUD and M/S enrollment or terminations. As a result, OHP FFS was excluded this year from all provider-based analyses. This finding suggests that OHP FFS lacks the appropriate systems to monitor and ensure compliance with MHP regulations and reporting requirements. The difference in the statewide CCO percentage of terminated providers for MH/SUD and M/S providers was either negligible or substantial with seven CCOs exhibiting little to no difference in the percentage of MH/SUD and M/S providers terminated or not recredentialed, four CCOs with substantial differences in the number of M/S providers compared to MH/SUD providers, and five CCOs and OHP FFS unable to report due to data quality concerns. Similar to prior years, the difference in the

statewide CCO percentage of provider applications approved for MH/SUD and M/S providers was also negligible, with all but one of the CCOs exhibiting little to no difference in the percentage of MH/SUD and M/S provider applications approved.

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Between 2023 and 2024, the CCOs continued to show general increases in the number of contracted MH and SUD provider counts across all CCOs, with only a few CCOs and OHP FFS demonstrating substantial decreases in the count of SUD providers. Several factors likely contributed to these increases, including the CCOs' efforts to increase enrollment and contracting with MH and SUD providers in response to members' needs as well as ongoing quality improvement efforts to address data quality. Additionally, provider-to-member ratios were generally low, indicating the CCOs and OHP FFS had a large number of providers contracted to perform MH and SUD services relative to members with an MH or SUD diagnosis.

Time and Distance

In 2024, OHA updated its acceptable travel time and distance requirements for providers across four urbanicities (i.e., large urban, urban, rural, and CEAC) for select provider types. To ensure appropriate comparisons, the MHP Evaluation assessed the geographic distribution of MH and SUD providers relative to members with an MH or SUD diagnosis. In general, the results demonstrated that the average drive time and distance to the nearest three MH and SUD providers were within acceptable travel times and distances within most large urban, urban, and CEAC urbanicities, with mixed performance for the CCOs' rural service areas. While more than 95 percent of members enrolled in CCOs and OHP FFS were within acceptable travel times and distances to MH providers across all urbanicities, results for SUD providers showed challenges in the rural (six CCOs) and large urban (one CCO) geographic areas. However, in all cases, the percentage of members within acceptable travel times and distances was greater than 90 percent. Although, these results suggest that MH and SUD providers were generally distributed in proportion to members' locations, the findings should be interpreted with caution, as time and distance metrics represent only one of several network monitoring metrics used to assess provider network adequacy.

Appointment Availability

The results from the 2023 BH Telephone Survey found that individual provider and practice data (i.e., phone number, address, specialty, OHP and CCO affiliation, and panel status) contained in the provider capacity data files and used to outreach providers was frequently incorrect. Overall, HSAG was unable to contact 56.1 percent of the OP MH cases. Of the total cases reached, 11.7 percent (N=298) of the cases were due to bad phone number information (i.e., disconnected number, fax number, or reaching a nonmedical facility). Additionally, of the total cases, survey results indicated 82.8 percent of cases were unable to be contacted, refused to participate, did not offer the requested services at the verified location, or did not accept the requested OHP or CCO. These results highlight ongoing challenges with the

collection and maintenance of provider directory information, representing a considerable barrier to scheduling appointments.

Overall, members seeking OP MH appointments experienced limited appointment availability with only 19.7 percent and 69.5 percent of outreach calls resulting in an appointment date for new and existing patients, respectively. In addition to barriers created through inaccurate provider data, common reasons for not scheduling an appointment included the schedule or calendar being unavailable (27.1 percent), requiring pre-registration or personal information to schedule (23.2 percent), or other limitations (20.5 percent). While some barriers pose unique limitations since the interviewer cannot provide the office personal information, other limitations may pose barriers to all OHP Medicaid members trying to schedule appointments.

Finally, the overall average wait times for non-urgent or routine MH visits were 19 calendar days for new patients and seven calendar days for existing patients. Of the cases reached for which a non-urgent or routine appointment was made, 53.7 percent and 87.6 percent of the appointments were compliant with appointment availability standards (i.e., seven calendar days) for new and established patients, respectively. The results suggest that while established patients are more likely to obtain an appointment within seven calendar days, just over half of new patients failed to get an appointment within seven calendar days. The overall average wait times for urgent BH visits was 16 calendar days for new patients and four calendar days for existing patients. Of the cases reached for which an urgent appointment was made, 24.7 percent and 62.0 percent of the appointments were compliant with appointment availability standards (i.e., 24 hours) for new and established patients, respectively. The results suggest that while established patients are more likely to obtain an appointment within 24 hours, nearly one-third do not.

Access-Related Grievances

Overall, only 2.9 percent of all CCO grievances were associated with MH/SUD benefits or service, with an average CCO rate of 4.1 percent demonstrating a small increase from prior years. Similar to prior findings, the results showed a consistent distribution of MH/SUD-related grievances, with most CCOs having less than 5 percent of all grievances related to MH/SUD services except for two CCOs. Further, while the percentage of access-related grievances associated with MH/SUD services was high for CCOs, with an aggregate rate of 20.0 percent, the range of access-related MH/SUD grievances varied considerably across individual CCOs (i.e., 0.0 percent to 100 percent). It is important to note that grievances are a limited monitoring tool for the CCOs, given that members must have both the means and the inclination to file a grievance. These results reinforce OHA's guidance that grievance monitoring, while required and valuable, likely captures only a fraction of members' overall experiences and should not be used as the total or primary mechanism for monitoring network adequacy and decision making. Further, due to the nature of MH/SUD clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan than those with an M/S diagnosis, contributing to the low rate of grievances and thereby underestimating these results.

As in prior years, OHP FFS continues to lack the operational infrastructures and systems to collect, monitor, and report on grievances in support of parity monitoring.

Special Topic Evaluation—Peer Support Services

Overall, the utilization of PSS among members with an MH diagnosis was 0.484/1,000 MM with individual CCO and OHP utilization, demonstrating considerable variation across organizations. Generally, the CCOs and OHP FFS with services comprised of largely rural and CEAC urbanicities exhibited higher utilization of PSS compared to the CCOs and OHP FFS with services of urban and large urban areas. When assessing the percentage of paid PSS claims, overall percentages were moderate to high among the CCOs and OHP FFS with a median percentage of PSS claims paid of 89.3 percent. Similarly, the CCOs and OHP FFS exhibited moderate to high timeliness of payment (i.e., date of service to date paid) where MH PSS claims were paid, on average, within 49 days of the date of service. Overall, 82.4 percent of MH PSS claims were paid with 60 days.

Overall, the median PSS utilization rate for members with an SUD diagnosis was somewhat higher (0.578/1,000 MM) compared to members with an MH diagnosis, with individual CCO and OHP FFS utilization rates demonstrating less variation across organizations than among MH members receiving PSS. Like members with an MH diagnosis, the percentage of paid PSS claims for the CCOs and OHP FFS among members with an SUD diagnosis was moderate to high with a median percentage of PSS claims paid of 92.2 percent. Finally, the CCOs and OHP FFS exhibited moderate to high timeliness of payment (i.e., date of service to date paid) where PSS claims were paid for SUD services, on average, within 36 days of the date of service. Overall, 94.1 percent of SUD PSS claims were paid with 60 days.

A review of the results by county demonstrated similar utilization patterns as describe above by organization. This is largely a by-product of the CCOs serving regional areas aligned with counties. As noted above, utilization for MH and SUD PSS was generally higher among less populated urbanicities and lower among urban and large urban areas. During the spring CP meetings, discussions focused on the importance of these services and structural limitations in place that limit use, reporting, and payment for PSS. Specifically, CP groups noted that PSS are most effective at the outset of treatment before comprehensive assessments and confirmed diagnoses are made, both of which are needed to submit claims. As such, claims-based utilization metrics, such as those described above, are likely to underestimate the use of these types of services. Moreover, given the challenges to the availability and accessibility of MH and SUD providers throughout the State, PSS represents an important mechanism for linking OHP members to treatment.

MHP Community Partner Input

OHA conducted meetings with four different CP groups (i.e., consumers, CCOs, providers, and BH policy advocates) to solicit feedback from the community and provide input on the assessment of parity as well as the direction of future MHP analyses. Feedback obtained from CPs (see Appendix R. MHP Community Partner Feedback) was used not only to help make final parity decisions but will be used to guide the development of future MHP analytic activities. Topics identified for future consideration included, but were not limited to:

- Assessing network adequacy by pediatric and adult providers.
- Evaluating the adequacy of provider networks based on MH and SUD levels of care available to members.

- Including an assessment of the timeliness of PA decisions.

Finally, CPs continued to emphasize the need to include qualitative assessments that focus on member experience in addition to quantitative assessments of parity.

Parity Determination

Based on the findings outlined in the 2024 MHP Evaluation, and in collaboration with the CP groups, the administration of MH/SUD and M/S benefits was largely found to be in parity for the CCOs. Although the evaluation identified several opportunities for improvement, results did not identify systemic issues that negatively impacted parity between MH/SUD and M/S services. Rather, findings frequently highlighted general regulatory compliance issues affecting both MH/SUD and M/S benefits uniformly. Individual CCO and OHP FFS results, as well as strengths, weaknesses, and recommendations, are provided for each organization in the appendices and should be reviewed by each respective organization to support and ensure continued compliance with parity standards.

However, the results continue to demonstrate challenges related to the availability and accessibility of MH and SUD services. While the CCOs have largely established mechanisms to support the fair and appropriate management of MH/SUD and M/S benefits, results from the Administrative Data Profile and adequacy of MH/SUD provider networks identified several opportunities for improvement and potential barriers to care.

Recommendations for Future MHP Studies

To ensure continued compliance with State and federal MHP requirements and address gaps in data quality, HSAG offers the following recommendations:

- Considering newly updated federal regulation, HSAG recommends that OHA review proposed CMS regulatory guidance to ensure ongoing alignment with HB 3046 and CCO contracts. Additionally, OHA should work with its EQRO to ensure the MHP Evaluation treatment limitation tools align with newly proposed templates out for public comment from CMS. Although these tools have not been finalized by CMS, HSAG recommends beginning to implement adjustments to ensure minimal impact on timelines in the future.
- Paired with 2023 MHP Evaluation findings and OHP FFS' continued findings associated with its ability to document, describe, and provide evidence that its UM programs ensure parity in the administration of MH/SUD and M/S benefits, OHA should consider conducting an independent, focused review of denial decisions to fully understand how OHP FFS' NQTLs impact MHP. This review should occur independently of the MHP analysis to ensure that a sufficient sample of MH/SUD and M/S case files can be reviewed in aggregate at the organization level as well as by benefit. This review should include an independent clinical review to determine whether denial decisions align with OHA's expectations for the evaluation of medical necessity and appropriateness. Additionally, a review of all uncategorized PA requests should be conducted to

determine the scope of these reviews and identify the root cause for OHP FFS' inability to classify nearly half of the of PA requests received.

- Based on the special investigation topics selected in collaboration with the CPs, OHA should begin working to develop study protocols and evaluation metrics for inclusion in the 2025 MHP Evaluation. To ensure the selection of appropriate MH and SUD services (e.g., PSS, MH residential services, crisis respite, and withdrawal management) to include in analyses, OHA should include key members from the CPs and OHA subject matter experts in the development process. This process includes incorporating the findings from the 2024 Special Topic Evaluation to expand and target more granular evaluation topics, as appropriate.
- HSAG recommends OHA assess the feasibility of incorporating payment-based analyses into the MHP Evaluation. In alignment with new and updated federal managed care rules, CMS is beginning to require the collection and reporting of provider payment rates and service costs to understand factors influencing utilization and access to care. This focus represents a vital source of information to understand disparities existing between the availability and use of MH/SUD and M/S services. These analyses could include either a focus on provider payment rates or comparative costs of evaluation services.

Appendix A. MHP Results for Advanced Health (AH)

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the coordinated care organization (CCO) to manage the administration of mental health (MH) and substance use disorder (SUD) and medical and surgical (M/S) covered benefits and assess whether documentation demonstrated compliance with Mental Health Parity (MHP) requirements in how they were applied to MH/SUD and M/S services. Health Services Advisory Group, Inc. (HSAG) used the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant* to indicate the degree to which changes identified by the CCOs and Oregon Health Plan (OHP) fee-for-service (FFS) in the *MHP Treatment Limitation Attestation Tool* remained compliant with parity requirements or the degree to which the 2023 MHP finding(s) were addressed in the *MHP Treatment Limitation Supplemental Questionnaire* and demonstrated compliance with parity requirements. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency*. A *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both, or there was insufficient information or clear evidence of parity associated with implemented non-quantitative treatment limitations (NQTLs). A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria or no documentation was submitted to evaluate the consistency and stringency of NQTLs.

The *MHP Treatment Limitation Attestation Tool* along with the *MHP Treatment Limitation Supplemental Questionnaire,* as applicable, were used to collect information on the four types of treatment limitations (i.e., financial requirements [FRs], aggregate lifetime and annual dollar limits [AL/ADLs], quantitative treatment limitations [QTLs], and NQTLs). A summary of the treatment limitations review by type is included below.

Financial Requirements

- AH reported the CCO did not make changes and did not apply any FRs or payments from members for services received that are in addition to payments made by the State (e.g., copayments, coinsurance, deductibles, or out-of-pocket maximums) for inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC) services for MH/SUD or M/S benefits.

Aggregate Lifetime and Annual Dollar Limits

- AH reported the CCO did not make any changes and did not apply any AL/ADLs on the total amount of a specified benefit over a lifetime or annually for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Quantitative Treatment Limitations

- AH reported the CCO did not make any changes and did not apply any QTLs or limits on the scope or duration of a benefit that are expressed numerically (e.g., day or visit limits) for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Non-Quantitative Treatment Limitations

Table A-1 highlights the overall ratings of compliance with parity requirements for the identified changes and 2023 findings for AH by NQTL domain and overall.

Table A-1—Compliance With Parity Requirements for AH by NQTL Domain and Overall

Organization Name	Medical Management	Provider Network	Pharmacy Management	Overall Compliance Rating
AH	Compliant	Compliant	Compliant	Compliant

Medical Management

- AH reported changes through the *MHP Treatment Limitation Attestation Tool* to utilization management (UM) processes (i.e., prior authorization [PA], concurrent review [CR], and retrospective review [RR]) for IP and OP services to manage the administration of MH/SUD and M/S covered benefits. Specifically, the CCO updated PA requirements for services/procedures according to guidelines, Oregon Administrative Rules (OARs), and statutes and developed an oversight process to ensure consistent application of review criteria for authorization requests. The changes to its UM processes, policies, and procedures applied to MH/SUD and M/S benefits demonstrated compliance with MHP requirements. AH also addressed less than *Compliant* ratings received in calendar year (CY) 2023 related to CR and RR through the *MHP Treatment Limitation Supplemental Questionnaire.* AH provided supporting documentation that demonstrated the process and requirements used to apply CR and RR NQTLs to MH/SUD benefits were applied with no more stringency than to M/S benefits in the same classification.

Provider Network

- AH reported changes through the *MHP Treatment Limitation Attestation Tool* to reimbursement rates for behavioral health services (BH) that included increased payment rates for BH services to align with OHA guidance and advance Medicaid program goals and priorities. The changes to its reimbursement rates for BH services did not affect compliance with parity requirements.

Pharmacy Management

- AH reported changes through the *MHP Treatment Limitation Attestation Tool* to PA processes, formulary design, and the use of step therapy or fail-first strategies for Rx services in the administration of MH/SUD and M/S services. AH implemented the following changes: removed the PA requirement for certain MH/SUD and M/S medications; increased the allowable dose of a SUD medication prior to a PA requirement; added medications to the formulary without a PA

requirement; implemented an inter-rater reliability process to ensure the consistent application of review criteria for PA requests for Rx services; and added or removed step therapy requirements to align with nationally recognized medical standards. None of the changes identified by AH for the Pharmacy Management NQTLs negatively affected parity; AH continued to demonstrate parity between MH/SUD and M/S services. AH also addressed a less than *Compliant* rating received in CY 2023 related to formulary design for Rx services through the *MHP Treatment Limitation Supplemental Questionnaire*. AH provided additional documentation to sufficiently address its formulary design NQTL. The rationale used to determine assignment of the formulary design NQTL was consistent between MH/SUD and M/S benefits, and the evidentiary standards used in administering the NQTL to MH/SUD benefits were comparable to the evidentiary standards used in administering the NQTL to M/S benefits. The CCO used evidence-based criteria for MH/SUD and M/S benefits to administer its processes with equivalent stringency.

Availability of Information

AH reported no changes were implemented regarding the mechanisms used to disseminate medical necessity information to members and/or providers.

Administrative Data Profile

Claims

Table A-2 presents a summary of the results from the analysis of paid claims by service type and benefit type. In general, AH showed a negligible difference (1.2 percentage points) in the percentage of paid claims between MH/SUD (90.2 percent) and M/S (89.0 percent) services. Similarly, a negligible difference (1.1 percentage points) was also noted between the total percentage of out-of-network MH/SUD (80.1 percent) and M/S (79.0 percent) paid claims. Across all service types, a greater percentage of MH/SUD claims were paid compared to M/S claims.

Table A-2—Number and Percentage of Claims by Service Type and Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims		Out-of-Network Paid Claims	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	13,528	11,735	86.7%	2,734	76.7%
	M/S	19,001	15,394	81.0%	6,393	74.4%
OP	MH/SUD	144,753	131,107	90.6%	19,584	80.5%
	M/S	332,900	297,811	89.5%	45,579	79.6%
Total	**MH/SUD**	**158,281**	**142,842**	**90.2%**	**22,318**	**80.1%**
	M/S	**351,901**	**313,205**	**89.0%**	**51,972**	**79.0%**

Utilization Management

Table A-3 presents a summary of the results from the analysis of PAs by service type and benefit type. Across all service types, a greater percentage of M/S PAs were denied compared to MH/SUD PAs. AH reported that there were no PA denials appealed for IP and OP MH/SUD services. Due to the low number of PA denials that were appealed (excluding Rx), results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity.

Table A-3—PA Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals		Hearings	
		Total	Denied Number	Percent	Total Percent	Overturned Percent	Total Percent	Overturned Percent
IP	**MH/SUD**	17	0	0.0%	0.0%	NA	0.0%	NA
	M/S	1,598	34	2.1%	100%	0.0%	0.0%	NA
OP	**MH/SUD**	410	31	7.6%	0.0%	NA	0.0%	NA
	M/S	13,856	2,865	20.7%	100%	8.3%	3.9%	37.5%
Rx	**MH/SUD**	739	396	53.6%	13.7%	0.0%	0.0%	NA
	M/S	4,124	2,248	54.5%	86.3%	2.3%	0.0%	NA

NA—indicates a denominator of zero; results could not be calculated.

Provider Enrollment

Table A-4 presents a summary of the results from the analysis of provider enrollment and terminations by benefit type. AH showed no difference between the percentage of MH/SUD and M/S provider applications approved in CY 2023. The CCO exhibited a minimal difference (2.3 percentage points) in the percentage of terminated MH/SUD providers (9.9 percent) compared to terminated M/S providers (12.2 percent).

Table A-4—CY 2023 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	305	100%	39	9.9%
M/S	221	100%	48	12.2%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table A-5 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Quarter 1 (Q1) 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

AH showed substantial increases in both MH and SUD providers between Q1 2023 and Q1 2024. At the same time, the CCO's overall network increased by approximately 110 providers. A comprehensive review of the CCO's provider network capacity was conducted through the annual Delivery System Network (DSN) Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table A-5—Number and Percentage of MH/SUD Providers by Quarter and Provider Type

Provider Type	Q1 2023			Q1 2024			Difference		
	All Providers (N)	MH/SUD Providers		All Providers (N)	MH/SUD Providers		MH/SUD Provider (N)	Percent Change	
		(N)	(%)		(N)	(%)			
MH	501	182	36.3%	611	250	40.9%	68	37.4%	▲
SUD		56	11.2%	611	74	12.1%	18	32.1%	▲

Provider-to-Member Ratios

Table A-6 presents the provider-to-member ratios for MH and SUD providers in Q1 2024 by provider type.

Table A-6—Provider-to-Member Ratios by Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	250	4,879	1:20
SUD	74	8,920	1:121

Time and Distance

Table A-7 presents the average time and distance to the nearest three MH and SUD providers by provider type and large urban and urban geographic settings. Table A-8 presents the average time and distance to the nearest three MH and SUD providers by provider type and rural geographic settings and counties with extreme access considerations (CEAC). Acceptable travel times and distances are 10 minutes/5 miles in large urban settings, 25 minutes/15 miles in urban settings, 30 minutes/20 miles in rural settings, and 40 minutes/30 miles in CEAC settings.

The average drive times and distances to the nearest three MH and SUD providers were within the acceptable travel times and distances set by OHA. The CCO had no large urban, urban, or CEAC settings within its service area as defined by state-established urbanicity parameters and are listed as *Not Applicable (NA)*. A comprehensive review of the CCO's provider network time and distance was conducted through the annual DSN Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table A-7—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Large Urban and Urban Geographic Settings

Provider Type	Large Urban						Urban					
	Time (Minutes)			Distance (Miles)			Time (Minutes)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
SUD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Table A-8—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Rural and CEAC Geographic Settings

Provider Type	Rural						CEAC					
	Time (Minutes)			Distance (Miles)			Time (Minutes)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	3.0	3.8	4.6	3.2	4.1	5.0	NA	NA	NA	NA	NA	NA
SUD	10.3	11.2	11.2	11.2	12.2	12.2	NA	NA	NA	NA	NA	NA

Table A-9 presents the percentages of CCO members with access to MH and SUD services by geographic setting. The results are aggregated across all members and not stratified by adult and pediatric populations. The CCO does not have large urban, urban, or CEAC settings within its service area and are listed as *Not Applicable (NA)*. Results showing less than 95 percent of members meeting the

acceptable times and distances are shaded red.[21] All AH members were within the acceptable travel times and distances except for members with a SUD diagnosis in rural areas; however, more than 90 percent of those members were still within acceptable travel times and distances.

Table A-9—Time and Distance Results by Geographic Setting

MH				SUD			
Large Urban	Urban	Rural	CEAC	Large Urban	Urban	Rural	CEAC
NA	NA	>99.9%	NA	NA	NA	92.2%	NA

Appointment Availability

The results from OHA's *CY 2023 Revealed Behavioral Health Telephone Survey Report* highlighting the accuracy of provider directory data and appointment availability for CCO members for behavioral health OP provider locations were incorporated into the *2024 Mental Health Parity Evaluation Summary Report* as well as the Oregon *2023 External Quality Review Technical Report*. OHA communicated and addressed individual CCO results from the surveys through established monitoring and oversight mechanisms.

Access-Related Grievances

Table A-10 presents the average percentage of access-related MH/SUD grievances compared to the overall number of MH/SUD grievances. The CCO showed a low percentage of grievances (1.8 percent) that were associated with MH/SUD services. Of those grievances, none were related to access issues. The results should be interpreted with caution due to the low overall total number of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.

Table A-10—Average Percentage of Access-Related MH/SUD Grievances

Total Grievances	MH/SUD Grievances		Access-Related MH/SUD Grievances	
	Number	Percent	Number	Percent
568	10	1.8%	0	0.0%

[21] Although OHA has established time and distance standards, CCO compliance is not assessed as part of this evaluation. OHA assesses CCO compliance to time and distance standards based on adult and pediatric provider types comprising three tiers; 95 percent or more pediatric and adult members must meet the acceptable travel times and distances to the nearest adult and pediatric provider, regardless of urbanicity.

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2024 MHP Evaluation, the following strengths, weakness, and recommendations with respect to the quality, timeliness, and accessibility of health care services were identified. Strengths and weaknesses specific to the adequacy of MH/SUD provider networks and appointment availability were identified and communicated to the CCO through the *CY 2023 Revealed Behavioral Health Telephone Survey Report* and DSN Evaluation.

Strength/ Weakness	Description	Domain(s)*
The CCO met performance expectations. No significant strengths or weakness were noted during the review.		

*= Quality, = Timeliness, = Access

Appendix B. MHP Results for AllCare CCO, Inc. (AllCare)

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the coordinated care organization (CCO) to manage the administration of mental health (MH) and substance use disorder (SUD) and medical and surgical (M/S) covered benefits, and assess whether documentation demonstrated compliance with Mental Health Parity (MHP) requirements in how they were applied to MH/SUD and M/S services. Health Services Advisory Group, Inc. (HSAG) used the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant* to indicate the degree to which changes identified by the CCOs and Oregon Health Plan (OHP) fee-for-service (FFS) in the *MHP Treatment Limitation Attestation Tool* remained compliant with parity requirements or the degree to which the 2023 MHP finding(s) were addressed in the *MHP Treatment Limitation Supplemental Questionnaire* and demonstrated compliance with parity requirements. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency*. A *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both, or there was insufficient information or clear evidence of parity associated with implemented non-quantitative treatment limitations (NQTLs). A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria or no documentation was submitted to evaluate the consistency and stringency of NQTLs.

The *MHP Treatment Limitation Attestation Tool* along with the *MHP Treatment Limitation Supplemental Questionnaire,* as applicable, were used to collect information on the four types of treatment limitations (i.e., financial requirements [FRs], aggregate lifetime and annual dollar limits [AL/ADLs], quantitative treatment limitations [QTLs], and NQTLs). A summary of the treatment limitations review by type is included below.

Financial Requirements

- AllCare reported the CCO did not make changes and did not apply any FRs or payments from members for services received that are in addition to payments made by the State (e.g., copayments, coinsurance, deductibles, or out-of-pocket maximums) for inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC) services for MH/SUD or M/S benefits.

Aggregate Lifetime and Annual Dollar Limits

- AllCare reported the CCO did not make any changes and did not apply any AL/ADLs on the total amount of a specified benefit over a lifetime or annually for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Quantitative Treatment Limitations

- AllCare reported the CCO did not make any changes and did not apply any QTLs or limits on the scope or duration of a benefit that are expressed numerically (e.g., day or visit limits) for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Non-Quantitative Treatment Limitations

Table B-1 highlights the overall ratings of compliance with parity requirements for the identified changes and 2023 findings for AllCare by NQTL domain and overall.

Table B-1—Compliance With Parity Requirements for AllCare by NQTL Domain and Overall

Organization Name	Medical Management	Provider Network	Pharmacy Management	Overall Compliance Rating
AllCare	Compliant	Compliant	Compliant	Compliant

Medical Management

- AllCare reported changes through the *MHP Treatment Limitation Attestation Tool* to prior authorization (PA) process for OP M/S benefits. Since the changes were limited to M/S benefits, they did not affect compliance with parity requirements. AllCare addressed less than *Compliant* ratings received in calendar year (CY) 2023 related to PA, concurrent review (CR), and medical necessity criteria through the *MHP Treatment Limitation Supplemental Questionnaire.* The rationale used to determine assignment of the PA, CR, and medical necessity criteria NQTLs was consistent between MH/SUD and M/S benefits, and the evidentiary standards used in administering the NQTL to MH/SUD benefits were comparable to the evidentiary standards used in administering the NQTL to M/S benefits. The CCO used evidence-based criteria for MH/SUD and M/S benefits to administer its processes with equivalent stringency. AllCare also addressed the following NQTLs through the *MHP Treatment Limitation Supplemental Questionnaire* by indicating they were not used to manage the administration of MH/SUD or M/S services: retrospective review, fail-first requirements, requirements that lower cost therapies be tried first, and failure to complete exclusions requirements.

Provider Network

- AllCare attested that no changes were implemented to the NQTLs that applied to MH/SUD or M/S benefits, which were evaluated during the CY 2023 MHP Evaluation and met parity requirements.

Pharmacy Management

- AllCare reported changes through the *MHP Treatment Limitation Attestation Tool* to PA processes and formulary design for Rx services. The changes included adding medications to the formulary with and without PA requirements. None of the changes identified by AllCare for the Pharmacy Management NQTLs negatively affected parity; the CCO demonstrated parity between MH/SUD and M/S services. AllCare addressed less than *Compliant* ratings received in CY 2023 related to formulary design for Rx services through the *MHP Treatment Limitation Supplemental*

Questionnaire. AllCare provided additional documentation to sufficiently address its formulary design NQTL. The rationale used to determine assignment of the formulary design NQTL was consistent between MH/SUD and M/S benefits, and the evidentiary standards used in administering the NQTL to MH/SUD benefits were comparable to the evidentiary standards used in administering the NQTL to M/S benefits. The CCO used evidence-based criteria for MH/SUD and M/S benefits to administer its processes with equivalent stringency. AllCare also addressed the methods for the determining reasonable charges NQTL by indicating the NQTL is not used to manage MH/SUD or M/S benefit coverage, and the CCO confirmed the prescription drug benefit tiers NQTL is used to support internal classification of prescription drugs and not used as an NQTL to manage MH/SUD and M/S Rx services.

Availability of Information

AllCare reported no changes were implemented regarding the mechanisms used to disseminate medical necessity information to members and/or providers.

Administrative Data Profile

Claims

Table B-2 presents a summary of the results from the analysis of paid claims by service type and benefit type. AllCare showed a substantial difference (14.5 percentage points) in the percentage of paid IP out-of-network (OON) claims between MH/SUD (82.1 percent) and M/S (96.6 percent), where MH/SUD claims were paid less frequently than M/S claims. Overall, MH/SUD claims were paid at a lower rate compared to M/S claims.

Table B-2—Number and Percentage of Claims by Service Type and Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims		Out-of-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	2,242	2,009	89.6%	558	82.1%
	M/S	49,517	48,405	97.8%	8,935	96.6%
OP	MH/SUD	245,549	239,690	97.6%	21,966	92.3%
	M/S	640,071	626,770	97.9%	53,927	95.0%
Total	**MH/SUD**	**247,791**	**241,699**	**97.5%**	**22,524**	**92.0%**
	M/S	**689,588**	**675,175**	**97.9%**	**62,862**	**95.2%**

[1] Differences of 10 percentage points or more where a greater percentage of M/S claims were paid compared to MH/SUD claims are presented in red text.

Utilization Management

Table B-3 presents a summary of the results from the analysis of PAs by service type and benefit type. No substantial differences in the percentage of denied M/S and MH/SUD PAs were found that would have suggested an MH parity concern. Only PA denials for OP services were greater among MH/SUD services (5.0 percent) compared to M/S services (4.5 percent). Due to the low number of PA denials that were appealed, results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity.

Table B-3—PA Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals		Hearings	
		Total	Denied Number	Percent	Total Percent	Overturned Percent	Total Percent	Overturned Percent
IP	**MH/SUD**	461	3	0.7%	0.0%	NA	0.0%	NA
	M/S	5,184	41	0.8%	100%	30.8%	0.0%	NA
OP	**MH/SUD**	1,606	80	5.0%	2.4%	40.0%	0.0%	NA
	M/S	49,510	2,238	4.5%	97.6%	61.8%	2.4%	0.0%
Rx	**MH/SUD**	530	221	41.7%	6.0%	45.7%	0.0%	NA
	M/S	6,884	3,678	53.4%	94.0%	48.4%	0.3%	0.0%

NA—indicates a denominator of zero; results could not be calculated.

Provider Enrollment

Table B-4 presents a summary of the results from the analysis of provider enrollment and terminations by benefit type. AllCare showed no difference in the percentages of MH/SUD and M/S provider applications approved in CY 2023. The CCO exhibited a substantial difference (42.4 percent percentage points) in the percentages of terminated providers, where MH/SUD providers were terminated at a higher rate (73.8 percent) than M/S providers (31.4 percent).

Table B-4—CY 2023 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	380	100%	110	73.8%
M/S	296	100%	72	31.4%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table B-5 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Quarter 1 (Q1) 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

AllCare showed an increase (2.7 percent) in MH providers and a substantial decrease (16.0 percent) in SUD providers between Q1 2023 and Q1 2024. A comprehensive review of the CCO's provider network capacity was conducted through the annual Delivery System Network (DSN) Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table B-5—Number and Percentage of MH/SUD Providers by Quarter and Provider Type

Provider Type	Q1 2023			Q1 2024			Difference		
	All Providers (N)	MH/SUD Providers		All Providers (N)	MH/SUD Providers		MH/SUD Provider (N)	Percent Change	
		(N)	(%)		(N)	(%)			
MH	1,501	488	32.5%	1,451	501	34.5%	13	2.7%	
SUD		144	9.6%	1,451	121	8.3%	-23	-16.0%	▼

Provider-to-Member Ratios

Table B-6 presents the provider-to-member ratios for MH and SUD providers in Q1 2024 by provider type.

Table B-6—Provider-to-Member Ratios by Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	501	10,707	1:22
SUD	121	3,729	1:32

Time and Distance

Table B-7 presents the average time and distance to the nearest three MH and SUD providers by provider type and large urban and urban geographic settings. Table B-8 presents the average time and distance to the nearest three MH and SUD providers by provider type and rural geographic settings and counties with extreme access considerations (CEAC). Acceptable travel times and distances are 10 minutes/5 miles in large urban settings, 25 minutes/15 miles in urban settings, 30 minutes/20 miles in rural settings, and 40 minutes/30 miles in CEAC settings.

The average drive times and distances to the nearest three MH and SUD providers were within the acceptable travel times and distances set by OHA. The CCO had no large urban or CEAC settings within its service area as defined by state-established urbanicity parameters and are listed as *Not Applicable (NA)*. A comprehensive review of the CCO's provider network time and distance was conducted through the annual DSN Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table B-7—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Large Urban and Urban Geographic Settings

Provider Type	Large Urban						Urban					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	NA	NA	NA	NA	NA	NA	1.1	1.4	1.5	1.2	1.5	1.7
SUD	NA	NA	NA	NA	NA	NA	1.6	2.4	2.5	1.9	2.8	2.9

Table B-8—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Rural and CEAC Geographic Settings

Provider Type	Rural						CEAC					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	4.2	4.3	4.4	4.6	4.6	4.7	NA	NA	NA	NA	NA	NA
SUD	5.1	5.5	6.2	5.5	6.0	6.8	NA	NA	NA	NA	NA	NA

Table B-9 presents the percentages of CCO members with access to MH and SUD services by geographic setting. The results are aggregated across all members and not stratified by adult and pediatric populations. The CCO does not have large urban or CEAC settings within its service area and are listed as *Not Applicable (NA)*. At least 95 percent of AllCare's members with an MH and/or SUD diagnosis were within the acceptable travel times and distances for all applicable geographic settings.

Table B-9—Time and Distance Results by Geographic Setting

MH				SUD			
Large Urban	Urban	Rural	CEAC	Large Urban	Urban	Rural	CEAC
NA	100%	99.7%	NA	NA	100%	97.9%	NA

Appointment Availability

The results from OHA's *CY 2023 Revealed Behavioral Health Telephone Survey Report* highlighting the accuracy of provider directory data and appointment availability for CCO members for behavioral health OP provider locations were incorporated into the *2024 Mental Health Parity Evaluation Summary Report* as well as the Oregon *2023 External Quality Review Technical Report*. OHA communicated and addressed individual CCO results from the surveys through established monitoring and oversight mechanisms.

Access-Related Grievances

Table B-10 presents the average percentage of access-related MH/SUD grievances compared to the overall number of MH/SUD grievances. The CCO showed 23.6 percent of grievances were associated with MH/SUD services. Of those grievances, 16.9 percent were related to access issues. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.

Table B-10—Average Percentage of Access-Related MH/SUD Grievances

Total Grievances	MH/SUD Grievances		Access-Related MH/SUD Grievances	
	Number	Percent	Number	Percent
276	65	23.6%	11	16.9%

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2024 MHP Evaluation, the following strengths, weakness, and recommendations with respect to the quality, timeliness, and accessibility of health care services were identified. Strengths and weaknesses specific to the adequacy of MH/SUD provider networks and appointment availability were identified and communicated to the CCO through the *CY 2023 Revealed Behavioral Health Telephone Survey Report* and DSN Evaluation.

Strength/ Weakness	Description	Domain(s)*
⊕	**Strength:** No strengths were identified.	
⊖	**Weakness:** AllCare showed a substantial difference in the percentage of paid, IP OON MH/SUD claims compared to IP M/S claims. Although the difference in the percentage of paid claims may be legitimate, it may also highlight procedural or network differences, indicating potential barriers for members accessing MH/SUD services. **Why the weakness exists:** IP OON MH/SUD claims were paid less frequently than M/S claims. **Recommendations:** AllCare should review OON claim denials to understand factors affecting the lower percentage of paid IP MH/SUD claims compared to IP M/S claims. The CCO should assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside of the CCO's network (e.g., appointment availability).	⏱🔑

*= Quality, ⏱ = Timeliness, 🔑 = Access

Appendix C. MHP Results for Cascade Health Alliance, LLC (CHA)

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the coordinated care organization (CCO) to manage the administration of mental health (MH) and substance use disorder (SUD) and medical and surgical (M/S) covered benefits, and assess whether documentation demonstrated compliance with Mental Health Parity (MHP) requirements in how they were applied to MH/SUD and M/S services. Health Services Advisory Group, Inc. (HSAG) used the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant* to indicate the degree to which changes identified by the CCOs and Oregon Health Plan (OHP) fee-for-service (FFS) in the *MHP Treatment Limitation Attestation Tool* remained compliant with parity requirements or the degree to which the 2023 MHP finding(s) were addressed in the *MHP Treatment Limitation Supplemental Questionnaire* and demonstrated compliance with parity requirements. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency*. A *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both, or there was insufficient information or clear evidence of parity associated with implemented non-quantitative treatment limitations (NQTLs). A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria or no documentation was submitted to evaluate the consistency and stringency of NQTLs.

The *MHP Treatment Limitation Attestation Tool* along with the *MHP Treatment Limitation Supplemental Questionnaire,* as applicable, were used to collect information on the four types of treatment limitations (i.e., financial requirements [FRs], aggregate lifetime and annual dollar limits [AL/ADLs], quantitative treatment limitations [QTLs], and NQTLs). A summary of the treatment limitations review by type is included below.

Financial Requirements

- CHA reported the CCO did not make changes and did not apply any FRs or payments from members for services received that are in addition to payments made by the State (e.g., copayments, coinsurance, deductibles, or out-of-pocket maximums) for inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC) services for MH/SUD or M/S benefits.

Aggregate Lifetime and Annual Dollar Limits

- CHA reported the CCO did not make any changes and did not apply any AL/ADLs on the total amount of a specified benefit over a lifetime or annually for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Quantitative Treatment Limitations

- CHA reported the CCO did not make any changes and did not apply any QTLs or limits on the scope or duration of a benefit that are expressed numerically (e.g., day or visit limits) for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Non-Quantitative Treatment Limitations

Table C-1 highlights the overall ratings of compliance with parity requirements for the identified changes and 2023 findings for CHA by NQTL domain and overall.

Table C-1—Compliance With Parity Requirements for CHA by NQTL Domain and Overall

Organization Name	Medical Management	Provider Network	Pharmacy Management	Overall Compliance Rating
CHA	Compliant	Compliant	Compliant	Compliant

Medical Management

- CHA reported changes through the *MHP Treatment Limitation Attestation Tool* to prior authorization (PA) processes to manage the administration of MH/SUD and M/S covered benefits. Specifically, the CCO removed the PA requirement for all in-state SUD treatment and detoxification services. The change identified by the CCO did not cause MH/SUD benefits to be more restrictive than M/S benefits, and the CCO continued to demonstrate parity between MH/SUD and M/S services.

Provider Network

- CHA reported changes through the *MHP Treatment Limitation Attestation Tool* to enrollment or credentialing and provider reimbursement rates of IP and OP providers. The changes included no longer delegating credentialing services and a rate increase for behavioral health services to align with Oregon Health Authority (OHA) guidance. None of the changes identified by the CCO for Provider Network NQTLs negatively affected parity; the organization demonstrated continued parity between MH/SUD and M/S services.

Pharmacy Management

- CHA attested that no changes were implemented to the NQTLs that applied to MH/SUD or M/S benefits, which were evaluated during the calendar year (CY) 2023 MHP Evaluation and met parity requirements.

Availability of Information

CHA reported no changes were implemented regarding the mechanisms used to disseminate medical necessity information to members and/or providers.

Administrative Data Profile

Claims

Table C-2 presents a summary of the results from the analysis of paid claims by service type and benefit type. CHA showed a moderate difference (5.7 percentage points) in the percentage of paid IP claims between MH/SUD (84.3 percent) and M/S (90.0 percent), where MH/SUD claims were paid less frequently than M/S claims. However, IP out-of-network (OON) MH/SUD claims, OP MH/SUD claims, and OP OON MH/SUD claims were paid at a greater percentage compared to M/S claims.

Table C-2—Number and Percentage of Claims by Service Type and Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims		Out-of-Network Paid Claims	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	8,693	7,324	84.3%	1,414	83.6%
	M/S	2,706	2,435	90.0%	542	80.9%
OP	MH/SUD	122,600	112,302	91.6%	9,153	88.4%
	M/S	329,351	290,810	88.3%	47,354	86.8%
Total	**MH/SUD**	**131,293**	**119,626**	**91.1%**	**10,567**	**87.7%**
	M/S	**332,057**	**293,245**	**88.3%**	**47,896**	**86.7%**

Utilization Management

Table C-3 presents a summary of the results from the analysis of PAs by service type and benefit type. No substantial differences in the percentage of denied M/S and MH/SUD PAs were found that would have suggested an MHP concern. Only PA denials for IP services were greater among MH/SUD services (0.2 percent) compared to M/S services (0.0 percent). There were no PA denials appealed for MH/SUD across service types. Due to the low number of PA denials that were appealed, results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity.

Table C-3—PA Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals		Hearings	
		Total	Denied Number	Percent	Total Percent	Overturned Percent	Total Percent	Overturned Percent
IP	**MH/SUD**	417	1	0.2%	NA	NA	NA	NA
	M/S	32	0	0.0%	NA	NA	NA	NA
OP	**MH/SUD**	786	62	7.9%	0.0%	NA	0.0%	NA
	M/S	16,730	2,140	12.8%	100%	53.2%	5.3%	20.0%

Service Type	Benefit Type	Prior Authorization			Appeals		Hearings	
		Total	Denied Number	Percent	Total Percent	Overturned Percent	Total Percent	Overturned Percent
Rx	**MH/SUD**	627	39	6.2%	0.0%	NA	0.0%	NA
	M/S	14,038	2,673	19.0%	100%	18.2%	0.0%	NA

NA—indicates a denominator of zero; results could not be calculated.

Provider Enrollment

Table C-4 presents a summary of the results from the analysis of provider enrollment and terminations by benefit type. CHA showed a substantial difference (10.6 percent) in the percentages of MH/SUD (100 percent) and M/S (89.4 percent) provider applications approved in CY 2023. The CCO exhibited a higher percentage of M/S provider terminations (56.3 percent) compared to MH/SUD providers (4.8 percent), the difference was substantial at 51.5 percentage points.

Table C-4—CY 2023 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	26	100%	14	4.8%
M/S	161	89.4%	58	56.3%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table C-5 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Quarter 1 (Q1) 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

CHA showed a decrease in the overall provider network between Q1 2023 to Q1 2024, with a substantial decrease (29.0 percent) in providers identified as SUD. A comprehensive review of the CCO's provider network capacity was conducted through the annual Delivery System Network (DSN)

Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table C-5—Number and Percentage of MH/SUD Providers by Quarter and Provider Type

Provider Type	Q1 2023			Q1 2024			Difference		
	All Providers (N)	MH/SUD Providers		All Providers (N)	MH/SUD Providers		MH/SUD Provider (N)	Percent Change	
		(N)	(%)		(N)	(%)			
MH	410	123	30.0%	369	120	32.5%	-3	-2.4%	
SUD		69	16.8%	369	49	13.3%	-20	-29.0%	▼

Provider-to-Member Ratios

Table C-6 presents the provider-to-member ratios for MH and SUD providers in Q1 2024 by provider type.

Table C-6—Provider-to-Member Ratios by Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	120	6,984	1:59
SUD	49	2,729	1:56

Time and Distance

Table C-7 presents the average time and distance to the nearest three MH and SUD providers by provider type and large urban and urban geographic settings. Table C-8 presents the average time and distance to the nearest three MH and SUD providers by provider type and rural geographic settings and counties with extreme access considerations (CEAC). Acceptable travel times and distances are 10 minutes/5 miles in large urban settings, 25 minutes/15 miles in urban settings, 30 minutes/20 miles in rural settings, and 40 minutes/30 miles in CEAC settings.

The average drive times and distances to the nearest three MH and SUD providers were within the acceptable travel times and distances set by OHA. The CCO had no large urban, urban, or CEAC settings within its service area as defined by state-established urbanicity parameters and are listed as *Not Applicable (NA)*. A comprehensive review of the CCO's provider network time and distance was conducted through the annual DSN Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table C-7—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Large Urban and Urban Geographic Settings

Provider Type	Large Urban						Urban					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
SUD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Table C-8—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Rural and CEAC Geographic Settings

Provider Type	Rural						CEAC					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	4.4	4.5	5.2	4.8	4.9	5.6	NA	NA	NA	NA	NA	NA
SUD	4.7	4.8	5.5	5.0	5.2	6.0	NA	NA	NA	NA	NA	NA

Table C-9 presents the percentages of CCO members with access to MH and SUD services by geographic setting. The results are aggregated across all members and not stratified by adult and pediatric populations. The CCO does not have large urban, urban, or CEAC settings within its service area and are listed as *Not Applicable (NA)*. At least 95 percent of CHA's members with an MH and/or SUD diagnosis were within the acceptable travel times and distances for all applicable geographic settings.

Table C-9—Time and Distance Results by Geographic Setting

MH				SUD			
Large Urban	Urban	Rural	CEAC	Large Urban	Urban	Rural	CEAC
NA	NA	97.6%	NA	NA	NA	96.9%	NA

Appointment Availability

The results from OHA's *CY 2023 Revealed Behavioral Health Telephone Survey Report* highlighting the accuracy of provider directory data and appointment availability for CCO members for behavioral health OP provider locations were incorporated into the *2024 Mental Health Parity Evaluation Summary Report* as well as the Oregon *2023 External Quality Review Technical Report*. OHA communicated and addressed individual CCO results from the surveys through established monitoring and oversight mechanisms.

Access-Related Grievances

Table C-10 presents the average percentage of access-related MH/SUD grievances compared to the overall number of MH/SUD grievances. The CCO showed a low percentage of grievances (0.6 percent) that were associated with MH/SUD services. The grievance associated with MH/SUD was unrelated to access. These low results should be interpreted with caution due to the overall low total number of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.

Table C-10—Average Percentage of Access-Related MH/SUD Grievances

Total Grievances	MH/SUD Grievances		Access-Related MH/SUD Grievances	
	Number	Percent	Number	Percent
171	1	0.6%	0	0.0%

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2024 MHP Evaluation, the following strengths, weakness, and recommendations with respect to the quality, timeliness, and accessibility of health care services were identified. Strengths and weaknesses specific to the adequacy of MH/SUD provider networks and appointment availability were identified and communicated to the CCO through the *CY 2023 Revealed Behavioral Health Telephone Survey Report* and DSN Evaluation.

Strength/ Weakness	Description	Domain(s)*
The CCO met performance expectations. No significant strengths or weaknesses were noted during the review.		

*= Quality, = Timeliness, = Access

Appendix D. MHP Results for Columbia Pacific CCO, LLC (CPCCO)

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the coordinated care organization (CCO) to manage the administration of mental health (MH) and substance use disorder (SUD) and medical and surgical (M/S) covered benefits, and assess whether documentation demonstrated compliance with Mental Health Parity (MHP) requirements in how they were applied to MH/SUD and M/S services. Health Services Advisory Group, Inc. (HSAG) used the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant* to indicate the degree to which changes identified by the CCOs and Oregon Health Plan (OHP) fee-for-service (FFS) in the *MHP Treatment Limitation Attestation Tool* remained compliant with parity requirements or the degree to which the 2023 MHP finding(s) were addressed in the *MHP Treatment Limitation Supplemental Questionnaire* and demonstrated compliance with parity requirements. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency*. A *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both, or there was insufficient information or clear evidence of parity associated with implemented non-quantitative treatment limitations (NQTLs). A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria or no documentation was submitted to evaluate the consistency and stringency of NQTLs.

The *MHP Treatment Limitation Attestation Tool* along with the *MHP Treatment Limitation Supplemental Questionnaire,* as applicable, were used to collect information on the four types of treatment limitations (i.e., financial requirements [FRs], aggregate lifetime and annual dollar limits [AL/ADLs], quantitative treatment limitations [QTLs], and NQTLs). A summary of the treatment limitations review by type is included below.

Financial Requirements

- CPCCO reported the CCO did not make changes and did not apply any FRs or payments from members for services received that are in addition to payments made by the State (e.g., copayments, coinsurance, deductibles, or out-of-pocket maximums) for inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC) services for MH/SUD or M/S benefits.

Aggregate Lifetime and Annual Dollar Limits

- CPCCO reported the CCO did not make any changes and did not apply any AL/ADLs on the total amount of a specified benefit over a lifetime or annually for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Quantitative Treatment Limitations

- CPCCO reported the CCO did not make any changes and did not apply any QTLs or limits on the scope or duration of a benefit that are expressed numerically (e.g., day or visit limits) for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Non-Quantitative Treatment Limitations

Table D-1 highlights the overall ratings of compliance with parity requirements for the identified changes and 2023 findings for CPCCO by NQTL domain and overall.

Table D-1—Compliance With Parity Requirements for CPCCO by NQTL Domain and Overall

Organization Name	Medical Management	Provider Network	Pharmacy Management	Overall Compliance Rating
CPCCO	Compliant	Compliant	Compliant	Compliant

Medical Management

- CPCCO attested that no changes were implemented to the NQTLs that applied to MH/SUD or M/S benefits, which were evaluated during the calendar year (CY) 2023 MHP Evaluation and met parity requirements.

Provider Network

- CPCCO reported changes through the *MHP Treatment Limitation Attestation Tool* to reimbursement rates for behavioral health (BH) services that included increased payment rates for BH services to align with OHA guidance and advance Medicaid program goals and priorities. The changes to its reimbursement rates for behavioral health services did not affect compliance with parity requirements.

Pharmacy Management

- CPCCO attested that no changes were implemented to the NQTLs that applied to MH/SUD or M/S benefits, which were evaluated during the CY 2023 MHP Evaluation and met parity requirements.

Availability of Information

CPCCO reported no changes were implemented regarding the mechanisms used to disseminate medical necessity information to members and/or providers.

Administrative Data Profile

Claims

Table D-2 presents a summary of the results from the analysis of paid claims by service type and benefit type. CPCCO showed a lower percentage of IP and OP MH/SUD claims were paid compared to IP and OP M/S claims. There was a substantial difference (15.9 percentage points) in the percentage of paid IP OON claims between MH/SUD (55.4 percent) and M/S (71.3 percent), where MH/SUD claims were paid less frequently than M/S claims.[22] There was also a negligible difference (0.7 percentage points) in the total percentage of paid claims between MH/SUD (88.3 percent) and M/S (89.0 percent).

Table D-2—Number and Percentage of Claims by Service Type and Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims		Out-of-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	5,634	4,443	78.9%	723	55.4%
	M/S	29,116	25,001	85.9%	3,741	71.3%
OP	MH/SUD	131,481	116,619	88.7%	17,675	81.1%
	M/S	376,193	335,649	89.2%	30,182	76.7%
Total	**MH/SUD**	**137,115**	**121,062**	**88.3%**	**18,398**	**79.6%**
	M/S	**405,309**	**360,650**	**89.0%**	**33,923**	**76.1%**

[1] Differences of 10 percentage points or more where a greater percentage of M/S claims were paid compared to MH/SUD claims are presented in red text.

Utilization Management

Table D-3 presents a summary of the results from the analysis of prior authorizations (PAs) by service type and benefit type. For OP and Rx, a greater percentage of M/S PAs were denied compared to MH/SUD PAs. While there was a substantial difference (61.1 percentage points) noted in the percentage of denied MH/SUD IP PAs (100 percent) and M/S IP PAs (38.9 percent), the CCO reported only five MH/SUD IP PAs in total, which was insufficient to detect a difference between the two groups. Due to the low number of PA denials that were appealed, results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity.

[22] During its review of the draft report, CPCCO identified a data quality issue related to its IP claims summary count submission. The CCO confirmed it included institutional claims from a CMS COBA contractor which should have been excluded from the analysis. These claims were rebilled and paid by the CCO and included as IN professional MH/SUD claims. Although the CCO resubmitted revised claims data counts, the information was not received in time for inclusion in the report. However, preliminary review suggests that the difference in the percentage of paid MH/SUD and M/S IP claims was negligible.

Table D-3—PA Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals		Hearings	
		Total	Denied Number	Percent	Total Percent	Overturned Percent	Total Percent	Overturned Percent
IP	MH/SUD	5	5	100%	0.0%	NA	0.0%	NA
	M/S	221	86	38.9%	100%	100%	0.0%	NA
OP	MH/SUD	64	1	1.6%	0.0%	NA	0.0%	NA
	M/S	14,985	847	5.7%	100%	58.0%	2.9%	50.0%
Rx	MH/SUD	295	193	65.4%	9.3%	55.6%	0.0%	NA
	M/S	2,508	1,773	70.7%	90.7%	52.0%	0.0%	NA

NA—indicates a denominator of zero; results could not be calculated.

Provider Enrollment

Table D-4 presents a summary of the results from the analysis of provider enrollment and terminations by benefit type. The difference between the percentage of MH/SUD (100 percent) and M/S (97.1 percent) provider applications approved was negligible. The CCO exhibited a substantial difference (46.4 percent percentage points) in the percentages of terminated providers, where MH/SUD providers were terminated at a higher rate (52.0 percent) than M/S providers (5.6 percent).

Table D-4—CY 2023 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	22	100%	154	52.0%
M/S	103	97.1%	64	5.6%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table D-5 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Quarter 1 (Q1) 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately one year. Although a

comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

CPCCO showed an increase in the overall provider network between Q1 2023 to Q1 2024 with a substantial increase (24.2 percent) in providers identified as MH. A decrease was noted in providers identified as SUD (3.2 percent). A comprehensive review of the CCO's provider network capacity was conducted through the annual Delivery System Network (DSN) Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table D-5—Number and Percentage of MH/SUD Providers by Quarter and Provider Type

Provider Type	Q1 2023			Q1 2024			Difference		
	All Providers (N)	MH/SUD Providers		All Providers (N)	MH/SUD Providers		MH/SUD Provider (N)	Percent Change	
		(N)	(%)		(N)	(%)			
MH	8,559	1,987	23.2%	9,180	2,467	26.9%	480	24.2%	▲
SUD		528	6.2%	9,180	511	5.6%	-17	-3.2%	

Provider-to-Member Ratios

Table D-6 presents the provider-to-member ratios for MH and SUD providers in Q1 2024 by provider type.

Table D-6—Provider-to-Member Ratios by Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	2,467	7,089	1:3
SUD	511	2,069	1:5

Time and Distance

Table D-7 presents the average time and distance to the nearest three MH and SUD providers by provider type and large urban and urban geographic settings. Table D-8 presents the average time and distance to the nearest three MH and SUD providers by provider type and rural geographic settings and counties with extreme access considerations (CEAC). Acceptable travel times and distances are 10 minutes/5 miles in large urban settings, 25 minutes/15 miles in urban settings, 30 minutes/20 miles in rural settings, and 40 minutes/30 miles in CEAC settings.

The average drive times and distances to the nearest three MH and SUD providers were within the acceptable travel times and distances set by OHA. The CCO had no large urban, urban, or CEAC settings within its service area as defined by state-established urbanicity parameters and are listed as *Not Applicable (NA)*. A comprehensive review of the CCO's provider network time and distance was

conducted through the annual DSN Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table D-7—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Large Urban and Urban Geographic Settings

Provider Type	Large Urban						Urban					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
SUD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Table D-8—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Rural and CEAC Geographic Settings

Provider Type	Rural						CEAC					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	3.0	3.7	5.1	3.2	4.0	5.6	NA	NA	NA	NA	NA	NA
SUD	6.7	6.7	6.9	7.3	7.3	7.5	NA	NA	NA	NA	NA	NA

Table D-9 presents the percentages of CCO members with access to MH and SUD services by geographic setting. The results are aggregated across all members and not stratified by adult and pediatric populations. The CCO does not have large urban, urban, or CEAC settings within its service area and are listed as *Not Applicable (NA)*. At least 95 percent of CPCCO's members with an MH and/or SUD diagnosis were within the acceptable travel times and distances for all applicable geographic settings.

Table D-9—Time and Distance Results by Geographic Setting

MH				SUD			
Large Urban	Urban	Rural	CEAC	Large Urban	Urban	Rural	CEAC
NA	NA	100%	NA	NA	NA	97.1%	NA

Appointment Availability

The results from OHA's *CY 2023 Revealed Behavioral Health Telephone Survey Report* highlighting the accuracy of provider directory data and appointment availability for CCO members for behavioral health OP provider locations were incorporated into the *2024 Mental Health Parity Evaluation Summary Report* as well as the Oregon *2023 External Quality Review Technical Report*. OHA communicated and addressed individual CCO results from the surveys through established monitoring and oversight mechanisms.

Access-Related Grievances

Table D-10 presents the average percentage of access-related MH/SUD grievances compared to the overall number of MH/SUD grievances. The CCO showed a low percentage of grievances (0.9 percent) that were associated with MH/SUD services. The CCO only had one recorded grievance related to access issues. Although these results suggest access as a potential focus for MH/SUD grievances, the results should be interpreted with caution due to the low overall total number of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.

Table D-10—Average Percentage of Access-Related MH/SUD Grievances

Total Grievances	MH/SUD Grievances		Access-Related MH/SUD Grievances	
	Number	Percent	Number	Percent
341	3	0.9%	1	33.3%

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2024 MHP Evaluation, the following strengths, weakness, and recommendations with respect to the quality, timeliness, and accessibility of health care services were identified. Strengths and weaknesses specific to the adequacy of MH/SUD provider networks and appointment availability were identified and communicated to the CCO through the *CY 2023 Revealed Behavioral Health Telephone Survey Report* and DSN Evaluation.

Strength/ Weakness	Description	Domain(s)*
+	**Strength:** No strengths were identified.	
−	**Weakness:** CPCCO was unable to prepare, extract, and submit accurate IP claims data for analysis of parity. Claims cannot be evaluated if relevant data are not reported. **Why the weakness exists:** CPCCO identified a data quality issue related to its IP claims summary count submission. The CCO confirmed it included institutional claims from a CMS COBA contractor which should have been excluded from the analysis. These claims were rebilled and paid by the CCO and included as IN professional MH/SUD claims. **Recommendations:** CPCCO should review its internal processes for the collection and submission of MHP-related data to ensure complete and accurate claims data are submitted in support of this activity, including data quality control procedures.	

*= Quality, = Timeliness, = Access

Appendix E. MHP Results for Eastern Oregon CCO, LLC (EOCCO)

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the coordinated care organization (CCO) to manage the administration of mental health (MH) and substance use disorder (SUD) and medical and surgical (M/S) covered benefits, and assess whether documentation demonstrated compliance with Mental Health Parity (MHP) requirements in how they were applied to MH/SUD and M/S services. Health Services Advisory Group, Inc. (HSAG) used the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant* to indicate the degree to which changes identified by the CCOs and Oregon Health Plan (OHP) fee-for-service (FFS) in the *MHP Treatment Limitation Attestation Tool* remained compliant with parity requirements or the degree to which the 2023 MHP finding(s) were addressed in the *MHP Treatment Limitation Supplemental Questionnaire* and demonstrated compliance with parity requirements. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency*. A *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both, or there was insufficient information or clear evidence of parity associated with implemented non-quantitative treatment limitations (NQTLs). A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria or no documentation was submitted to evaluate the consistency and stringency of NQTLs.

The *MHP Treatment Limitation Attestation Tool* along with the *MHP Treatment Limitation Supplemental Questionnaire,* as applicable, were used to collect information on the four types of treatment limitations (i.e., financial requirements [FRs], aggregate lifetime and annual dollar limits [AL/ADLs], quantitative treatment limitations [QTLs], and NQTLs). A summary of the treatment limitations review by type is included below.

Financial Requirements

- EOCCO reported the CCO did not make changes and did not apply any FRs or payments from members for services received that are in addition to payments made by the State (e.g., copayments, coinsurance, deductibles, or out-of-pocket maximums) for inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC) services for MH/SUD or M/S benefits.

Aggregate Lifetime and Annual Dollar Limits

- EOCCO reported the CCO did not make any changes and did not apply any AL/ADLs on the total amount of a specified benefit over a lifetime or annually for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Quantitative Treatment Limitations

- EOCCO reported the CCO did not make any changes and did not apply any QTLs or limits on the scope or duration of a benefit that are expressed numerically (e.g., day or visit limits) for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Non-Quantitative Treatment Limitations

Table E-1 highlights the overall ratings of compliance with parity requirements for the identified changes and 2023 findings for AH by NQTL domain and overall.

Table E-1—Compliance With Parity Requirements for EOCCO by NQTL Domain and Overall

Organization Name	Medical Management	Provider Network	Pharmacy Management	Overall Compliance Rating
EOCCO	Compliant	Compliant	Compliant	Compliant

Medical Management

- EOCCO sufficiently addressed the concurrent review (CR) NQTL through the *MHP Treatment Limitation Supplemental Questionnaire*. The rationale used to apply the CR NQTL was consistent between MH/SUD and M/S benefits, and the evidentiary standards used in administering the NQTL to MH/SUD benefits were comparable to the evidentiary standards used in administering the NQTL to M/S benefits. The CCO used evidence-based criteria for MH/SUD and M/S benefits to administer its processes with equivalent stringency.

Provider Network

- EOCCO attested that no changes were implemented to the NQTLs that applied to MH/SUD or M/S benefits, which were evaluated during the calendar year (CY) 2023 MHP Evaluation and met parity requirements.

Pharmacy Management

- EOCCO sufficiently addressed the step therapy or fail-first strategies NQTL through the *MHP Treatment Limitation Supplemental Questionnaire*. The rationale used to apply the step therapy or fail-first strategies NQTL was consistent between MH/SUD and M/S benefits, and the evidentiary standards used in administering the NQTL to MH/SUD benefits were comparable to the evidentiary standards used in administering the NQTL to M/S benefits. The CCO used evidence-based criteria for MH/SUD and M/S benefits to administer its processes with equivalent stringency.

Availability of Information

EOCCO reported no changes were implemented regarding the mechanisms used to disseminate medical necessity information to members and/or providers.

Administrative Data Profile

Claims

Table E-2 presents a summary of the results from the analysis of paid claims by service type and benefit type. EOCCO showed a greater percentage of IP, OP, and out-of-network (OON) OP MH/SUD claims were paid compared to IP, OP, and OON OP M/S claims. There was a negligible difference (0.8 percentage points) between the percentage of IP OON MH/SUD claims (69.7 percent) and M/S claims (70.5 percent), where MH/SUD claims were paid less frequently than M/S claims.

Table E-2—Number and Percentage of Claims by Service Type and Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims		Out-of-Network Paid Claims	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	7,192	6,106	84.9%	1,339	69.7%
	M/S	107,533	84,954	79.0%	32,189	70.5%
OP	MH/SUD	264,556	234,996	88.8%	34,629	73.3%
	M/S	1,000,383	878,604	87.8%	72,063	67.3%
Total	**MH/SUD**	**271,748**	**241,102**	**88.7%**	**35,968**	**73.1%**
	M/S	**1,107,916**	**963,558**	**87.0%**	**104,252**	**68.3%**

Utilization Management

Table E-3 presents a summary of the results from the analysis of prior authorizations (PAs) by service type and benefit type. No substantial differences in the percentage of denied M/S and MH/SUD PAs were found that would have suggested an MHP concern. Only PA denials for IP services were greater among MH/SUD services (4.7 percent) compared to M/S services (2.8 percent). Due to the low number of PA denials that were appealed, results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity.

Table E-3—PA Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals		Hearings	
		Total	Denied Number	Percent	Total Percent	Overturned Percent	Total Percent	Overturned Percent
IP	**MH/SUD**	1,294	61	4.7%	0.0%	NA	0.0%	NA
	M/S	2,683	75	2.8%	100%	25.0%	25.0%	100%
OP	**MH/SUD**	2,880	71	2.5%	3.0%	0.0%	0.6%	100%
	M/S	30,492	2,708	8.9%	97.0%	21.7%	3.0%	60.0%

Service Type	Benefit Type	Prior Authorization			Appeals		Hearings	
		Total	Denied Number	Percent	Total Percent	Overturned Percent	Total Percent	Overturned Percent
Rx	**MH/SUD**	701	263	37.5%	1.9%	0.0%	0.0%	NA
	M/S	5,694	3,279	57.6%	98.1%	45.3%	0.0%	NA

NA—indicates a denominator of zero; results could not be calculated.

Provider Enrollment

Table E-4 presents a summary of the results from the analysis of provider enrollment and terminations by benefit type. The difference between the percentage of MH/SUD (100 percent) and M/S (99.7 percent) provider applications approved was negligible. The CCO exhibited a minimal difference (0.3 percentage points) in the percentage of terminated MH/SUD providers (0.2 percent) compared to terminated M/S providers (0.5 percent).

Table E-4—CY 2023 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	68	100%	4	0.2%
M/S	399	99.7%	53	0.5%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table E-5 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Q1 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

EOCCO showed a substantial increase (13.3 percent) in MH providers and a substantial increase (40.1 percent) in SUD providers between Q1 2023 and Q1 2024. A comprehensive review of the CCO's provider network capacity was conducted through the annual Delivery System Network (DSN)

Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table E-5—Number and Percentage of MH/SUD Providers by Quarter and Provider Type

Provider Type	Q1 2023			Q1 2024			Difference		
	All Providers (N)	MH/SUD Providers		All Providers (N)	MH/SUD Providers		MH/SUD Provider (N)	Percent Change	
		(N)	(%)		(N)	(%)			
MH	6,803	1,100	16.2%	6,473	1,246	19.2%	146	13.3%	▲
SUD		292	4.3%	6,473	409	6.3%	117	40.1%	▲

Provider-to-Member Ratios

Table E-6 presents the provider-to-member ratios for MH and SUD providers in Q1 2024 by provider type.

Table E-6—Provider-to-Member Ratios by Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	1,246	14,016	1:12
SUD	409	3,431	1:9

Time and Distance

Table E-7 presents the average time and distance to the nearest three MH and SUD providers by provider type and large urban and urban geographic settings. Table E-8 presents the average time and distance to the nearest three MH and SUD providers by provider type and rural geographic settings and counties with extreme access considerations (CEAC). Acceptable travel times and distances are 10 minutes/5 miles in large urban settings, 25 minutes/15 miles in urban settings, 30 minutes/20 miles in rural settings, and 40 minutes/30 miles in CEAC settings.

The average drive times and distances to the nearest three MH and SUD providers were within the acceptable travel times and distances set by OHA. The CCO had no large urban or urban settings within its service area as defined by state-established urbanicity parameters and are listed as *Not Applicable (NA)*. A comprehensive review of the CCO's provider network time and distance was conducted through the annual DSN Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table E-7—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Large Urban and Urban Geographic Settings

Provider Type	Large Urban						Urban					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
SUD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Table E-8—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Rural and CEAC Geographic Settings

Provider Type	Rural						CEAC					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	2.9	3.8	3.9	3.1	4.1	4.2	6.6	7.9	8.2	7.2	8.6	8.9
SUD	3.7	3.9	6.7	4.0	4.2	7.2	7.3	7.7	7.8	8.0	8.3	8.4

Table E-9 presents the percentages of CCO members with access to MH and SUD services by geographic setting. The results are aggregated across all members and not stratified by adult and pediatric populations. The CCO does not have large urban or urban settings within its service area and are listed as *Not Applicable (NA)*. At least 95 percent of EOCCO's members with an MH and/or SUD diagnosis were within the acceptable travel times and distances for all applicable geographic settings.

Table E-9—Time and Distance Results by Geographic Setting

MH				SUD			
Large Urban	Urban	Rural	CEAC	Large Urban	Urban	Rural	CEAC
NA	NA	99.6%	96.7%	NA	NA	99.7%	96.8%

Appointment Availability

The results from OHA's *CY 2023 Revealed Behavioral Health Telephone Survey Report* highlighting the accuracy of provider directory data and appointment availability for CCO members for behavioral health OP provider locations were incorporated into the *2024 Mental Health Parity Evaluation Summary Report* as well as the Oregon *2023 External Quality Review Technical Report*. OHA communicated and addressed individual CCO results from the surveys through established monitoring and oversight mechanisms.

Access-Related Grievances

Table E-10 presents the average percentage of access-related MH/SUD grievances compared to the overall number of MH/SUD grievances. The CCO showed a low percentage of grievances (4.0 percent) that were associated with MH/SUD services. Of those grievances, 24.4 percent were related to access issues. Although these results suggest access as a potential focus for MH/SUD grievances, the results should be interpreted with caution due to the low overall total number of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.

Table E-10—Average Percentage of Access-Related MH/SUD Grievances

Total Grievances	MH/SUD Grievances		Access-Related MH/SUD Grievances	
	Number	Percent	Number	Percent
1,020	41	4.0%	10	24.4%

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2024 MHP Evaluation, the following strengths, weakness, and recommendations with respect to the quality, timeliness, and accessibility of health care services were identified. Strengths and weaknesses specific to the adequacy of MH/SUD provider networks and appointment availability were identified and communicated to the CCO through the *CY 2023 Revealed Behavioral Health Telephone Survey Report* and DSN Evaluation.

Strength/ Weakness	Description	Domain(s)*
The CCO met performance expectations. No significant strengths or weaknesses were noted during the review.		

*= Quality, = Timeliness, = Access

Appendix F. MHP Results for Health Share of Oregon (HSO)

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the coordinated care organization (CCO) to manage the administration of mental health (MH) and substance use disorder (SUD) and medical and surgical (M/S) covered benefits, and assess whether documentation demonstrated compliance with Mental Health Parity (MHP) requirements in how they were applied to MH/SUD and M/S services. Health Services Advisory Group, Inc. (HSAG) used the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant* to indicate the degree to which changes identified by the CCOs and Oregon Health Plan (OHP) fee-for-service (FFS) in the *MHP Treatment Limitation Attestation Tool* remained compliant with parity requirements or the degree to which the 2023 MHP finding(s) were addressed in the *MHP Treatment Limitation Supplemental Questionnaire* and demonstrated compliance with parity requirements. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency*. A *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both, or there was insufficient information or clear evidence of parity associated with implemented non-quantitative treatment limitations (NQTLs). A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria or no documentation was submitted to evaluate the consistency and stringency of NQTLs.

The *MHP Treatment Limitation Attestation Tool* along with the *MHP Treatment Limitation Supplemental Questionnaire,* as applicable, were used to collect information on the four types of treatment limitations (i.e., financial requirements [FRs], aggregate lifetime and annual dollar limits [AL/ADLs], quantitative treatment limitations [QTLs], and NQTLs). A summary of the treatment limitations review by type is included below.

Financial Requirements

- HSO reported the CCO did not make changes and did not apply any FRs or payments from members for services received that are in addition to payments made by the State (e.g., copayments, coinsurance, deductibles, or out-of-pocket maximums) for inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC) services for MH/SUD or M/S benefits.

Aggregate Lifetime and Annual Dollar Limits

- HSO reported the CCO did not make any changes and did not apply any AL/ADLs on the total amount of a specified benefit over a lifetime or annually for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Quantitative Treatment Limitations

- HSO reported the CCO did not make any changes and did not apply any QTLs or limits on the scope or duration of a benefit that are expressed numerically (e.g., day or visit limits) for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Non-Quantitative Treatment Limitations

Table F-1 highlights the overall ratings of compliance with parity requirements for the identified changes and 2023 findings for HSO by NQTL domain and overall.

Table F-1—Compliance With Parity Requirements for HSO by NQTL Domain and Overall

Organization Name	Medical Management	Provider Network	Pharmacy Management	Overall Compliance Rating
HSO	Compliant	Compliant	Partially Compliant	Partially Compliant

Medical Management

- HSO sufficiently addressed its concurrent review (CR) and practice guidelines NQTLs through the *MHP Treatment Limitation Supplemental Questionnaire*. The rationale used to determine assignment of the CR and practice guidelines NQTLs were consistent between MH/SUD and M/S benefits, and the evidentiary standards used in administering the NQTL to MH/SUD benefits were comparable to the evidentiary standards used in administering the NQTL to M/S benefits. The CCO used evidence-based criteria for MH/SUD and M/S benefits to administer its processes with equivalent stringency. HSO also addressed the step therapy or fail-first strategies NQTL through the *MHP Treatment Limitation Supplemental Questionnaire* by indicating step therapy or fail-first strategies were not used to manage the administration of MH/SUD or M/S services.

Provider Network

- HSO addressed the geographic restrictions NQTL through the *MHP Treatment Limitation Supplemental Questionnaire* by indicating geographic restrictions were not used to manage the administration of MH/SUD services.

Pharmacy Management

- HSO sufficiently addressed its quantity limits NQTL through the *MHP Treatment Limitation Supplemental Questionnaire*. The rationale used to determine assignment of the quantity limits NQTL were consistent between MH/SUD and M/S benefits, and the evidentiary standards used in administering the NQTL to MH/SUD benefits were comparable to the evidentiary standards used in administering the NQTL to M/S benefits. The CCO used evidence-based criteria for MH/SUD and M/S benefits to administer its processes with equivalent stringency. However, the NQTL of formulary design for prescription drugs was unable to be fully evaluated for parity with MHP requirements due to a lack of sufficient information and/or supporting documentation to demonstrate how each subcontractor is applying the formulary design NQTL, including the rationale for the

NQTL; procedures, processes, and requirements used to apply the NQTL; frequency and strictness of the NQTL; and evidentiary standards to support the rationale for how frequently and strictly the NQTL is applied. In the absence of supporting documentation from each subcontractor, the evaluation could not be fully met, resulting in a *Partially Compliant* finding.

Availability of Information

An HSO subcontractor reported the reorganization of its provider page to provide better access to the criteria for medical necessity information to its providers. HSO continued to demonstrate that medical necessity criteria information was made available to members and/or network providers.

Administrative Data Profile

Claims

Table F-2 presents a summary of the results from the analysis of paid claims by service type and benefit type. HSO showed a greater percentage of OON IP and OON OP MH/SUD claims were paid compared to OON IP and OON OP M/S claims. However, there was a minimal difference (2.9 percentage points) in the percentage of paid OP MH/SUD claims compared to paid OP M/S claims. There was also a minimal difference (2.7 percentage points) in the total percentage of paid OP claims between MH/SUD (88.7 percent) and M/S (91.4 percent).

Table F-2—Number and Percentage of Claims by Service Type and Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims		Out-of-Network Paid Claims	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	205,008	179,336	87.5%	170,317	88.8%
	M/S	171,758	150,440	87.6%	52,755	85.7%
OP	MH/SUD	2,951,356	2,619,234	88.7%	2,255,050	89.2%
	M/S	2,468,586	2,262,129	91.6%	310,105	87.1%
Total	**MH/SUD**	**3,156,364**	**2,798,570**	**88.7%**	**2,425,367**	**89.2%**
	M/S	**2,640,344**	**2,412,569**	**91.4%**	**362,860**	**86.9%**

Utilization Management

Table F-3 presents a summary of the results from the analysis of prior authorizations (PAs) by service type and benefit type. HSO showed a lower percentage of denied IP and OP claims for MH/SUD compared to M/S. HSO showed a minimal difference (3.5 percentage points) in the percentage of denied Rx claims between MH/SUD (60.4 percent) and M/S (56.9 percent), where MH/SUD PAs were approved less frequently than M/S PAs. Due to the low number of PA denials that were appealed, results

associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity.

Table F-3—PA Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals		Hearings	
		Total	Denied Number	Percent	Total Percent	Overturned Percent	Total Percent	Overturned Percent
IP	**MH/SUD**	3,597	4	0.1%	0.0%	NA	0.0%	NA
	M/S	7,034	642	9.1%	100%	44.8%	6.9%	50.0%
OP	**MH/SUD**	5,773	189	3.3%	1.5%	46.7%	0.0%	NA
	M/S	145,896	12,657	8.7%	98.5%	44.9%	3.5%	17.1%
Rx	**MH/SUD**	4,060	2,453	60.4%	11.4%	51.8%	0.0%	NA
	M/S	25,244	14,376	56.9%	88.6%	44.3%	1.0%	33.3%

NA—indicates a denominator of zero; results could not be calculated.

Provider Enrollment

Table F-4 presents a summary of the results from the analysis of provider enrollment and terminations by benefit type. HSO showed no difference in the percentage of provider applications approved in calendar year (CY) 2023. The CCO exhibited a minimal difference (4.0 percentage points) in the percentage of terminated providers, where M/S providers were terminated at higher rates (23.6 percent) than MH/SUD providers (19.6 percent).

Table F-4—CY 2023 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	1,844	99.9%	596	19.6%
M/S	10,560	99.9%	2,556	23.6%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table F-5 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Quarter 1 (Q1) 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

HSO showed an increase in the overall provider network between Q1 2023 to Q1 2024 with a substantial increase (47.3 percent) in providers identified as MH. However, a minimal decrease (4.1 percent) was noted in the number of SUD providers. A comprehensive review of the CCO's provider network capacity was conducted through the annual Delivery System Network (DSN) Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table F-5—Number and Percentage of MH/SUD Providers by Quarter and Provider Type

Provider Type	Q1 2023			Q1 2024			Difference		
	All Providers (N)	MH/SUD Providers		All Providers (N)	MH/SUD Providers		MH/SUD Provider (N)	Percent Change	
		(N)	(%)		(N)	(%)			
MH	10,833	2,012	18.6%	11,535	2,964	25.7%	952	47.3%	▲
SUD		582	5.4%	11,535	558	4.8%	-24	-4.1%	

Provider-to-Member Ratios

Table F-6 presents the provider-to-member ratios for MH and SUD providers in Q1 2024 by provider type.

Table F-6—Provider-to-Member Ratios by Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	2,964	87,555	1:30
SUD	558	20,718	1:38

Time and Distance

Table F-7 presents the average time and distance to the nearest three MH and SUD providers by provider type and large urban and urban geographic settings. Table F-8 presents the average time and distance to the nearest three MH and SUD providers by provider type and rural geographic settings and counties with extreme access considerations (CEAC). Acceptable travel times and distances are 10 minutes/5 miles in large urban settings, 25 minutes/15 miles in urban settings, 30 minutes/20 miles in rural settings, and 40 minutes/30 miles in CEAC settings.

The average drive times and distances to the nearest three MH and SUD providers were within the acceptable travel times and distances set by OHA. The CCO had no urban or CEAC settings within its service area as defined by state-established urbanicity parameters and are listed as *Not Applicable (NA)*. A comprehensive review of the CCO's provider network time and distance was conducted through the annual DSN Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table F-7—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Large Urban and Urban Geographic Settings

Provider Type	Large Urban						Urban					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	0.7	0.9	1.0	1.2	1.4	1.6	NA	NA	NA	NA	NA	NA
SUD	1.5	1.8	1.9	2.4	2.9	3.1	NA	NA	NA	NA	NA	NA

Table F-8—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Rural and CEAC Geographic Settings

Provider Type	Rural						CEAC					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	3.2	4.6	4.9	3.4	5.0	5.3	NA	NA	NA	NA	NA	NA
SUD	13.3	13.9	14.0	15.3	16.0	16.0	NA	NA	NA	NA	NA	NA

Table F-9 presents the percentages of CCO members with access to MH and SUD services by geographic setting. The results are aggregated across all members and not stratified by adult and pediatric populations. The CCO does not have urban or CEAC settings within its service area and are listed as *Not Applicable (NA)*. Results showing less than 95 percent of members meeting the acceptable

times and distances are shaded red.[23] All HSO members were within the acceptable travel times and distances except for members with a SUD diagnosis in rural areas; however, more than 90 percent of those members were still within acceptable travel times and distances.

Table F-9—Time and Distance Results by Geographic Setting

MH				SUD			
Large Urban	Urban	Rural	CEAC	Large Urban	Urban	Rural	CEAC
100%	NA	100%	NA	99.4%	NA	94.8%	NA

Appointment Availability

The results from OHA's *CY 2023 Revealed Behavioral Health Telephone Survey Report* highlighting the accuracy of provider directory data and appointment availability for CCO members for behavioral health OP provider locations were incorporated into the *2024 Mental Health Parity Evaluation Summary Report* as well as the Oregon *2023 External Quality Review Technical Report*. OHA communicated and addressed individual CCO results from the surveys through established monitoring and oversight mechanisms.

Access-Related Grievances

Table F-10 presents the average percentage of access-related MH/SUD grievances compared to the overall number of MH/SUD grievances. The CCO showed a low percentage of grievances (2.5 percent) that were associated with MH/SUD services. Of those grievances, more than 14 percent were related to access issues. Although these results suggest access as a potential focus for MH/SUD grievances, the results should be interpreted with caution due to the low overall total number of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.

Table F-10—Average Percentage of Access-Related MH/SUD Grievances

Total Grievances	MH/SUD Grievances		Access-Related MH/SUD Grievances	
	Number	Percent	Number	Percent
7,974	197	2.5%	28	14.2%

[23] Although OHA has established time and distance standards, CCO compliance is not assessed as part of this evaluation. OHA assesses CCO compliance to time and distance standards based on adult and pediatric provider types comprising three tiers; 95 percent or more pediatric and adult members must meet the acceptable travel times and distances to the nearest adult and pediatric provider, regardless of urbanicity.

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2024 MHP Evaluation, the following strengths, weakness, and recommendations with respect to the quality, timeliness, and accessibility of health care services were identified. Strengths and weaknesses specific to the adequacy of MH/SUD provider networks and appointment availability were identified and communicated to the CCO through the *CY 2023 Revealed Behavioral Health Telephone Survey Report* and DSN Evaluation.

Strength/ Weakness	Description	Domain(s)*
⊕	**Strength:** No strengths were identified.	
⊖	**Weakness:** HSO was partially compliant with the Pharmacy Management–formulary design NQTL requirement. **Why the weakness exists:** The CCO did not provide documentation related its rationale for the assignment of the NQTL (i.e., prescription drug formulary), procedures used for the development of the formulary (e.g., individuals involved in formulary development, professional guidelines used, and how often the formulary is reviewed and updated or by whom), or how frequently or strictly the NQTL is applied (e.g., ability of the provider to request an exception). **Recommendations:** The CCO should provide supporting documentation to identify processes, strategies, evidentiary standards, and other factors that are used in formulary design and the application for prescription drugs.	🔑

*= Quality, = Timeliness, 🔑 = Access

Appendix G. MHP Results for InterCommunity Health Network (IHN)

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the coordinated care organization (CCO) to manage the administration of mental health (MH) and substance use disorder (SUD) and medical and surgical (M/S) covered benefits, and assess whether documentation demonstrated compliance with Mental Health Parity (MHP) requirements in how they were applied to MH/SUD and M/S services. Health Services Advisory Group, Inc. (HSAG) used the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant* to indicate the degree to which changes identified by the CCOs and Oregon Health Plan (OHP) fee-for-service (FFS) in the *MHP Treatment Limitation Attestation Tool* remained compliant with parity requirements or the degree to which the 2023 MHP finding(s) were addressed in the *MHP Treatment Limitation Supplemental Questionnaire* and demonstrated compliance with parity requirements. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency*. A *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both, or there was insufficient information or clear evidence of parity associated with implemented non-quantitative treatment limitations (NQTLs). A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria or no documentation was submitted to evaluate the consistency and stringency of NQTLs.

The *MHP Treatment Limitation Attestation Tool* along with the *MHP Treatment Limitation Supplemental Questionnaire,* as applicable, were used to collect information on the four types of treatment limitations (i.e., financial requirements [FRs], aggregate lifetime and annual dollar limits [AL/ADLs], quantitative treatment limitations [QTLs], and NQTLs). A summary of the treatment limitations review by type is included below.

Financial Requirements

- IHN reported the CCO did not make changes and did not apply any FRs or payments from members for services received that are in addition to payments made by the State (e.g., copayments, coinsurance, deductibles, or out-of-pocket maximums) for inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC) services for MH/SUD or M/S benefits.

Aggregate Lifetime and Annual Dollar Limits

- IHN reported the CCO did not make any changes and did not apply any AL/ADLs on the total amount of a specified benefit over a lifetime or annually for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Quantitative Treatment Limitations

- IHN reported implementing changes to QTLs in the management of MH/SUD and M/S benefits. Specifically, IHN reported that it removed the prior authorization (PA) requirement for the first 30 occupational/physical therapy/speech therapy visits and 76 presumptive and 24 definitive urine drug tests. However, the QTLs were identified as soft limits and categorized as NQTLs since IHN allowed members to receive additional services based on an evaluation of medical necessity through PA.

Non-Quantitative Treatment Limitations

Table G-1 highlights the overall ratings of compliance with parity requirements for the identified changes and 2023 findings for IHN by NQTL domain and overall.

Table G-1—Compliance With Parity Requirements for IHN by NQTL Domain and Overall

CCO Name	Medical Management	Provider Network	Pharmacy Management	Overall Compliance Rating
IHN	Compliant	Compliant	Compliant	Compliant

Medical Management

- IHN reported changes through the *MHP Treatment Limitation Attestation Tool* to PA and concurrent review (CR) processes to manage the administration of MH/SUD and M/S covered benefits. Specifically, the CCO reported that it removed the PA requirement for the first 30 occupational/physical therapy/speech therapy visits and 76 presumptive and 24 definitive urine drug tests, and updated CR processes to better align with Oregon Administrative Rules (OARs). The changes reported for the PA and CR NQTLs for MH/SUD and M/S benefits did not impact compliance with parity requirements. The evidentiary standards used in administering the NQTL to MH/SUD benefits were comparable to the evidentiary standards used in administering the NQTL to M/S benefits. The CCO also reported changes to retrospective review processes; however, the changes only applied to OP services for M/S benefits and did not affect compliance with parity requirements.

Provider Network

- IHN attested that no changes were implemented to the NQTLs that applied to MH/SUD or M/S benefits, which were evaluated during the calendar year (CY) 2023 MHP Evaluation and met parity requirements.

Pharmacy Management

- IHN reported changes through the *MHP Treatment Limitation Attestation Tool* to PA processes for Rx services across benefit types. Specifically, PA requirements were added or removed based on the Prioritized List of Health Services and its corresponding treatment guidelines, Food and Drug Administration (FDA) indications, and nationally recognized medical standards. The changes

reported for PA processes for the Rx services NQTL for MH/SUD and M/S benefits did not impact compliance with parity requirements. The evidentiary standards used in administering the NQTL to MH/SUD benefits were comparable to the evidentiary standards used in administering the NQTL to M/S benefits. The CCO used evidence-based criteria for MH/SUD and M/S benefits to administer its processes with equivalent stringency.

Availability of Information

IHN reported no changes were implemented regarding the mechanisms used to disseminate medical necessity information to members and/or providers.

Administrative Data Profile

Claims

Table G-2 presents a summary of the results from the analysis of paid claims by service type and benefit type. Across all service types, a greater percentage of MH/SUD claims were paid compared to M/S claims. There was a negligible difference (0.9 percentage points) in the percentage of paid OP claims between MH/SUD (94.7 percent) and M/S (93.8 percent).

Table G-2—Number and Percentage of Claims by Service Type and Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims		Out-of-Network Paid Claims	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	6,315	6,151	97.4%	1,391	97.8%
	M/S	62,632	56,407	90.1%	6,029	79.2%
OP	MH/SUD	167,698	158,882	94.7%	8,521	89.4%
	M/S	823,478	772,730	93.8%	26,439	74.0%
Total	**MH/SUD**	**174,013**	**165,033**	**94.8%**	**9,912**	**90.5%**
	M/S	**886,110**	**829,137**	**93.6%**	**32,468**	**74.9%**

Utilization Management

Table G-3 presents a summary of the results from the analysis of PAs by service type and benefit type. For OP and Rx, a greater percentage of M/S PAs were denied compared to MH/SUD PAs. No substantial differences in the percentage of denied M/S and MH/SUD PAs were found that would have suggested an MHP concern. Only PA denials for IP services were greater among MH/SUD services (4.0 percent) compared to M/S services (3.7 percent). Due to the low number of PA denials that were appealed, results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity.

Table G-3—PA Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals		Hearings	
		Total	Denied Number	Percent	Total Percent[1]	Overturned Percent	Total Percent	Overturned Percent
IP	**MH/SUD**	803	32	4.0%	42.9%	83.3%	0.0%	NA
	M/S	5,664	208	3.7%	57.1%	50.0%	0.0%	NA
OP	**MH/SUD**	7,746	261	3.4%	8.9%	23.5%	0.0%	NA
	M/S	44,816	3,970	8.9%	91.1%	34.3%	2.1%	25.0%
Rx	**MH/SUD**	1,409	580	41.2%	0.0%	NA	0.0%	NA
	M/S	11,184	6,214	55.6%	100%	50.0%	0.0%	NA

NA—indicates a denominator of zero; results could not be calculated.

Provider Enrollment

Table G-4 presents a summary of the results from the analysis of provider enrollment and terminations by benefit type. IHN showed no difference between the percentage of MH/SUD and M/S provider applications approved in CY 2023. The CCO exhibited a minimal difference (2.7 percentage points) in the percentage of M/S terminated providers (3.8 percent) compared to MH/SUD providers (6.5 percent).

Table G-4—CY 2023 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	975	99.7%	138	6.5%
M/S	1,210	99.7%	350	3.8%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table G-5 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Quarter 1 (Q1) 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately one year. Although a

comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

IHN showed a decrease in the overall provider network between Q1 2023 to Q1 2024. However, a substantial increase (12.9 percent) was noted in providers identified as SUD, and a minimal increase was noted in providers identified as MH (3.9 percent). A comprehensive review of the CCO's provider network capacity was conducted through the annual Delivery System Network (DSN) Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table G-5—Number and Percentage of MH/SUD Providers by Quarter and Provider Type

Provider Type	Q1 2023			Q1 2024			Difference		
	All Providers (N)	MH/SUD Providers		All Providers (N)	MH/SUD Providers		MH/SUD Provider (N)	Percent Change	
		(N)	(%)		(N)	(%)			
MH	5,306	1,217	22.9%	5,260	1,265	24.0%	48	3.9%	
SUD		411	7.7%	5,260	464	8.8%	53	12.9%	▲

Provider-to-Member Ratios

Table G-6 presents the provider-to-member ratios for MH and SUD providers in Q1 2024 by provider type.

Table G-6—Provider-to-Member Ratios by Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	1,265	57,195	1:46
SUD	464	44,281	1:96

Time and Distance

Table G-7 presents the average time and distance to the nearest three MH and SUD providers by provider type and large urban and urban geographic settings. Table G-8 presents the average time and distance to the nearest three MH and SUD providers by provider type and rural geographic settings and counties with extreme access considerations (CEAC). Acceptable travel times and distances are 10 minutes/5 miles in large urban settings, 25 minutes/15 miles in urban settings, 30 minutes/20 miles in rural settings, and 40 minutes/30 miles in CEAC settings.

The average drive times and distances to the nearest three MH and SUD providers were within the acceptable travel times and distances set by OHA. The CCO had no large urban or CEAC settings within its service area as defined by state-established urbanicity parameters and are listed as *Not Applicable (NA)*. A comprehensive review of the CCO's provider network time and distance was conducted through

the annual DSN Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table G-7—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Large Urban and Urban Geographic Settings

Provider Type	Large Urban						Urban					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	NA	NA	NA	NA	NA	NA	0.8	1.1	1.2	0.8	1.1	1.2
SUD	NA	NA	NA	NA	NA	NA	1.4	1.6	1.8	1.5	1.7	1.9

Table G-8—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Rural and CEAC Geographic Settings

Provider Type	Rural						CEAC					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	1.9	2.5	3.0	2.1	2.6	3.2	NA	NA	NA	NA	NA	NA
SUD	5.8	10.3	10.4	6.3	11.2	11.3	NA	NA	NA	NA	NA	NA

Table G-9 presents the percentages of CCO members with access to MH and SUD services by geographic setting. The results are aggregated across all members and not stratified by adult and pediatric populations. The CCO does not have large urban or CEAC settings within its service area and are listed as *Not Applicable (NA)*. At least 95 percent of IHN's members with an MH and/or SUD diagnosis were within the acceptable travel times and distances for all applicable geographic settings.

Table G-9—Time and Distance Results by Geographic Setting

MH				SUD			
Large Urban	Urban	Rural	CEAC	Large Urban	Urban	Rural	CEAC
NA	100%	100%	NA	NA	100%	98.4%	NA

Appointment Availability

The results from OHA's *CY 2023 Revealed Behavioral Health Telephone Survey Report* highlighting the accuracy of provider directory data and appointment availability for CCO members for behavioral health OP provider locations were incorporated into the *2024 Mental Health Parity Evaluation Summary Report* as well as the Oregon *2023 External Quality Review Technical Report*. OHA communicated and addressed individual CCO results from the surveys through established monitoring and oversight mechanisms.

Access-Related Grievances

Table G-10 presents the average percentage of access-related MH/SUD grievances compared to the overall number of MH/SUD grievances. The CCO showed a low percentage of grievances (1.7 percent) that were associated with MH/SUD services. Of those grievances, only 6.3 percent were related to access issues. The results should be interpreted with caution due to the low overall total number of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.

Table G-10—Average Percentage of Access-Related MH/SUD Grievances

Total Grievances	MH/SUD Grievances		Access-Related MH/SUD Grievances	
	Number	Percent	Number	Percent
963	16	1.7%	1	6.3%

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2024 MHP Evaluation, the following strengths, weakness, and recommendations with respect to the quality, timeliness, and accessibility of health care services were identified. Strengths and weaknesses specific to the adequacy of MH/SUD provider networks and appointment availability were identified and communicated to the CCO through the *CY 2023 Revealed Behavioral Health Telephone Survey Report* and DSN Evaluation.

Strength/ Weakness	Description	Domain(s)*
➕	**Strength:** No strengths were identified.	
➖	**Weakness:** IHN demonstrated 83.3 percent of MH/SUD IP denial decisions were overturned at the appeal level. **Why the weakness exists:** Although the total number of appeals was low (i.e., six), the fact that 83.3 percent of the denial decisions were overturned at the appeal level may highlight issues with potentially ineffective PA processes and/or individuals making inappropriate decisions. **Recommendations:** IHN should review MH/SUD IP appeals to understand the factors affecting the 83.3 percent overturn rate. The CCO should review PA criteria and/or decision-making processes and make appropriate changes to ensure appropriate access to MH/SUD IP services.	⏱️🔑

*= Quality, ⏱️ = Timeliness, 🔑 = Access

Appendix H. MHP Results for Jackson Care Connect (JCC)

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the coordinated care organization (CCO) to manage the administration of mental health (MH) and substance use disorder (SUD) and medical and surgical (M/S) covered benefits, and assess whether documentation demonstrated compliance with Mental Health Parity (MHP) requirements in how they were applied to MH/SUD and M/S services. Health Services Advisory Group, Inc. (HSAG) used the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant* to indicate the degree to which changes identified by the CCOs and Oregon Health Plan (OHP) fee-for-service (FFS) in the *MHP Treatment Limitation Attestation Tool* remained compliant with parity requirements or the degree to which the 2023 MHP finding(s) were addressed in the *MHP Treatment Limitation Supplemental Questionnaire* and demonstrated compliance with parity requirements. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency*. A *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both, or there was insufficient information or clear evidence of parity associated with implemented non-quantitative treatment limitations (NQTLs). A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria or no documentation was submitted to evaluate the consistency and stringency of NQTLs.

The *MHP Treatment Limitation Attestation Tool* along with the *MHP Treatment Limitation Supplemental Questionnaire,* as applicable, were used to collect information on the four types of treatment limitations (i.e., financial requirements [FRs], aggregate lifetime and annual dollar limits [AL/ADLs], quantitative treatment limitations [QTLs], and NQTLs). A summary of the treatment limitations review by type is included below.

Financial Requirements

- JCC reported the CCO did not make changes and did not apply any FRs or payments from members for services received that are in addition to payments made by the State (e.g., copayments, coinsurance, deductibles, or out-of-pocket maximums) for inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC) services for MH/SUD or M/S benefits.

Aggregate Lifetime and Annual Dollar Limits

- JCC reported the CCO did not make any changes and did not apply any AL/ADLs on the total amount of a specified benefit over a lifetime or annually for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Quantitative Treatment Limitations

- JCC reported the CCO did not make any changes and did not apply any QTLs or limits on the scope or duration of a benefit that are expressed numerically (e.g., day or visit limits) for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Non-Quantitative Treatment Limitations

Table H-1 highlights the overall ratings of compliance with parity requirements for the identified changes and 2023 findings for JCC by NQTL domain and overall.

Table H-1—Compliance With Parity Requirements for JCC by NQTL Domain and Overall

Organization Name	Medical Management	Provider Network	Pharmacy Management	Overall Compliance Rating
JCC	Compliant	Compliant	Compliant	Compliant

Medical Management

- JCC attested that no changes were implemented to the NQTLs that applied to MH/SUD or M/S benefits, which were evaluated during the calendar year (CY) 2023 MHP Evaluation and met parity requirements.

Provider Network

- JCC reported changes to reimbursement rates, including a rate increase for behavioral health and SUD services. The reported change to the reimbursement rates NQTL for MH/SUD benefits does not affect compliance with parity requirements.

Pharmacy Management

- JCC attested that no changes were implemented to the NQTLs that applied to MH/SUD or M/S benefits, which were evaluated during the CY 2023 MHP Evaluation and met parity requirements.

Availability of Information

JCC reported no changes were implemented regarding the mechanisms used to disseminate medical necessity information to members and/or providers.

Administrative Data Profile

Claims

Table H-2 presents a summary of the results from the analysis of paid claims by service type and benefit type. JCC showed a greater percentage of paid MH/SUD claims across all service types (IP, OP, and OON) compared to M/S claims.

Table H-2—Number and Percentage of Claims by Service Type and Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims		Out-of-Network Paid Claims	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	19,299	18,279	94.7%	619	66.6%
	M/S	52,398	46,595	88.9%	2,127	56.2%
OP	MH/SUD	309,240	295,456	95.5%	58,688	91.6%
	M/S	748,625	678,299	90.6%	33,369	75.9%
Total	**MH/SUD**	**328,539**	**313,735**	**95.5%**	**59,307**	**91.2%**
	M/S	**801,023**	**724,894**	**90.5%**	**35,496**	**74.4%**

Utilization Management

Table H-3 presents a summary of the results from the analysis of prior authorizations (PAs) by service type and benefit type. JCC showed a greater percentage of M/S OP and Rx PAs were denied compared to MH/SUD PAs. While there was a substantial difference (72.3 percentage points) noted in the percentage of denied MH/SUD IP PAs (100 percent) and M/S IP PAs (27.7 percent), the CCO reported only two MH/SUD IP PAs in total, which was insufficient to detect a difference between the two groups.

Table H-3—PA Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals		Hearings	
		Total	Denied Number	Percent	Total Percent	Overturned Percent	Total Percent	Overturned Percent
IP	**MH/SUD**	2	2	100%	0.0%	NA	0.0%	NA
	M/S	480	133	27.7%	100%	0.0%	7.7%	0.0%
OP	**MH/SUD**	197	9	4.6%	0.0%	NA	0.0%	NA
	M/S	34,671	2,405	6.9%	100%	44.8%	5.2%	22.2%
Rx	**MH/SUD**	515	345	67.0%	11.0%	43.2%	0.0%	NA
	M/S	4,541	3,500	77.1%	89.0%	38.9%	0.0%	NA

NA—indicates a denominator of zero; results could not be calculated.

Provider Enrollment

Table H-4 presents a summary of the results from the analysis of provider enrollment and terminations by benefit type. JCC showed no difference in the percentage of provider applications approved in CY 2023. The CCO exhibited a substantial difference (49.7 percentage points) in the percentages of terminated providers, where MH/SUD providers were terminated at higher rates (56.0 percent) than M/S providers (6.3 percent).

Table H-4—CY 2023 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	76	100%	173	56.0%
M/S	122	100%	72	6.3%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table H-5 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Quarter 1 (Q1) 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

JCC showed an increase in the overall provider network between Q1 2023 to Q1 2024 with a substantial increase (26.2 percent) in providers identified as MH. A minimal increase was also noted in providers identified as SUD (0.4 percent). A comprehensive review of the CCO's provider network capacity was conducted through the annual Delivery System Network (DSN) Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table H-5—Number and Percentage of MH/SUD Providers by Quarter and Provider Type

Provider Type	Q1 2023			Q1 2024			Difference		
	All Providers (N)	MH/SUD Providers		All Providers (N)	MH/SUD Providers		MH/SUD Provider (N)	Percent Change	
		(N)	(%)		(N)	(%)			
MH	8,684	2,108	24.3%	9,458	2,661	28.1%	553	26.2%	▲
SUD		534	6.1%	9,458	536	5.7%	2	0.4%	

Provider-to-Member Ratios

Table H-6 presents the provider-to-member ratios for MH and SUD providers in Q1 2024 by provider type.

Table H-6—Provider-to-Member Ratios by Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	2,661	13,368	1:6
SUD	536	1,899	1:4

Time and Distance

Table H-7 presents the average time and distance to the nearest three MH and SUD providers by provider type and large urban and urban geographic settings. Table H-8 presents the average time and distance to the nearest three MH and SUD providers by provider type and rural geographic settings and counties with extreme access considerations (CEAC). Acceptable travel times and distances are 10 minutes/5 miles in large urban settings, 25 minutes/15 miles in urban settings, 30 minutes/20 miles in rural settings, and 40 minutes/30 miles in CEAC settings.

The average drive times and distances to the nearest three MH and SUD providers were within the acceptable travel times and distances set by OHA. The CCO had no large urban or CEAC settings within its service area as defined by state-established urbanicity parameters and are listed as *Not Applicable (NA)*. A comprehensive review of the CCO's provider network time and distance was conducted through the annual DSN Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table H-7—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Geographic Setting

Provider Type	Large Urban						Urban					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	NA	NA	NA	NA	NA	NA	0.8	0.9	1.1	0.9	1.0	1.2
SUD	NA	NA	NA	NA	NA	NA	2.6	2.6	2.7	3.0	3.0	3.1

Table H-8—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Rural and CEAC Geographic Settings

Provider Type	Rural						CEAC					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	3.4	4.1	4.3	3.7	4.5	4.6	NA	NA	NA	NA	NA	NA
SUD	15.9	15.9	16.0	18.1	18.2	18.2	NA	NA	NA	NA	NA	NA

Table H-9 presents the percentages of CCO members with access to MH and SUD services by geographic setting. The results are aggregated across all members and not stratified by adult and pediatric populations. The CCO does not have large urban or CEAC settings within its service area and are listed as *Not Applicable (NA)*. Results showing less than 95 percent of members meeting the acceptable times and distances are shaded red.[24] All JCC members were within the acceptable travel times and distances except for members with a SUD diagnosis in rural areas; however, more than 90 percent of those members were still within acceptable travel times and distances.

Table H-9—Time and Distance Results by Geographic Setting

MH				SUD			
Large Urban	Urban	Rural	CEAC	Large Urban	Urban	Rural	CEAC
NA	100%	99.9%	NA	NA	100%	92.5%	NA

Appointment Availability

The results from OHA's *CY 2023 Revealed Behavioral Health Telephone Survey Report* highlighting the accuracy of provider directory data and appointment availability for CCO members for behavioral health OP provider locations were incorporated into the *2024 Mental Health Parity Evaluation Summary*

[24] Although OHA has established time and distance standards, CCO compliance is not assessed as part of this evaluation. OHA assesses CCO compliance to time and distance standards based on adult and pediatric provider types comprising three tiers; 95 percent or more pediatric and adult members must meet the acceptable travel times and distances to the nearest adult and pediatric provider, regardless of urbanicity.

Report as well as the Oregon *2023 External Quality Review Technical Report*. OHA communicated and addressed individual CCO results from the surveys through established monitoring and oversight mechanisms.

Access-Related Grievances

Table H-10 presents the average percentage of access-related MH/SUD grievances compared to the overall number of MH/SUD grievances. The CCO showed a low percentage of grievances (4.1 percent) that were associated with MH/SUD services. Of those grievances, 9.5 percent were related to access issues. The results should be interpreted with caution due to the low overall total number of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.

Table H-10—Average Percentage of Access-Related MH/SUD Grievances

Total Grievances	MH/SUD Grievances		Access-Related MH/SUD Grievances	
	Number	Percent	Number	Percent
509	21	4.1%	2	9.5%

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2024 MHP Evaluation, the following strengths, weakness, and recommendations with respect to the quality, timeliness, and accessibility of health care services were identified. Strengths and weaknesses specific to the adequacy of MH/SUD provider networks and appointment availability were identified and communicated to the CCO through the *CY 2023 Revealed Behavioral Health Telephone Survey Report* and DSN Evaluation.

Strength/ Weakness	Description	Domain(s)*
The CCO met performance expectations. No significant strengths or weaknesses were noted during the review.		

*= Quality, = Timeliness, = Access

Appendix I. MHP Results for PacificSource Community Solutions–Central Oregon (PCS-CO)

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the coordinated care organization (CCO) to manage the administration of mental health (MH) and substance use disorder (SUD) and medical and surgical (M/S) covered benefits, and assess whether documentation demonstrated compliance with Mental Health Parity (MHP) requirements in how they were applied to MH/SUD and M/S services. Health Services Advisory Group, Inc. (HSAG) used the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant* to indicate the degree to which changes identified by the CCOs and Oregon Health Plan (OHP) fee-for-service (FFS) in the *MHP Treatment Limitation Attestation Tool* remained compliant with parity requirements or the degree to which the 2023 MHP finding(s) were addressed in the *MHP Treatment Limitation Supplemental Questionnaire* and demonstrated compliance with parity requirements. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency*. A *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both, or there was insufficient information or clear evidence of parity associated with implemented non-quantitative treatment limitations (NQTLs). A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria or no documentation was submitted to evaluate the consistency and stringency of NQTLs.

The *MHP Treatment Limitation Attestation Tool* along with the *MHP Treatment Limitation Supplemental Questionnaire,* as applicable, were used to collect information on the four types of treatment limitations (i.e., financial requirements [FRs], aggregate lifetime and annual dollar limits [AL/ADLs], quantitative treatment limitations [QTLs], and NQTLs). A summary of the treatment limitations review by type is included below.

Financial Requirements

- PCS-CO reported the CCO did not make changes and did not apply any FRs or payments from members for services received that are in addition to payments made by the State (e.g., copayments, coinsurance, deductibles, or out-of-pocket maximums) for inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC) services for MH/SUD or M/S benefits.

Aggregate Lifetime and Annual Dollar Limits

- PCS-CO reported the CCO did not make any changes and did not apply any AL/ADLs on the total amount of a specified benefit over a lifetime or annually for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Quantitative Treatment Limitations

- PCS-CO reported the CCO did not make any changes and did not apply any QTLs or limits on the scope or duration of a benefit that are expressed numerically (e.g., day or visit limits) for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Non-Quantitative Treatment Limitations

Table I-1 highlights the overall ratings of compliance with parity requirements for the identified changes and 2023 findings for PCS-CO by NQTL domain and overall.

Table I-1—Compliance With Parity Requirements for PCS-CO by NQTL Domain and Overall

Organization Name	Medical Management	Provider Network	Pharmacy Management	Overall Compliance Rating
PCS-CO	Compliant	Compliant	Compliant	Compliant

Medical Management

- PCS-CO reported changes to utilization management processes (i.e., prior authorization [PA], concurrent review [CR], and retrospective review [RR]) for IP and OP to manage the administration of MH/SUD and M/S covered benefits through the *MHP Treatment Limitation Attestation Tool*. Specifically, the CCO updated coverage criteria for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and radiology and genetic testing, MH/SUD and M/S level-of-care criteria, and the RR process for EPSDT. The changes reported for the PA NQTL across services for MH/SUD and M/S benefits did not impact compliance with parity requirements. The evidentiary standards used in administering the NQTL to MH/SUD benefits are comparable to the evidentiary standards used in administering the NQTL to M/S benefits. The CCO used evidence-based criteria for MH/SUD and M/S benefits to administer its processes with equivalent stringency.

Provider Network

- PCS-CO attested that no changes were implemented to the NQTLs that applied to MH/SUD or M/S benefits, which were evaluated during the calendar year (CY) 2023 MHP Evaluation and met parity requirements.

Pharmacy Management

- PCS-CO sufficiently addressed its formulary design NQTL through the *MHP Treatment Limitation Supplemental Questionnaire*. The rationale used to determine assignment of the formulary design NQTL was consistent between MH/SUD and M/S benefits, and the evidentiary standards used in administering the NQTL to MH/SUD benefits were comparable to the evidentiary standards used in administering the NQTL to M/S benefits. The CCO used evidence-based criteria for MH/SUD and M/S benefits to administer its processes with equivalent stringency.

Availability of Information

PCS-CO reported no changes were implemented regarding the mechanisms used to disseminate medical necessity information to members and/or providers.

Administrative Data Profile

Claims

Table I-2 presents a summary of the results from the analysis of paid claims by service type and benefit type. PCS-CO showed a greater percentage of paid MH/SUD claims across all service types (IP, OP, and out-of-network) compared to M/S claims.

Table I-2—Number and Percentage of Claims by Service Type and Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims		Out-of-Network Paid Claims	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	2,481	2,182	87.9%	308	62.5%
	M/S	7,560	6,556	86.7%	105	27.4%
OP	MH/SUD	502,915	462,682	92.0%	12,482	57.8%
	M/S	1,723,261	1,508,544	87.5%	28,197	53.7%
Total	**MH/SUD**	**505,396**	**464,864**	**92.0%**	**12,790**	**57.9%**
	M/S	**1,730,821**	**1,515,100**	**87.5%**	**28,302**	**53.6%**

Utilization Management

Table I-3 presents a summary of the results from the analysis of PAs by service type and benefit type. PCS-CO showed a minimal difference (0.3 percentage point) in the percentage of denied IP MH/SUD PAs (0.4 percent) compared to denied IP M/S PAs (0.1 percent). For OP and Rx service types, M/S PAs were denied at a higher percentage than MH/SUD PAs. Due to the low number of PA denials that were appealed (excluding Rx), results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity.

Table I-3—PA Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals		Hearings	
		Total	Denied Number	Percent	Total Percent	Overturned Percent	Total Percent	Overturned Percent
IP	**MH/SUD**	2,273	8	0.4%	NA	NA	NA	NA
	M/S	3,390	5	0.1%	NA	NA	NA	NA

Service Type	Benefit Type	Prior Authorization			Appeals		Hearings	
		Total	Denied Number	Percent	Total Percent	Overturned Percent	Total Percent	Overturned Percent
OP	**MH/SUD**	1,990	199	10.0%	13.4%	31.1%	0.2%	0.0%
	M/S	42,454	4,704	11.1%	86.6%	42.9%	1.3%	33.3%
Rx	**MH/SUD**	895	369	41.2%	10.4%	27.3%	0.0%	NA
	M/S	5,310	3,156	59.4%	89.6%	27.6%	0.0%	NA

NA—indicates a denominator of zero; results could not be calculated.

Provider Enrollment

Table I-4 presents a summary of the results from the analysis of provider enrollment and terminations by benefit type. The difference between the percentage of MH/SUD (100 percent) and M/S (99.9 percent) provider applications approved was negligible. A substantially higher number of M/S providers (1,687) were terminated compared to the number of MH/SUD providers (616).

Table I-4—CY 2023 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	2,561	100%	616	3.5%
M/S	1,948	99.9%	1,687	26.2%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table I-5 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Quarter 1 (Q1) 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

PCS-CO showed an increase in the overall provider network from Q1 2023 to Q1 2024 with a substantial increase (10.8 percent) in providers identified as MH. An increase was also noted in providers identified as

SUD (5.1 percent). A comprehensive review of the CCO's provider network capacity was conducted through the annual Delivery System Network (DSN) Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table I-5—Number and Percentage of MH/SUD Providers by Quarter and Provider Type

Provider Type	Q1 2023			Q1 2024			Difference		
	All Providers (N)	MH/SUD Providers		All Providers (N)	MH/SUD Providers		MH/SUD Provider (N)	Percent Change	
		(N)	(%)		(N)	(%)			
MH	9,322	3,682	39.5%	9,460	4,079	43.1%	397	10.8%	▲
SUD		550	5.9%	9,460	578	6.1%	28	5.1%	

Provider-to-Member Ratios

Table I-6 presents the provider-to-member ratios for MH and SUD providers in Q1 2024 by provider type.

Table I-6—Provider-to-Member Ratios by Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	4,079	19,489	1:5
SUD	578	5,520	1:10

Time and Distance

Table I-7 presents the average time and distance to the nearest three MH and SUD providers by provider type and large urban and urban geographic settings. Table I-8 presents the average time and distance to the nearest three MH and SUD providers by provider type and rural geographic settings and counties with extreme access considerations (CEAC). Acceptable travel times and distances are 10 minutes/5 miles in large urban settings, 25 minutes/15 miles in urban settings, 30 minutes/20 miles in rural settings, and 40 minutes/30 miles in CEAC settings.

The average drive times and distances to the nearest three MH and SUD providers were within the acceptable travel times and distances set by OHA. The CCO had no large urban setting within its service area as defined by state-established urbanicity parameters and is listed as *Not Applicable (NA)*. A comprehensive review of the CCO's provider network time and distance was conducted through the annual DSN Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table I-7—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Large Urban and Urban Geographic Settings

Provider Type	Large Urban						Urban					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	NA	NA	NA	NA	NA	NA	0.6	0.8	0.9	0.6	0.8	0.9
SUD	NA	NA	NA	NA	NA	NA	1.4	1.8	2.0	1.4	1.9	2.2

Table I-8—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Rural and CEAC Geographic Settings

Provider Type	Rural						CEAC					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	2.6	3.0	3.4	2.8	3.3	3.6	2.2	3.3	3.4	2.4	3.6	3.6
SUD	4.9	5.1	5.1	5.3	5.5	5.6	4.1	4.6	4.6	4.4	4.9	4.9

Table I-9 presents the percentages of CCO members with access to MH and SUD services by geographic setting. The results are aggregated across all members and not stratified by adult and pediatric populations. The CCO does not have a large urban setting within its service area and is listed as *Not Applicable (NA)*. At least 95 percent of PCS-CO's members with an MH and/or SUD diagnosis were within the acceptable travel times and distances for all applicable geographic settings.

Table I-9—Time and Distance Results by Geographic Setting

MH				SUD			
Large Urban	Urban	Rural	CEAC	Large Urban	Urban	Rural	CEAC
NA	100%	99.7%	99.8%	NA	100%	98.5%	99.3%

Appointment Availability

The results from OHA's *CY 2023 Revealed Behavioral Health Telephone Survey Report* highlighting the accuracy of provider directory data and appointment availability for CCO members for behavioral health OP provider locations were incorporated into the *2024 Mental Health Parity Evaluation Summary Report* as well as the Oregon *2023 External Quality Review Technical Report*. OHA communicated and addressed individual CCO results from the surveys through established monitoring and oversight mechanisms.

Access-Related Grievances

Table I-10 presents the average percentage of access-related MH/SUD grievances compared to the overall number of MH/SUD grievances. The CCO showed a low percentage of grievances (1.8 percent) that were associated with MH/SUD services. Of those grievances, only one was related to access issues. These low results should be interpreted with caution due to the low overall total number of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.

Table I-10—Average Percentage of Access-Related MH/SUD Grievances

Total Grievances	MH/SUD Grievances		Access-Related MH/SUD Grievances	
	Number	Percent	Number	Percent
820	15	1.8%	1	6.7%

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2024 MHP Evaluation, the following strengths, weakness, and recommendations with respect to the quality, timeliness, and accessibility of health care services were identified. Strengths and weaknesses specific to the adequacy of MH/SUD provider networks and appointment availability were identified and communicated to the CCO through the *CY 2023 Revealed Behavioral Health Telephone Survey Report* and DSN Evaluation.

Strength/ Weakness	Description	Domain(s)*
+	**Strength:** PCS-CO submitted a detailed summary of the changes implemented in CY 2023 to medical management and sufficiently addressed pharmacy management NQTLs as required from the previous year's MHP Evaluation. The information provided was clearly communicated in the narrative and was accompanied by supporting documentation.	

*= Quality, = Timeliness, = Access

Appendix J. MHP Results for PacificSource Community Solutions–Columbia Gorge (PCS-CG)

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the coordinated care organization (CCO) to manage the administration of mental health (MH) and substance use disorder (SUD) and medical and surgical (M/S) covered benefits, and assess whether documentation demonstrated compliance with Mental Health Parity (MHP) requirements in how they were applied to MH/SUD and M/S services. Health Services Advisory Group, Inc. (HSAG) used the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant* to indicate the degree to which changes identified by the CCOs and Oregon Health Plan (OHP) fee-for-service (FFS) in the *MHP Treatment Limitation Attestation Tool* remained compliant with parity requirements or the degree to which the 2023 MHP finding(s) were addressed in the *MHP Treatment Limitation Supplemental Questionnaire* and demonstrated compliance with parity requirements. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency*. A *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both, or there was insufficient information or clear evidence of parity associated with implemented non-quantitative treatment limitations (NQTLs). A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria or no documentation was submitted to evaluate the consistency and stringency of NQTLs.

The *MHP Treatment Limitation Attestation Tool* along with the *MHP Treatment Limitation Supplemental Questionnaire,* as applicable, were used to collect information on the four types of treatment limitations (i.e., financial requirements [FRs], aggregate lifetime and annual dollar limits [AL/ADLs], quantitative treatment limitations [QTLs], and NQTLs). A summary of the treatment limitations review by type is included below.

Financial Requirements

- PCS-CG reported the CCO did not make changes and did not apply any FRs or payments from members for services received that are in addition to payments made by the State (e.g., copayments, coinsurance, deductibles, or out-of-pocket maximums) for inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC) services for MH/SUD or M/S benefits.

Aggregate Lifetime and Annual Dollar Limits

- PCS-CG reported the CCO did not make any changes and did not apply any AL/ADLs on the total amount of a specified benefit over a lifetime or annually for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Quantitative Treatment Limitations

- PCS-CG reported the CCO did not make any changes and did not apply any QTLs or limits on the scope or duration of a benefit that are expressed numerically (e.g., day or visit limits) for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Non-Quantitative Treatment Limitations

Table J-1 highlights the overall ratings of compliance with parity requirements for the identified changes and 2023 findings for PCS-CG by NQTL domain and overall.

Table J-1—Compliance With Parity Requirements for PCS-CG by NQTL Domain and Overall

Organization Name	Medical Management	Provider Network	Pharmacy Management	Overall Compliance Rating
PCS-CG	Compliant	Compliant	Compliant	Compliant

Medical Management

- PCS-CG reported changes to utilization management processes (i.e., prior authorization [PA], concurrent review [CR], and retrospective review [RR]) for IP and OP to manage the administration of MH/SUD and M/S covered benefits through the *MHP Treatment Limitation Attestation Tool*. Specifically, the CCO updated coverage criteria for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and radiology and genetic testing, MH/SUD and M/S level-of-care criteria, and the RR process for EPSDT. The changes reported for the PA NQTL across services for MH/SUD and M/S benefits did not impact compliance with parity requirements. The evidentiary standards used in administering the NQTL to MH/SUD benefits are comparable to the evidentiary standards used in administering the NQTL to M/S benefits. The CCO used evidence-based criteria for MH/SUD and M/S benefits to administer its processes with equivalent stringency.

Provider Network

- PCS-CG attested that no changes were implemented to the NQTLs that applied to MH/SUD or M/S benefits, which were evaluated during the calendar year (CY) 2023 MHP Evaluation and met parity requirements.

Pharmacy Management

- PCS-CG sufficiently addressed its formulary design NQTL through the *MHP Treatment Limitation Supplemental Questionnaire*. The rationale used to determine assignment of the formulary design NQTL was consistent between MH/SUD and M/S benefits, and the evidentiary standards used in administering the NQTL to MH/SUD benefits were comparable to the evidentiary standards used in administering the NQTL to M/S benefits. The CCO used evidence-based criteria for MH/SUD and M/S benefits to administer its processes with equivalent stringency.

Availability of Information

PCS-CG reported no changes were implemented regarding the mechanisms used to disseminate medical necessity information to members and/or providers.

Administrative Data Profile

Claims

Table J-2 presents a summary of the results from the analysis of paid claims by service type and benefit type. PCS-CG showed a greater percentage of IP, OP, and out-of-network (OON) IP MH/SUD paid claims compared to IP, OP, and OON IP M/S paid claims. However, PCS-CG showed a substantial difference (23.4 percentage points) in the total percentage of OON paid claims between MH/SUD (47.3 percent) and M/S (70.7 percent), as well as OON OP claims (25.1 percentage points) individually.

Table J-2—Number and Percentage of Claims by Service Type and Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims		Out-of-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	393	339	86.3%	87	79.8%
	M/S	2,182	1,681	77.0%	86	35.8%
OP	MH/SUD	70,312	65,337	92.9%	1,350	46.0%
	M/S	377,374	328,518	87.1%	15,627	71.1%
Total	**MH/SUD**	**70,705**	**65,676**	**92.9%**	**1,437**	**47.3%**
	M/S	**379,556**	**330,199**	**87.0%**	**15,713**	**70.7%**

[1] Differences of 10 percentage points or more where a greater percentage of M/S claims were paid compared to MH/SUD claims are presented in red text.

Utilization Management

Table J-3 presents a summary of the results from the analysis of PAs by service type and benefit type. PCS-CG showed no denials of MH/SUD or M/S IP services. For OP and Rx, a greater percentage of M/S PAs were denied compared to MH/SUD PAs. Due to the low number of PA denials that were appealed (excluding Rx), results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity.

Table J-3—PA Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals		Hearings	
		Total	Denied Number	Percent	Total Percent	Overturned Percent	Total Percent	Overturned Percent
IP	MH/SUD	387	0	0.0%	NA	NA	NA	NA
	M/S	792	0	0.0%	NA	NA	NA	NA
OP	MH/SUD	177	23	13.0%	3.7%	60.0%	0.0%	NA
	M/S	8,378	1,105	13.2%	96.3%	47.3%	1.5%	0.0%
Rx	MH/SUD	110	48	43.6%	8.8%	18.2%	0.0%	NA
	M/S	1,238	737	59.5%	91.2%	41.2%	1.6%	0.0%

NA—indicates a denominator of zero; results could not be calculated.

Provider Enrollment

Table J-4 presents a summary of the results from the analysis of provider enrollment and terminations by benefit type. The difference between the percentage of MH/SUD (100 percent) and M/S (99.9 percent) provider applications approved was negligible. A substantially higher number of M/S providers (1,687) were terminated compared to the number of MH/SUD providers (616).

Table J-4—CY 2023 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	2,561	100%	616	3.5%
M/S	1,948	99.9%	1,687	26.2%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table J-5 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Quarter 1 (Q1) 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately one year. Although a

comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

PCS-CG showed an increase in the overall provider network from Q1 2023 to Q1 2024 with a substantial increase (10.8 percent) in providers identified as MH. An increase was also noted in providers identified as SUD (5.1 percent). A comprehensive review of the CCO's provider network capacity was conducted through the annual Delivery System Network (DSN) Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table J-5—Number and Percentage of MH/SUD Providers by Quarter and Provider Type

Provider Type	Q1 2023			Q1 2024			Difference		
	All Providers (N)	MH/SUD Providers		All Providers (N)	MH/SUD Providers		MH/SUD Provider (N)	Percent Change	
		(N)	(%)		(N)	(%)			
MH	9,159	3,681	40.2%	9,306	4,079	43.8%	398	10.8%	▲
SUD		550	6.0%	9,306	578	6.2%	28	5.1%	

Provider-to-Member Ratios

Table J-6 presents the provider-to-member ratios for MH and SUD providers in Q1 2024 by provider type.

Table J-6—Provider-to-Member Ratios by Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	4,079	3,403	1:1
SUD	578	861	1:2

Time and Distance

Table J-7 presents the average time and distance to the nearest three MH and SUD providers by provider type and large urban and urban geographic settings. Table J-8 presents the average time and distance to the nearest three MH and SUD providers by provider type and rural geographic settings and counties with extreme access considerations (CEAC). Acceptable travel times and distances are 10 minutes/5 miles in large urban settings, 25 minutes/15 miles in urban settings, 30 minutes/20 miles in rural settings, and 40 minutes/30 miles in CEAC settings.

The average drive times and distances to the nearest three MH and SUD providers were within the acceptable travel times and distances set by OHA. The CCO had no large urban, urban, or CEAC settings within its service area as defined by state-established urbanicity parameters and are listed as *Not Applicable (NA)*. A comprehensive review of the CCO's provider network time and distance was

conducted through the annual DSN Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table J-7—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Geographic Setting

Provider Type	Large Urban						Urban					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
SUD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Table J-8—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Rural and CEAC Geographic Settings

Provider Type	Rural						CEAC					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	2.8	3.3	3.5	3.1	3.6	3.7	NA	NA	NA	NA	NA	NA
SUD	10.0	10.0	10.0	10.9	10.9	10.9	NA	NA	NA	NA	NA	NA

Table J-9 presents the percentages of CCO members with access to MH and SUD services by geographic setting. The results are aggregated across all members and not stratified by adult and pediatric populations. The CCO does not have large urban, urban, or CEAC settings within its service area and are listed as *Not Applicable (NA)*. At least 95 percent of PCS-CG's members with an MH and/or SUD diagnosis were within the acceptable travel times and distances for all applicable geographic settings.

Table J-9—Time and Distance Results by Geographic Setting

MH				SUD			
Large Urban	Urban	Rural	CEAC	Large Urban	Urban	Rural	CEAC
NA	NA	98.2%	NA	NA	NA	95.4%	NA

Appointment Availability

The results from OHA's *CY 2023 Revealed Behavioral Health Telephone Survey Report* highlighting the accuracy of provider directory data and appointment availability for CCO members for behavioral health OP provider locations were incorporated into the *2024 Mental Health Parity Evaluation Summary Report* as well as the Oregon *2023 External Quality Review Technical Report*. OHA communicated and addressed individual CCO results from the surveys through established monitoring and oversight mechanisms.

Access-Related Grievances

Table J-10 presents the average percentage of access-related MH/SUD grievances compared to the overall number of MH/SUD grievances. The CCO showed a low percentage of grievances (1.4 percent) that were associated with MH/SUD services. Of those grievances (n=2), both were related to access issues. These low results should be interpreted with caution due to the low overall total number of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.

Table J-10—Average Percentage of Access-Related MH/SUD Grievances

Total Grievances	MH/SUD Grievances		Access-Related MH/SUD Grievances	
	Number	Percent	Number	Percent
141	2	1.4%	2	100.0%

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2024 MHP Evaluation, the following strengths, weakness, and recommendations with respect to the quality, timeliness, and accessibility of health care services were identified. Strengths and weaknesses specific to the adequacy of MH/SUD provider networks and appointment availability were identified and communicated to the CCO through the *CY 2023 Revealed Behavioral Health Telephone Survey Report* and DSN Evaluation.

Strength/ Weakness	Description	Domain(s)*
+	**Strength:** PCS-CG submitted a detailed summary of the changes implemented in CY 2023 to medical management and sufficiently addressed pharmacy management NQTLs as required from the previous year's MHP Evaluation. The information provided was clearly communicated in the narrative and was accompanied by supporting documentation.	
−	**Weakness:** PCS-CG showed substantial differences in the percentage of paid, OON OP MH/SUD claims compared to OP M/S paid claims. Although the difference in the percentage of paid claims may be legitimate, they may also highlight procedural or network differences, indicating potential barriers for members accessing MH/SUD services. **Why the weakness exists:** OON OP MH/SUD claims were paid less frequently than M/S claims. **Recommendations:** PCS-CG should review OON claim denials to understand the factors affecting the lower percentage of OON OP MH/SUD paid claims compared to OON OP M/S paid claims. The CCO should assess whether any barriers exist for members accessing	

Strength/ Weakness	Description	Domain(s)*
	MH/SUD services, including the need to seek services outside of the CCO's network (e.g., appointment availability).	

*= Quality, = Timeliness, = Access

Appendix K. MHP Results for PacificSource Community Solutions–Lane (PCS-LN)

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the coordinated care organization (CCO) to manage the administration of mental health (MH) and substance use disorder (SUD) and medical and surgical (M/S) covered benefits, and assess whether documentation demonstrated compliance with Mental Health Parity (MHP) requirements in how they were applied to MH/SUD and M/S services. Health Services Advisory Group, Inc. (HSAG) used the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant* to indicate the degree to which changes identified by the CCOs and Oregon Health Plan (OHP) fee-for-service (FFS) in the *MHP Treatment Limitation Attestation Tool* remained compliant with parity requirements or the degree to which the 2023 MHP finding(s) were addressed in the *MHP Treatment Limitation Supplemental Questionnaire* and demonstrated compliance with parity requirements. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency*. A *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both, or there was insufficient information or clear evidence of parity associated with implemented non-quantitative treatment limitations (NQTLs). A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria or no documentation was submitted to evaluate the consistency and stringency of NQTLs.

The *MHP Treatment Limitation Attestation Tool* along with the *MHP Treatment Limitation Supplemental Questionnaire,* as applicable, were used to collect information on the four types of treatment limitations (i.e., financial requirements [FRs], aggregate lifetime and annual dollar limits [AL/ADLs], quantitative treatment limitations [QTLs], and NQTLs). A summary of the treatment limitations review by type is included below.

Financial Requirements

- PCS-LN reported the CCO did not make changes and did not apply any FRs or payments from members for services received that are in addition to payments made by the State (e.g., copayments, coinsurance, deductibles, or out-of-pocket maximums) for inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC) services for MH/SUD or M/S benefits.

Aggregate Lifetime and Annual Dollar Limits

- PCS-LN reported the CCO did not make any changes and did not apply any AL/ADLs on the total amount of a specified benefit over a lifetime or annually for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Quantitative Treatment Limitations

- PCS-LN reported the CCO did not make any changes and did not apply any QTLs or limits on the scope or duration of a benefit that are expressed numerically (e.g., day or visit limits) for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Non-Quantitative Treatment Limitations

Table K-1highlights the overall ratings of compliance with parity requirements for the identified changes and 2023 findings for PCS-CO by NQTL domain and overall.

Table K-1—Compliance With Parity Requirements for PCS-LN by NQTL Domain and Overall

Organization Name	Medical Management	Provider Network	Pharmacy Management	Overall Compliance Rating
PCS-LN	Compliant	Compliant	Compliant	Compliant

Medical Management

- PCS-LN reported changes to utilization management processes (i.e., prior authorization [PA], concurrent review [CR], and retrospective review [RR]) for IP and OP to manage the administration of MH/SUD and M/S covered benefits through the *MHP Treatment Limitation Attestation Tool*. Specifically, the CCO updated coverage criteria for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and radiology and genetic testing, MH/SUD and M/S level-of-care criteria, and the RR process for EPSDT. The changes reported for the PA NQTL across services for MH/SUD and M/S benefits did not impact compliance with parity requirements. The evidentiary standards used in administering the NQTL to MH/SUD benefits are comparable to the evidentiary standards used in administering the NQTL to M/S benefits. The CCO used evidence-based criteria for MH/SUD and M/S benefits to administer its processes with equivalent stringency.

Provider Network

- PCS-LN attested that no changes were implemented to the NQTLs that applied to MH/SUD or M/S benefits, which were evaluated during the calendar year (CY) 2023 MHP Evaluation and met parity requirements.

Pharmacy Management

- PCS-LN sufficiently addressed its formulary design NQTL through the *MHP Treatment Limitation Supplemental Questionnaire*. The rationale used to determine assignment of the formulary design NQTL was consistent between MH/SUD and M/S benefits, and the evidentiary standards used in administering the NQTL to MH/SUD benefits were comparable to the evidentiary standards used in administering the NQTL to M/S benefits. The CCO used evidence-based criteria for MH/SUD and M/S benefits to administer its processes with equivalent stringency.

Availability of Information

PCS-LN reported no changes were implemented regarding the mechanisms used to disseminate medical necessity information to members and/or providers.

Administrative Data Profile

Claims

Table K-2 presents a summary of the results from the analysis of paid claims by service type and benefit type. PCS-LN showed a greater percentage of IP, OP, and out-of-network (OON) IP MH/SUD claims were paid compared to IP, OP, and OON IP M/S claims. However, PCS-LN showed a substantial difference (15.5 percentage points) in the total percentage of OON paid claims between MH/SUD (57.2 percent) and M/S (72.7 percent), as well as OON OP claims (15.4 percentage points) individually.

Table K-2—Number and Percentage of Claims by Service Type and Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims		Out-of-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	4,355	3,851	88.4%	217	45.6%
	M/S	10,264	8,790	85.6%	169	42.9%
OP	MH/SUD	654,113	599,528	91.7%	20,114	57.4%
	M/S	2,372,848	2,062,554	86.9%	87,958	72.8%
Total	**MH/SUD**	**658,468**	**603,379**	**91.6%**	**20,331**	**57.2%**
	M/S	**2,383,112**	**2,071,344**	**86.9%**	**88,127**	**72.7%**

[1] Differences of 10 percentage points or more where a greater percentage of M/S claims were paid compared to MH/SUD claims are presented in red text.

Utilization Management

Table K-3 presents a summary of the results from the analysis of PAs by service type and benefit type. PCS-LN showed the same percentage (0.4 percent) of MH/SUD and M/S IP PA denials. For OP and Rx, a greater percentage of M/S PAs were denied compared to MH/SUD PAs. Due to the low number of PA denials that were appealed (excluding Rx), results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity.

Table K-3—PA Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals		Hearings	
		Total	Denied Number	Percent	Total Percent	Overturned Percent	Total Percent	Overturned Percent
IP	MH/SUD	3,605	13	0.4%	NA	NA	NA	NA
	M/S	4,247	15	0.4%	NA	NA	NA	NA
OP	MH/SUD	2,371	269	11.3%	14.0%	16.1%	0.0%	NA
	M/S	40,328	5,600	13.9%	86.0%	45.3%	0.8%	14.3%
Rx	MH/SUD	1,178	545	46.3%	13.9%	35.2%	0.0%	NA
	M/S	7,572	4,147	54.8%	86.1%	28.4%	0.3%	50.0%

NA—indicates a denominator of zero; results could not be calculated.

Provider Enrollment

Table K-4 presents a summary of the results from the analysis of provider enrollment and terminations by benefit type. The difference between the percentage of MH/SUD (100 percent) and M/S (99.9 percent) provider applications approved was negligible. A substantially higher number of M/S providers (1,687) were terminated compared to the number of MH/SUD providers (616).

Table K-4—CY 2023 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	2,561	100%	616	3.5%
M/S	1,948	99.9%	1,687	26.2%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table K-5 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Quarter 1 (Q1) 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately one year. Although a

comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

PCS-LN showed an increase in the overall provider network from Q1 2023 to Q1 2024 with a substantial increase (10.8 percent) in providers identified as MH. An increase was also noted in providers identified as SUD (5.1 percent). A comprehensive review of the CCO's provider network capacity was conducted through the annual Delivery System Network (DSN) Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table K-5—Number and Percentage of MH/SUD Providers by Quarter and Provider Type

Provider Type	Q1 2023			Q1 2024			Difference		
	All Providers (N)	MH/SUD Providers		All Providers (N)	MH/SUD Providers		MH/SUD Provider (N)	Percent Change	
		(N)	(%)		(N)	(%)			
MH	9,472	3,681	38.9%	9,577	4,079	42.6%	398	10.8%	▲
SUD		550	5.8%	9,577	578	6.0%	28	5.1%	

Provider-to-Member Ratios

Table K-6 presents the provider-to-member ratios for MH and SUD providers in Q1 2024 by provider type.

Table K-6—Provider-to-Member Ratios by Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	4,079	24,896	1:7
SUD	578	5,520	1:10

Time and Distance

Table K-7 presents the average time and distance to the nearest three MH and SUD providers by provider type and large urban and urban geographic settings. Table K-8 presents the average time and distance to the nearest three MH and SUD providers by provider type and rural geographic settings and counties with extreme access considerations (CEAC). Acceptable travel times and distances are 10 minutes/5 miles in large urban settings, 25 minutes/15 miles in urban settings, 30 minutes/20 miles in rural settings, and 40 minutes/30 miles in CEAC settings.

The average drive times and distances to the nearest three MH and SUD providers were within the acceptable travel times and distances set by OHA. The CCO had no large urban or CEAC settings within its service area as defined by state-established urbanicity parameters and are listed as *Not Applicable (NA)*. A comprehensive review of the CCO's provider network time and distance was conducted through

the annual DSN Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table K-7—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Large Urban and Urban Geographic Settings

Provider Type	Large Urban						Urban					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	NA	NA	NA	NA	NA	NA	0.7	0.9	1.2	0.9	1.2	1.5
SUD	NA	NA	NA	NA	NA	NA	1.6	1.7	2.0	2.0	2.2	2.8

Table K-8—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Rural and CEAC Geographic Settings

Provider Type	Rural						CEAC					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	2.8	3.3	3.7	3.0	3.6	4.0	NA	NA	NA	NA	NA	NA
SUD	9.0	9.0	16.5	9.8	9.8	18.1	NA	NA	NA	NA	NA	NA

Table K-9 presents the percentages of CCO members with access to MH and SUD services by geographic setting. The results are aggregated across all members and not stratified by adult and pediatric populations. The CCO does not have large urban or CEAC settings within its service area and are listed as *Not Applicable (NA)*. Results showing less than 95 percent of members meeting the acceptable times and distances are shaded red.[25] All PCS-LN members were within the acceptable travel times and distances except for members with a SUD diagnosis in rural areas; however, more than 90 percent of those members were still within acceptable travel times and distances.

Table K-9—Time and Distance Results by Geographic Setting

MH				SUD			
Large Urban	Urban	Rural	CEAC	Large Urban	Urban	Rural	CEAC
NA	100%	100%	NA	NA	100%	91.2%	NA

[25] Although OHA has established time and distance standards, CCO compliance is not assessed as part of this evaluation. OHA assesses CCO compliance to time and distance standards based on adult and pediatric provider types comprising three tiers; 95 percent or more pediatric and adult members must meet the acceptable travel times and distances to the nearest adult and pediatric provider, regardless of urbanicity.

Appointment Availability

The results from OHA's *CY 2023 Revealed Behavioral Health Telephone Survey Report* highlighting the accuracy of provider directory data and appointment availability for CCO members for behavioral health OP provider locations were incorporated into the *2024 Mental Health Parity Evaluation Summary Report* as well as the Oregon *2023 External Quality Review Technical Report*. OHA communicated and addressed individual CCO results from the surveys through established monitoring and oversight mechanisms.

Access-Related Grievances

Table K-10 presents the average percentage of access-related MH/SUD grievances compared to the overall number of MH/SUD grievances. The CCO showed a low percentage of grievances (1.0 percent) that were associated with MH/SUD services. Of those grievances, over 25 percent were related to access issues. Although these results suggest access as a potential focus for MH/SUD grievances, the results should be interpreted with caution due to the low overall total number of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.

Table K-10—Average Percentage of Access-Related MH/SUD Grievances

Total Grievances	MH/SUD Grievances		Access-Related MH/SUD Grievances	
	Number	Percent	Number	Percent
2,565	26	1.0%	7	26.9%

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2024 MHP Evaluation, the following strengths, weakness, and recommendations with respect to the quality, timeliness, and accessibility of health care services were identified. Strengths and weaknesses specific to the adequacy of MH/SUD provider networks and appointment availability were identified and communicated to the CCO through the *CY 2023 Revealed Behavioral Health Telephone Survey Report* and DSN Evaluation.

Strength/ Weakness	Description	Domain(s)*
+	**Strength:** PCS-LN submitted a detailed summary of the changes implemented in CY 2023 to medical management and sufficiently addressed pharmacy management NQTLs as required from the previous year's MHP Evaluation. The information provided was clearly communicated in the narrative and was accompanied by supporting documentation.	

Strength/ Weakness	Description	Domain(s)*
–	**Weakness:** PCS-LN showed substantial differences in the percentage of paid, OON OP MH/SUD claims compared to OP M/S paid claims. Although the difference in the percentage of paid claims may be legitimate, they may also highlight procedural or network differences, indicating potential barriers for members accessing MH/SUD services. **Why the weakness exists:** OON OP MH/SUD claims were paid less frequently than M/S claims. **Recommendations:** PCS-LN should review OON claim denials to understand the factors affecting the lower percentage of OON OP MH/SUD paid claims compared to OON OP M/S paid claims. The CCO should assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside of the CCO's network (e.g., appointment availability).	⏱️🔑

*= Quality, ⏱️ = Timeliness, 🔑 = Access

Appendix L. MHP Results for PacificSource Community Solutions–Marion Polk (PCS-MP)

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the coordinated care organization (CCO) to manage the administration of mental health (MH) and substance use disorder (SUD) and medical and surgical (M/S) covered benefits, and assess whether documentation demonstrated compliance with Mental Health Parity (MHP) requirements in how they were applied to MH/SUD and M/S services. Health Services Advisory Group, Inc. (HSAG) used the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant* to indicate the degree to which changes identified by the CCOs and Oregon Health Plan (OHP) fee-for-service (FFS) in the *MHP Treatment Limitation Attestation Tool* remained compliant with parity requirements or the degree to which the 2023 MHP finding(s) were addressed in the *MHP Treatment Limitation Supplemental Questionnaire* and demonstrated compliance with parity requirements. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency*. A *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both, or there was insufficient information or clear evidence of parity associated with implemented non-quantitative treatment limitations (NQTLs). A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria or no documentation was submitted to evaluate the consistency and stringency of NQTLs.

The *MHP Treatment Limitation Attestation Tool* along with the *MHP Treatment Limitation Supplemental Questionnaire,* as applicable, were used to collect information on the four types of treatment limitations (i.e., financial requirements [FRs], aggregate lifetime and annual dollar limits [AL/ADLs], quantitative treatment limitations [QTLs], and NQTLs). A summary of the treatment limitations review by type is included below.

Financial Requirements

- PCS-MP reported the CCO did not make changes and did not apply any FRs or payments from members for services received that are in addition to payments made by the State (e.g., copayments, coinsurance, deductibles, or out-of-pocket maximums) for inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC) services for MH/SUD or M/S benefits.

Aggregate Lifetime and Annual Dollar Limits

- PCS-MP reported the CCO did not make any changes and did not apply any AL/ADLs on the total amount of a specified benefit over a lifetime or annually for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Quantitative Treatment Limitations

- PCS-MP reported the CCO did not make any changes and did not apply any QTLs or limits on the scope or duration of a benefit that are expressed numerically (e.g., day or visit limits) for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Non-Quantitative Treatment Limitations

Table L-1 highlights the overall ratings of compliance with parity requirements for the identified changes and 2023 findings for PCS-MP by NQTL domain and overall.

Table L-1—Compliance With Parity Requirements for PCS-MP by NQTL Domain and Overall

Organization Name	Medical Management	Provider Network	Pharmacy Management	Overall Compliance Rating
PCS-MP	Compliant	Compliant	Compliant	Compliant

Medical Management

- PCS-MP reported changes to utilization management processes (i.e., prior authorization [PA], concurrent review [CR], and retrospective review [RR]) for IP and OP to manage the administration of MH/SUD and M/S covered benefits through the *MHP Treatment Limitation Attestation Tool*. Specifically, the CCO updated coverage criteria for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and radiology and genetic testing, MH/SUD and M/S level-of-care criteria, and the RR process for EPSDT. The changes reported for the PA NQTL across services for MH/SUD and M/S benefits did not impact compliance with parity requirements. The evidentiary standards used in administering the NQTL to MH/SUD benefits are comparable to the evidentiary standards used in administering the NQTL to M/S benefits. The CCO used evidence-based criteria for MH/SUD and M/S benefits to administer its processes with equivalent stringency.

Provider Network

- PCS-MP attested that no changes were implemented to the NQTLs that applied to MH/SUD or M/S benefits, which were evaluated during the calendar year (CY) 2023 MHP Evaluation and met parity requirements.

Pharmacy Management

- PCS-MP sufficiently addressed its formulary design NQTL through the *MHP Treatment Limitation Supplemental Questionnaire*. The rationale used to determine assignment of the formulary design NQTL was consistent between MH/SUD and M/S benefits, and the evidentiary standards used in administering the NQTL to MH/SUD benefits were comparable to the evidentiary standards used in administering the NQTL to M/S benefits. The CCO used evidence-based criteria for MH/SUD and M/S benefits to administer its processes with equivalent stringency.

Availability of Information

PCS-MP reported no changes were implemented regarding the mechanisms used to disseminate medical necessity information to members and/or providers.

Administrative Data Profile

Claims

Table L-2 presents a summary of the results from the analysis of paid claims by service type and benefit type. PCS-MP showed a greater percentage of MH/SUD paid claims across all service and benefit types when compared to M/S.

Table L-2—Number and Percentage of Claims by Service Type and Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims		Out-of-Network Paid Claims	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	5,305	4,948	93.3%	337	70.9%
	M/S	17,609	15,182	86.2%	651	50.7%
OP	MH/SUD	737,095	671,713	91.1%	21,771	54.8%
	M/S	3,126,599	2,683,213	85.8%	42,805	50.1%
Total	**MH/SUD**	**742,400**	**676,661**	**91.1%**	**22,108**	**55.0%**
	M/S	**3,144,208**	**2,698,395**	**85.8%**	**43,456**	**50.1%**

Utilization Management

Table L-3 presents a summary of the results from the analysis of PAs by service type and benefit type. PCS-MP showed a minimal difference (0.2 percentage point) in the percentage of denied IP MH/SUD PAs (0.6 percent) compared to denied IP M/S PAs (0.4 percent). For OP and Rx service types, M/S PAs were denied at a higher percentage than MH/SUD PAs. Due to the low number of PA denials that were appealed (excluding Rx), results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity.

Table L-3—PA Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals		Hearings	
		Total	Denied Number	Percent	Total Percent	Overturned Percent	Total Percent	Overturned Percent
IP	**MH/SUD**	2,975	19	0.6%	NA	NA	NA	NA
	M/S	6,347	28	0.4%	NA	NA	NA	NA

Service Type	Benefit Type	Prior Authorization			Appeals		Hearings	
		Total	Denied Number	Percent	Total Percent	Overturned Percent	Total Percent	Overturned Percent
OP	**MH/SUD**	2,726	339	12.4%	6.6%	32.8%	0.2%	50.0%
	M/S	56,024	7,824	14.0%	93.4%	44.9%	1.0%	55.6%
Rx	**MH/SUD**	855	420	49.1%	8.3%	24.6%	0.0%	NA
	M/S	7,992	4,734	59.2%	91.7%	29.9%	0.1%	0.0%

NA—indicates a denominator of zero; results could not be calculated.

Provider Enrollment

Table L-4 presents a summary of the results from the analysis of provider enrollment and terminations by benefit type. The difference between the percentage of MH/SUD (100 percent) and M/S (99.9 percent) provider applications approved was negligible. A substantially higher number of M/S providers (1,687) were terminated compared to the number of MH/SUD providers (616).

Table L-4—CY 2023 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	2,561	100%	616	3.5%
M/S	1,948	99.9%	1,687	26.2%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table L-5 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Quarter 1 (Q1) 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

PCS-MP showed an increase in the overall provider network from Q1 2023 to Q1 2024 with a substantial increase (10.8 percent) in providers identified as MH. An increase was also noted in providers identified as

SUD (5.1 percent). A comprehensive review of the CCO's provider network capacity was conducted through the annual Delivery System Network (DSN) Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table L-5—Number and Percentage of MH/SUD Providers by Quarter and Provider Type

Provider Type	Q1 2023			Q1 2024			Difference		
	All Providers (N)	MH/SUD Providers		All Providers (N)	MH/SUD Providers		MH/SUD Provider (N)	Percent Change	
		(N)	(%)		(N)	(%)			
MH	9,480	3,684	38.9%	9,646	4,082	42.3%	398	10.8%	▲
SUD		550	5.8%	9,646	578	6.0%	28	5.1%	

Provider-to-Member Ratios

Table L-6 presents the provider-to-member ratios for MH and SUD providers in Q1 2024 by provider type.

Table L-6—Provider-to-Member Ratios by Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	4,082	28,143	1:7
SUD	578	6,973	1:13

Time and Distance

Table L-7 presents the average time and distance to the nearest three MH and SUD providers by provider type and large urban and urban geographic settings. Table L-8 presents the average time and distance to the nearest three MH and SUD providers by provider type and rural geographic settings and counties with extreme access considerations (CEAC). Acceptable travel times and distances are 10 minutes/5 miles in large urban settings, 25 minutes/15 miles in urban settings, 30 minutes/20 miles in rural settings, and 40 minutes/30 miles in CEAC settings.

The average drive times and distances to the nearest three MH and SUD providers were within the acceptable travel times and distances set by OHA. The CCO had no large urban or CEAC settings within its service area as defined by state-established urbanicity parameters and are listed as *Not Applicable (NA)*. A comprehensive review of the CCO's provider network time and distance was conducted through the annual DSN Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table L-7—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Large Urban and Urban Geographic Settings

Provider Type	Large Urban						Urban					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	NA	NA	NA	NA	NA	NA	0.8	0.9	1.1	0.9	1.1	1.4
SUD	NA	NA	NA	NA	NA	NA	1.4	1.7	1.8	1.8	2.2	2.3

Table L-8—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Rural and CEAC Geographic Settings

Provider Type	Rural						CEAC					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	1.7	2.1	2.4	1.8	2.2	2.6	NA	NA	NA	NA	NA	NA
SUD	2.9	7.8	9.9	3.1	8.6	11.1	NA	NA	NA	NA	NA	NA

Table L-9 presents the percentages of CCO members with access to MH and SUD services by geographic setting. The results are aggregated across all members and not stratified by adult and pediatric populations. The CCO does not have large urban or CEAC settings within its service area and are listed as *Not Applicable (NA)*. At least 95 percent of PCS-MP's members with an MH and/or SUD diagnosis were within the acceptable travel times and distances for all applicable geographic settings.

Table L-9—Time and Distance Results by Geographic Setting

MH				SUD			
Large Urban	Urban	Rural	CEAC	Large Urban	Urban	Rural	CEAC
NA	100%	>99.9%	NA	NA	100%	99.6%	NA

Appointment Availability

The results from OHA's *CY 2023 Revealed Behavioral Health Telephone Survey Report* highlighting the accuracy of provider directory data and appointment availability for CCO members for behavioral health OP provider locations were incorporated into the *2024 Mental Health Parity Evaluation Summary Report* as well as the Oregon *2023 External Quality Review Technical Report*. OHA communicated and addressed individual CCO results from the surveys through established monitoring and oversight mechanisms.

Access-Related Grievances

Table L-10 presents the average percentage of access-related MH/SUD grievances compared to the overall number of MH/SUD grievances. The CCO showed a low percentage of grievances (3.6 percent) that were associated with MH/SUD services. Of those grievances, 12.7 percent were related to access issues. These low results should be interpreted with caution due to the low overall total number of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.

Table L-10—Average Percentage of Access-Related MH/SUD Grievances

Total Grievances	MH/SUD Grievances		Access-Related MH/SUD Grievances	
	Number	Percent	Number	Percent
2,173	79	3.6%	10	12.7%

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2024 MHP Evaluation, the following strengths, weakness, and recommendations with respect to the quality, timeliness, and accessibility of health care services were identified. Strengths and weaknesses specific to the adequacy of MH/SUD provider networks and appointment availability were identified and communicated to the CCO through the *CY 2023 Revealed Behavioral Health Telephone Survey Report* and DSN Evaluation.

Strength/ Weakness	Description	Domain(s)*
+	**Strength:** PCS-MP submitted a detailed summary of the changes implemented in CY 2023 to medical management and sufficiently addressed pharmacy management NQTLs as required from the previous year's MHP Evaluation. The information provided was clearly communicated in the narrative and was accompanied by supporting documentation.	

*= Quality, = Timeliness, = Access

Appendix M. MHP Results for Trillium Community Health Plan, Inc.–Southwest (TCHP-SW)

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the coordinated care organization (CCO) to manage the administration of mental health (MH) and substance use disorder (SUD) and medical and surgical (M/S) covered benefits, and assess whether documentation demonstrated compliance with Mental Health Parity (MHP) requirements in how they were applied to MH/SUD and M/S services. Health Services Advisory Group, Inc. (HSAG) used the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant* to indicate the degree to which changes identified by the CCOs and Oregon Health Plan (OHP) fee-for-service (FFS) in the *MHP Treatment Limitation Attestation Tool* remained compliant with parity requirements or the degree to which the 2023 MHP finding(s) were addressed in the *MHP Treatment Limitation Supplemental Questionnaire* and demonstrated compliance with parity requirements. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency*. A *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both, or there was insufficient information or clear evidence of parity associated with implemented non-quantitative treatment limitations (NQTLs). A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria or no documentation was submitted to evaluate the consistency and stringency of NQTLs.

The *MHP Treatment Limitation Attestation Tool* along with the *MHP Treatment Limitation Supplemental Questionnaire,* as applicable, were used to collect information on the four types of treatment limitations (i.e., financial requirements [FRs], aggregate lifetime and annual dollar limits [AL/ADLs], quantitative treatment limitations [QTLs], and NQTLs). A summary of the treatment limitations review by type is included below.

Financial Requirements

- TCHP-SW reported the CCO did not make changes and did not apply any FRs or payments from members for services received that are in addition to payments made by the State (e.g., copayments, coinsurance, deductibles, or out-of-pocket maximums) for inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC) services for MH/SUD or M/S benefits.

Aggregate Lifetime and Annual Dollar Limits

- TCHP-SW reported the CCO did not make any changes and did not apply any AL/ADLs on the total amount of a specified benefit over a lifetime or annually for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Quantitative Treatment Limitations

- TCHP-SW reported the CCO did not make any changes and did not apply any QTLs or limits on the scope or duration of a benefit that are expressed numerically (e.g., day or visit limits) for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Non-Quantitative Treatment Limitations

Table M-1 highlights the overall ratings of compliance with parity requirements for the identified changes and 2023 findings for TCHP-SW by NQTL domain and overall.

Table M-1—Compliance With Parity Requirements for TCHP-SW by NQTL Domain and Overall

Organization Name	Medical Management	Provider Network	Pharmacy Management	Overall Compliance Rating
TCHP-SW	Compliant	Compliant	Compliant	Compliant

Medical Management

- TCHP-SW attested that no changes were implemented to the NQTLs that applied to MH/SUD or M/S benefits, which were evaluated during the calendar year (CY) 2023 MHP Evaluation and met parity requirements.

Provider Network

- TCHP-SW attested that no changes were implemented to the NQTLs that applied to MH/SUD or M/S benefits, which were evaluated during the CY 2023 MHP Evaluation and met parity requirements.

Pharmacy Management

- TCHP-SW attested that no changes were implemented to the NQTLs that applied to MH/SUD or M/S benefits, which were evaluated during the CY 2023 MHP Evaluation and met parity requirements.

Availability of Information

TCHP-SW reported no changes were implemented regarding the mechanisms used to disseminate medical necessity information to members and/or providers.

Administrative Data Profile

Claims

Table M-2 presents a summary of the results from the analysis of paid claims by service type and benefit type. TCHP-SW showed a moderate difference (8.4 percentage points) in the overall percentage of paid claims between MH/SUD (89.8 percent) and M/S (81.4 percent) services. A moderate difference (8.8 percentage points) was also noted between OON MH/SUD paid claims (70.9 percent) and M/S paid claims (62.1 percent). Across all service types, with the exception of OON MH/SUD IP claims, a greater percentage of MH/SUD claims were paid compared to M/S claims. In the case of OON MH/SUD IP claims, the difference between OON MH/SUD IP paid claims (70.7 percent) and OON M/S IP paid claims (72.7 percent) was minimal (2.0 percentage points).

Table M-2—Number and Percentage of Claims by Service Type and Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims		Out-of-Network Paid Claims	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	10,257	8,498	82.9%	2,526	70.7%
	M/S	35,022	26,605	76.0%	10,239	72.7%
OP	MH/SUD	180,475	162,777	90.2%	10,353	70.9%
	M/S	381,386	312,417	81.9%	26,843	58.8%
Total	**MH/SUD**	**190,732**	**171,275**	**89.8%**	**12,879**	**70.9%**
	M/S	**416,408**	**339,022**	**81.4%**	**37,082**	**62.1%**

Utilization Management

Table M-3 presents a summary of the results from the analysis of prior authorizations (PAs) by service type and benefit type. Across all service types, a greater percentage of M/S PAs were denied compared to MH/SUD PAs. Due to the low number of PA denials that were appealed, results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity.

Table M-3—PA Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals		Hearings	
		Total	Denied Number	Percent	Total Percent	Overturned Percent	Total Percent	Overturned Percent
IP	**MH/SUD**	770	26	3.4%	33.3%	100%	0.0%	NA
	M/S	3,316	388	11.7%	66.7%	100%	0.0%	NA
OP	**MH/SUD**	2,699	68	2.5%	2.2%	75.0%	0.0%	NA

Service Type	Benefit Type	Prior Authorization			Appeals		Hearings	
		Total	Denied Number	Percent	Total Percent	Overturned Percent	Total Percent	Overturned Percent
	M/S	13,301	2,377	17.9%	97.8%	42.3%	3.9%	100%
Rx	MH/SUD	394	143	36.3%	7.3%	75.0%	0.0%	NA
	M/S	3,433	1,430	41.7%	92.7%	68.6%	0.0%	NA

NA—indicates a denominator of zero; results could not be calculated.

Provider Enrollment

Table M-4 presents a summary of the results from the analysis of provider enrollment and terminations by benefit type. Differences between the percentage of MH/SUD (96.0 percent) and M/S (95.7 percent) provider applications approved and the percentage of MH/SUD (9.2 percent) and M/S (9.3 percent) providers terminated in CY 2023 were negligible (0.3 percentage point and 0.1 percentage point, respectively).

Table M-4—CY 2023 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	644	96.0%	534	9.2%
M/S	2,734	95.7%	978	9.3%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table M-5 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Quarter 1 (Q1) 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

TCHP-SW showed an increase in the overall provider network between Q1 2023 to Q1 2024 with a substantial increase (44.9 percent) in providers identified as MH. An increase was also noted in providers

identified as SUD (9.9 percent). A comprehensive review of the CCO's provider network capacity was conducted through the annual Delivery System Network (DSN) Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table M-5—Number and Percentage of MH/SUD Providers by Quarter and Provider Type

Provider Type	Q1 2023			Q1 2024			Difference		
	All Providers (N)	MH/SUD Providers		All Providers (N)	MH/SUD Providers		MH/SUD Provider (N)	Percent Change	
		(N)	(%)		(N)	(%)			
MH	4,452	1,739	39.1%	5,188	2,519	48.6%	780	44.9%	▲
SUD		414	9.3%	5,188	455	8.8%	41	9.9%	

Provider-to-Member Ratios

Table M-6 presents the provider-to-member ratios for MH and SUD providers in Q1 2024 by provider type.

Table M-6—Provider-to-Member Ratios by Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	1,933	5,497	1:3
SUD	358	1,745	1:5

Time and Distance

Table M-7 presents the average time and distance to the nearest three MH and SUD providers by provider type and large urban and urban geographic settings. Table M-8 presents the average time and distance to the nearest three MH and SUD providers by provider type and rural geographic settings and counties with extreme access considerations (CEAC). Acceptable travel times and distances are 10 minutes/5 miles in large urban settings, 25 minutes/15 miles in urban settings, 30 minutes/20 miles in rural settings, and 40 minutes/30 miles in CEAC settings.

The average drive times and distances to the nearest three MH and SUD providers were within the acceptable travel times and distances set by OHA. For the rural setting, the CCO was less than one mile over the acceptable travel times and distances to the third nearest SUD provider. The CCO had no large urban or CEAC settings within its service area as defined by state-established urbanicity parameters and are listed as *Not Applicable (NA)*. A comprehensive review of the CCO's provider network time and distance was conducted through the annual DSN Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table M-7—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Large Urban and Urban Geographic Settings

Provider Type	Large Urban						Urban					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	NA	NA	NA	NA	NA	NA	1.0	1.2	1.2	1.3	1.7	1.7
SUD	NA	NA	NA	NA	NA	NA	1.8	2.1	2.1	2.4	2.9	2.9

Table M-8—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Rural and CEAC Geographic Settings

Provider Type	Rural						CEAC					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	3.0	3.7	3.9	3.3	4.0	4.3	NA	NA	NA	NA	NA	NA
SUD	11.7	12.0	19.0	12.8	13.1	20.7	NA	NA	NA	NA	NA	NA

Table M-9 presents the percentages of CCO members with access to MH and SUD services by geographic setting. The results are aggregated across all members and not stratified by adult and pediatric populations. The CCO does not have large urban or CEAC settings within its service area and are listed as *Not Applicable (NA)*. Results showing less than 95 percent of members meeting the acceptable times and distances are shaded red.[26] All TCHP-SW members were within the acceptable travel times and distances except for members with a SUD diagnosis in rural areas; however, more than 90 percent of those members were still within acceptable travel times and distances.

Table M-9—Time and Distance Results by Geographic Setting

MH				SUD			
Large Urban	Urban	Rural	CEAC	Large Urban	Urban	Rural	CEAC
NA	100%	99.5%	NA	NA	100%	92.0%	NA

Appointment Availability

The results from OHA's *CY 2023 Revealed Behavioral Health Telephone Survey Report* highlighting the accuracy of provider directory data and appointment availability for CCO members for behavioral

[26] Although OHA has established time and distance standards, CCO compliance is not assessed as part of this evaluation. OHA assesses CCO compliance to time and distance standards based on adult and pediatric provider types comprising three tiers; 95 percent or more pediatric and adult members must meet the acceptable travel times and distances to the nearest adult and pediatric provider, regardless of urbanicity.

health OP provider locations were incorporated into the *2024 Mental Health Parity Evaluation Summary Report* as well as the Oregon *2023 External Quality Review Technical Report*. OHA communicated and addressed individual CCO results from the surveys through established monitoring and oversight mechanisms.

Access-Related Grievances

Table M-10 presents the average percentage of access-related MH/SUD grievances compared to the overall number of MH/SUD grievances. The CCO showed a low percentage of grievances (2.5 percent) that were associated with MH/SUD services. Of those grievances, 25 percent were related to access issues. Although these results suggest access as a potential focus for MH/SUD grievances, the results should be interpreted with caution due to the low overall total numbers of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.

Table M-10—Average Percentage of Access-Related MH/SUD Grievances

Total Grievances	MH/SUD Grievances		Access-Related MH/SUD Grievances	
	Number	Percent	Number	Percent
488	12	2.5%	3	25.0%

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2024 MHP Evaluation, the following strengths, weakness, and recommendations with respect to the quality, timeliness, and accessibility of health care services were identified. Strengths and weaknesses specific to the adequacy of MH/SUD provider networks and appointment availability were identified and communicated to the CCO through the *CY 2023 Revealed Behavioral Health Telephone Survey Report* and DSN Evaluation.

Strength/ Weakness	Description	Domain(s)*
The CCO met performance expectations. No significant strengths or weaknesses were noted during the review.		

*= Quality, = Timeliness, = Access

Appendix N. MHP Results for Trillium Community Health Plan, Inc.–Tri-County (TCHP-TC)

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the coordinated care organization (CCO) to manage the administration of mental health (MH) and substance use disorder (SUD) and medical and surgical (M/S) covered benefits, and assess whether documentation demonstrated compliance with Mental Health Parity (MHP) requirements in how they were applied to MH/SUD and M/S services. Health Services Advisory Group, Inc. (HSAG) used the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant* to indicate the degree to which changes identified by the CCOs and Oregon Health Plan (OHP) fee-for-service (FFS) in the *MHP Treatment Limitation Attestation Tool* remained compliant with parity requirements or the degree to which the 2023 MHP finding(s) were addressed in the *MHP Treatment Limitation Supplemental Questionnaire* and demonstrated compliance with parity requirements. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency*. A *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both, or there was insufficient information or clear evidence of parity associated with implemented non-quantitative treatment limitations (NQTLs). A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria or no documentation was submitted to evaluate the consistency and stringency of NQTLs.

The *MHP Treatment Limitation Attestation Tool* along with the *MHP Treatment Limitation Supplemental Questionnaire,* as applicable, were used to collect information on the four types of treatment limitations (i.e., financial requirements [FRs], aggregate lifetime and annual dollar limits [AL/ADLs], quantitative treatment limitations [QTLs], and NQTLs). A summary of the treatment limitations review by type is included below.

Financial Requirements

- TCHP-TC reported the CCO did not make changes and did not apply any FRs or payments from members for services received that are in addition to payments made by the State (e.g., copayments, coinsurance, deductibles, or out-of-pocket maximums) for inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC) services for MH/SUD or M/S benefits.

Aggregate Lifetime and Annual Dollar Limits

- TCHP-TC reported the CCO did not make any changes and did not apply any AL/ADLs on the total amount of a specified benefit over a lifetime or annually for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Quantitative Treatment Limitations

- TCHP-TC reported the CCO did not make any changes and did not apply any QTLs or limits on the scope or duration of a benefit that are expressed numerically (e.g., day or visit limits) for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Non-Quantitative Treatment Limitations

Table N-1 highlights the overall ratings of compliance with parity requirements for the identified changes and 2023 findings for TCHP-TC by NQTL domain and overall.

Table N-1—Compliance With Parity Requirements for TCHP-TC by NQTL Domain and Overall

Organization Name	Medical Management	Provider Network	Pharmacy Management	Overall Compliance Rating
TCHP-TC	Compliant	Compliant	Compliant	Compliant

Medical Management

- TCHP-TC attested that no changes were implemented to the NQTLs that applied to MH/SUD or M/S benefits, which were evaluated during the calendar year (CY) 2023 MHP Evaluation and met parity requirements.

Provider Network

- TCHP-TC attested that no changes were implemented to the NQTLs that applied to MH/SUD or M/S benefits, which were evaluated during the CY 2023 MHP Evaluation and met parity requirements.

Pharmacy Management

- TCHP-TC attested that no changes were implemented to the NQTLs that applied to MH/SUD or M/S benefits, which were evaluated during the CY 2023 MHP Evaluation and met parity requirements.

Availability of Information

TCHP-TC reported no changes were implemented regarding the mechanisms used to disseminate medical necessity information to members and/or providers.

Administrative Data Profile

Claims

Table N-2 presents a summary of the results from the analysis of paid claims by service type and benefit type. TCHP-TC showed a moderate difference (7.8 percentage points) in the percentage of paid IP claims between MH/SUD (84.5 percent) and M/S (76.7 percent) services. A minimal difference (2.8 percentage points) was noted between MH/SUD OP paid claims (87.7 percent) and M/S OP paid claims (84.9 percent). In both cases, MH/SUD claims were paid more frequently than M/S claims. Minimal differences were also noted for the percentage of paid claims for MH/SUD and M/S OON IP (4.2 percentage points) and OON OP (0.3 percentage points), where MH/SUD OON IP and OP claims were paid less frequently than M/S claims.

Table N-2—and Percentage of Claims by Service Type and Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims		Out-of-Network Paid Claims	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	6,692	5,657	84.5%	1,559	75.3%
	M/S	34,874	26,752	76.7%	9,574	79.5%
OP	MH/SUD	110,796	97,157	87.7%	20,235	75.7%
	M/S	338,011	286,950	84.9%	44,456	76.0%
Total	**MH/SUD**	**117,488**	**102,814**	**87.5%**	**21,794**	**75.6%**
	M/S	**372,885**	**313,702**	**84.1%**	**54,030**	**76.6%**

Utilization Management

Table N-3 presents a summary of the results from the analysis of prior authorizations (PAs) by service type and benefit type. TCHP-TC showed a moderate difference in the percentage of denied MH/SUD and M/S PAs for both IP (5.3 percentage points) and OP (8.6 percentage points), where a greater percentage of M/S PAs were denied compared to MH/SUD PAs. A minimal difference (1.1 percentage points) was noted in the percentage of denied MH/SUD (45.9 percent) Rx PAs and M/S Rx PAs (44.8 percent). No concerns for parity were identified. Due to the low number of PA denials that were appealed, results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity. However, of the 6.3 percent of denied MH/SUD Rx PAs that were appealed, 100 percent were overturned.

Table N-3—PA Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals		Hearings	
		Total	Denied Number	Percent	Total Percent	Overturned Percent	Total Percent	Overturned Percent
IP	MH/SUD	814	38	4.7%	NA	NA	NA	NA
	M/S	4,272	426	10.0%	NA	NA	NA	NA
OP	MH/SUD	2,753	98	3.6%	10.3%	47.4%	0.0%	NA
	M/S	34,449	4,204	12.2%	89.7%	50.3%	6.5%	100%
Rx	MH/SUD	364	167	45.9%	6.3%	100%	0.0%	NA
	M/S	2,907	1,303	44.8%	93.8%	65.0%	0.0%	NA

NA—indicates a denominator of zero; results could not be calculated.

Provider Enrollment

Table N-4 presents a summary of the results from the analysis of provider enrollment and terminations by benefit type. Differences between the percentage of MH/SUD (96.0 percent) and M/S (95.7 percent) provider applications approved and the percentage of MH/SUD (9.2 percent) and M/S (9.3 percent) providers terminated in CY 2023 were negligible (0.3 percentage point and 0.1 percentage point, respectively).

Table N-4—CY 2023 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	644	96.0%	534	9.2%
M/S	2,734	95.7%	978	9.3%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table N-5 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Quarter 1 (Q1) 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately one year. Although a

comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

TCHP-TC showed an increase in the overall provider network between Q1 2023 to Q1 2024 with a substantial increase (16.4 percent) in providers identified as MH as well as a substantial increase (22.6 percent) in providers identified as SUD. A comprehensive review of the CCO's provider network capacity was conducted through the annual Delivery System Network (DSN) Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table N-5—Number and Percentage of MH/SUD Providers by Quarter and Provider Type

Provider Type	Q1 2023			Q1 2024			Difference		
	All Providers (N)	MH/SUD Providers		All Providers (N)	MH/SUD Providers		MH/SUD Provider (N)	Percent Change	
		(N)	(%)		(N)	(%)			
MH	5,241	1,660	31.7%	6,840	1,933	28.3%	273	16.4%	▲
SUD		292	5.6%	6,840	358	5.2%	66	22.6%	▲

Provider-to-Member Ratios

Table N-6 presents the provider-to-member ratios for MH and SUD providers in Q1 2024 by provider type.

Table N-6—Provider-to-Member Ratios by Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	2,519	6,866	1:3
SUD	455	2,151	1:5

Time and Distance

Table N-7 presents the average time and distance to the nearest three MH and SUD providers by provider type and large urban and urban geographic settings. Table N-8 presents the average time and distance to the nearest three MH and SUD providers by provider type and rural geographic settings and counties with extreme access considerations (CEAC). Acceptable travel times and distances are 10 minutes/5 miles in large urban settings, 25 minutes/15 miles in urban settings, 30 minutes/20 miles in rural settings, and 40 minutes/30 miles in CEAC settings.

The average drive times and distances to the nearest three MH and SUD providers were within the acceptable travel times and distances set by OHA. The CCO had no urban or CEAC settings within its service area as defined by state-established urbanicity parameters and are listed as *Not Applicable (NA)*. A comprehensive review of the CCO's provider network time and distance was conducted through the

annual DSN Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table N-7—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Large Urban and Urban Geographic Settings

Provider Type	Large Urban						Urban					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	0.8	0.9	1.0	1.3	1.5	1.7	NA	NA	NA	NA	NA	NA
SUD	1.6	1.8	1.8	2.7	3.0	3.0	NA	NA	NA	NA	NA	NA

Table N-8—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Rural and CEAC Geographic Settings

Provider Type	Rural						CEAC					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	6.1	6.2	6.2	6.6	6.7	6.7	NA	NA	NA	NA	NA	NA
SUD	14.1	15.0	15.1	15.8	17.0	17.1	NA	NA	NA	NA	NA	NA

Table N-9 presents the percentages of CCO members with access to MH and SUD services by geographic setting. The results are aggregated across all members and not stratified by adult and pediatric populations. The CCO does not have urban or CEAC settings within its service area and are listed as *Not Applicable (NA)*. Results showing less than 95 percent of members meeting the acceptable times and distances are shaded red.[27] All TCHP-TC members were within the acceptable travel times and distances except for members with a SUD diagnosis in rural areas; however, more than 90 percent of those members were still within acceptable travel times and distances.

Table N-9—Time and Distance Results by Geographic Setting

MH				SUD			
Large Urban	Urban	Rural	CEAC	Large Urban	Urban	Rural	CEAC
99.8%	NA	99.2%	NA	98.3%	NA	93.8%	NA

[27] Although OHA has established time and distance standards, CCO compliance is not assessed as part of this evaluation. OHA assesses CCO compliance to time and distance standards based on adult and pediatric provider types comprising three tiers; 95 percent or more pediatric and adult members must meet the acceptable travel times and distances to the nearest adult and pediatric provider, regardless of urbanicity.

Appointment Availability

The results from OHA's *CY 2023 Revealed Behavioral Health Telephone Survey Report* highlighting the accuracy of provider directory data and appointment availability for CCO members for behavioral health OP provider locations were incorporated into the *2024 Mental Health Parity Evaluation Summary Report* as well as the Oregon *2023 External Quality Review Technical Report*. OHA communicated and addressed individual CCO results from the surveys through established monitoring and oversight mechanisms.

Access-Related Grievances

Table N-10 presents the average percentage of access-related MH/SUD grievances compared to the overall number of MH/SUD grievances. The CCO showed a low percentage of grievances (3.5 percent) that were associated with MH/SUD services. Of those grievances, two were related to access issues. The results should be interpreted with caution due to the low overall total number of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.

Table N-10—Average Percentage of Access-Related MH/SUD Grievances

Total Grievances	MH/SUD Grievances		Access-Related MH/SUD Grievances	
	Number	Percent	Number	Percent
753	26	3.5%	2	7.7%

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2024 MHP Evaluation, the following strengths, weakness, and recommendations with respect to the quality, timeliness, and accessibility of health care services were identified. Strengths and weaknesses specific to the adequacy of MH/SUD provider networks and appointment availability were identified and communicated to the CCO through the *CY 2023 Revealed Behavioral Health Telephone Survey Report* and DSN Evaluation.

Strength/ Weakness	Description	Domain(s)*
	**Strength:** No strengths were identified.	
	**Weakness:** TCHP-TC demonstrated 100 percent of MH/SUD Rx denial decisions were overturned at the appeal level. **Why the weakness exists:** Although the total number of appeals was low (i.e., four), the fact that 100 percent of the denial decisions were overturned at the appeal level may highlight issues with potentially	

Strength/ Weakness	Description	Domain(s)*
	ineffective PA processes and/or individuals making inappropriate decisions. **Recommendations:** TCHP-TC should review the MH/SUD Rx appeals to understand the factors affecting the 100 percent overturn rate. The CCO should review PA criteria and/or decision-making processes and make appropriate changes to ensure appropriate access to MH/SUD Rx services.	

*✅ = Quality, ⏱️ = Timeliness, 🔑 = Access

Appendix O. MHP Results for Umpqua Health Alliance, LLC (UHA)

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the coordinated care organization (CCO) to manage the administration of mental health (MH) and substance use disorder (SUD) and medical and surgical (M/S) covered benefits, and assess whether documentation demonstrated compliance with Mental Health Parity (MHP) requirements in how they were applied to MH/SUD and M/S services. Health Services Advisory Group, Inc. (HSAG) used the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant* to indicate the degree to which changes identified by the CCOs and Oregon Health Plan (OHP) fee-for-service (FFS) in the *MHP Treatment Limitation Attestation Tool* remained compliant with parity requirements or the degree to which the 2023 MHP finding(s) were addressed in the *MHP Treatment Limitation Supplemental Questionnaire* and demonstrated compliance with parity requirements. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency*. A *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both, or there was insufficient information or clear evidence of parity associated with implemented non-quantitative treatment limitations (NQTLs). A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria or no documentation was submitted to evaluate the consistency and stringency of NQTLs.

The *MHP Treatment Limitation Attestation Tool* along with the *MHP Treatment Limitation Supplemental Questionnaire,* as applicable, were used to collect information on the four types of treatment limitations (i.e., financial requirements [FRs], aggregate lifetime and annual dollar limits [AL/ADLs], quantitative treatment limitations [QTLs], and NQTLs). A summary of the treatment limitations review by type is included below.

Financial Requirements

- UHA reported the CCO did not make changes and did not apply any FRs or payments from members for services received that are in addition to payments made by the State (e.g., copayments, coinsurance, deductibles, or out-of-pocket maximums) for inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC) services for MH/SUD or M/S benefits.

Aggregate Lifetime and Annual Dollar Limits

- UHA reported the CCO did not make any changes and did not apply any AL/ADLs on the total amount of a specified benefit over a lifetime or annually for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Quantitative Treatment Limitations

- UHA reported the CCO did not make any changes to the MH/SUD QTLs that were reported during the calendar year (CY) 2023 MHP Evaluation, and they were evaluated as NQTLs due to their dependence on medical necessity and appropriateness and found to be compliant with parity requirements.

Non-Quantitative Treatment Limitations

Table O-1 highlights the overall ratings of compliance with parity requirements for the identified changes and 2023 findings for UHA by NQTL domain and overall.

Table O-1—Compliance With Parity Requirements for UHA by NQTL Domain and Overall

Organization Name	Medical Management	Provider Network	Pharmacy Management	Overall Compliance Rating
UHA	Compliant	Compliant	Compliant	Compliant

Medical Management

- UHA attested that no changes were implemented to the NQTLs that applied to MH/SUD or M/S benefits, which were evaluated during the CY 2023 MHP Evaluation and met parity requirements.

Provider Network

- UHA attested that no changes were implemented to the NQTLs that applied to MH/SUD or M/S benefits, which were evaluated during the CY 2023 MHP Evaluation and met parity requirements.

Pharmacy Management

- UHA sufficiently addressed its formulary design NQTL through the *MHP Treatment Limitation Supplemental Questionnaire*. The rationale used to determine assignment of the formulary design NQTL was consistent between MH/SUD and M/S benefits, and the evidentiary standards used in administering the NQTL to MH/SUD benefits were comparable to the evidentiary standards used in administering the NQTL to M/S benefits. The CCO used evidence-based criteria for MH/SUD and M/S benefits to administer its processes with equivalent stringency.

Availability of Information

UHA reported no changes were implemented regarding the mechanisms used to disseminate medical necessity information to members and/or providers.

Administrative Data Profile

Claims

Table O-2 presents a summary of the results from the analysis of paid claims by service type and benefit type. In general, UHA exhibited a moderate difference (6.9 percentage points) in the percentage of paid claims between MH/SUD (91.1 percent) and M/S (84.2 percent) services, as well as for IP and OP claims individually (6.3 percentage points and 7.0 percentage points, respectively). However, the differences between OON paid claims between MH/SUD and M/S services were negligible.

Table O-2—Number and Percentage of Claims by Service Type and Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims		Out-of-Network Paid Claims	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	7,481	6,356	85.0%	826	64.0%
	M/S	3,781	2,975	78.7%	472	68.6%
OP	MH/SUD	214,399	195,700	91.3%	19,090	76.8%
	M/S	510,204	430,042	84.3%	101,111	77.6%
Total	**MH/SUD**	**221,880**	**202,056**	**91.1%**	**19,916**	**76.1%**
	M/S	**513,985**	**433,017**	**84.2%**	**101,583**	**77.5%**

Utilization Management

Table O-3 presents a summary of the results from the analysis of prior authorizations (PAs) by service type and benefit type. No substantial differences in the percentage of denied M/S and MH/SUD PAs were found that would have suggested an MHP concern. Only PA denials for IP services were greater among MH/SUD services (3.5 percent) compared to M/S services (3.3 percent). Due to the low number of PA denials that were appealed, results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity.

Table O-3—PA Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals		Hearings	
		Total	Denied Number	Percent	Total Percent	Overturned Percent	Total Percent	Overturned Percent
IP	**MH/SUD**	1,563	54	3.5%	75.0%	66.7%	0.0%	NA
	M/S	1,718	56	3.3%	25.0%	50.0%	0.0%	NA
OP	**MH/SUD**	2,467	84	3.4%	2.7%	25.0%	0.0%	NA
	M/S	24,891	3,390	13.6%	97.3%	45.2%	1.3%	50.0%

Service Type	Benefit Type	Prior Authorization			Appeals		Hearings	
		Total	Denied Number	Percent	Total Percent	Overturned Percent	Total Percent	Overturned Percent
Rx	**MH/SUD**	1,896	340	17.9%	9.6%	60.0%	0.0%	NA
	M/S	6,812	2,710	39.8%	90.4%	36.2%	0.0%	NA

NA—indicates a denominator of zero; results could not be calculated.

Provider Enrollment

Table O-4 presents a summary of the results from the analysis of provider enrollment and terminations by benefit type. UHA showed a minimal difference (3.0 percent) in the percentages of MH/SUD (100 percent) and M/S (97.0 percent) provider applications approved in CY 2023. Although the CCO exhibited a higher percentage of MH/SUD provider terminations (19.6 percent) compared to M/S providers (17.4 percent), the difference was negligible, at 2.2 percentage points.

Table O-4—CY 2023 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	67	100%	91	19.6%
M/S	132	97.0%	121	17.4%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table O-5 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Quarter 1 (Q1) 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

UHA showed an increase in its overall provider network between Q1 2023 to Q1 2024 with a substantial increase in providers identified as MH and SUD (50.4 percent and 50.0 percent, respectively). A comprehensive review of the CCO's provider network capacity was conducted through the annual

Delivery System Network (DSN) Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table O-5—Number and Percentage of MH/SUD Providers by Quarter and Provider Type

Provider Type	Q1 2023			Q1 2024			Difference		
	All Providers (N)	MH/SUD Providers		All Providers (N)	MH/SUD Providers		MH/SUD Provider (N)	Percent Change	
		(N)	(%)		(N)	(%)			
MH	586	139	23.7%	1,173	209	17.8%	70	50.4%	▲
SUD		100	17.1%	1,173	150	12.8%	50	50.0%	▲

Provider-to-Member Ratios

Table O-6 presents the provider-to-member ratios for MH and SUD providers in Q1 2024 by provider type.

Table O-6—Provider-to-Member Ratios by Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	209	8,783	1:43
SUD	150	2,961	1:20

Time and Distance

Table O-7 presents the average time and distance to the nearest three MH and SUD providers by provider type and large urban and urban geographic settings. Table O-8 presents the average time and distance to the nearest three MH and SUD providers by provider type and rural geographic settings and counties with extreme access considerations (CEAC). Acceptable travel times and distances are 10 minutes/5 miles in large urban settings, 25 minutes/15 miles in urban settings, 30 minutes/20 miles in rural settings, and 40 minutes/30 miles in CEAC settings.

The average drive times and distances to the nearest three MH and SUD providers were within the acceptable travel times and distances set by OHA. The CCO had no large urban, urban, or CEAC settings within its service area as defined by state-established urbanicity parameters and are listed as *Not Applicable (NA)*. A comprehensive review of the CCO's provider network time and distance was conducted through the annual DSN Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table O-7—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Large Urban and Urban Geographic Settings

Provider Type	Large Urban						Urban					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
SUD	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Table O-8—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Rural and CEAC Geographic Settings

Provider Type	Rural						CEAC					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	3.5	5.4	5.5	3.8	5.8	6.0	NA	NA	NA	NA	NA	NA
SUD	6.9	7.3	8.8	7.5	7.9	9.6	NA	NA	NA	NA	NA	NA

Table O-9 presents the percentages of CCO members with access to MH and SUD services by geographic setting. The results are aggregated across all members and not stratified by adult and pediatric populations. The CCO does not have large urban, urban, or CEAC settings within its service area and are listed as *Not Applicable (NA)*. At least 95 percent of UHA's members with an MH and/or SUD diagnosis were within the acceptable travel times and distances for all applicable geographic settings.

Table O-9—Time and Distance Results by Geographic Setting

MH				SUD			
Large Urban	Urban	Rural	CEAC	Large Urban	Urban	Rural	CEAC
NA	NA	99.8%	NA	NA	NA	97.6%	NA

Appointment Availability

The results from OHA's *CY 2023 Revealed Behavioral Health Telephone Survey Report* highlighting the accuracy of provider directory data and appointment availability for CCO members for behavioral health OP provider locations were incorporated into the *2024 Mental Health Parity Evaluation Summary Report* as well as the Oregon *2023 External Quality Review Technical Report*. OHA communicated and addressed individual CCO results from the surveys through established monitoring and oversight mechanisms.

Access-Related Grievances

Table O-10 presents the average percentage of access-related MH/SUD grievances compared to the overall number of MH/SUD grievances. The CCO showed 10.2 percent of grievances were associated with MH/SUD services. Of those grievances, 66.0 percent were related to access issues. Although these results suggest access as a potential focus for MH/SUD grievances, the results should be interpreted with caution due to the low overall total numbers of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.

Table O-10—Average Percentage of Access-Related MH/SUD Grievances

Total Grievances	MH/SUD Grievances		Access-Related MH/SUD Grievances	
	Number	Percent	Number	Percent
522	53	10.2%	35	66.0%

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2024 MHP Evaluation, the following strengths, weakness, and recommendations with respect to the quality, timeliness, and accessibility of health care services were identified. Strengths and weaknesses specific to the adequacy of MH/SUD provider networks and appointment availability were identified and communicated to the CCO through the *CY 2023 Revealed Behavioral Health Telephone Survey Report* and DSN Evaluation.

Strength/ Weakness	Description	Domain(s)*
+	**Strength:** UHA provided a detailed summary and sufficiently addressed pharmacy management NQTLs as required from the previous year's MHP Evaluation. The information provided was clearly communicated in the narrative and was accompanied by supporting documentation.	
−	**Weakness:** UHA demonstrated that 66.0 percent of the MH/SUD grievances received were related to access issues. **Why the weakness exists:** Although the total number of MH/SUD grievances was low and represented only 10.2 percent of all grievances, more than half were related to access, which may highlight that the CCO has challenges ensuring timely access to MH/SUD covered services. **Recommendations:** UHA should review the access-related MH/SUD grievances to understand the factors that triggered the grievances and assess whether barriers exist for members accessing MH/SUD services (e.g., finding qualified IN providers, excessive travel, or appointment availability).	

*= Quality, = Timeliness, = Access

Appendix P. MHP Results for Yamhill Community Care Organization (YCCO)

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the coordinated care organization (CCO) to manage the administration of mental health (MH) and substance use disorder (SUD) and medical and surgical (M/S) covered benefits, and assess whether documentation demonstrated compliance with Mental Health Parity (MHP) requirements in how they were applied to MH/SUD and M/S services. Health Services Advisory Group, Inc. (HSAG) used the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant* to indicate the degree to which changes identified by the CCOs and Oregon Health Plan (OHP) fee-for-service (FFS) in the *MHP Treatment Limitation Attestation Tool* remained compliant with parity requirements or the degree to which the 2023 MHP finding(s) were addressed in the *MHP Treatment Limitation Supplemental Questionnaire* and demonstrated compliance with parity requirements. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency*. A *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both, or there was insufficient information or clear evidence of parity associated with implemented non-quantitative treatment limitations (NQTLs). A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria or no documentation was submitted to evaluate the consistency and stringency of NQTLs.

The *MHP Treatment Limitation Attestation Tool* along with the *MHP Treatment Limitation Supplemental Questionnaire,* as applicable, were used to collect information on the four types of treatment limitations (i.e., financial requirements [FRs], aggregate lifetime and annual dollar limits [AL/ADLs], quantitative treatment limitations [QTLs], and NQTLs). A summary of the treatment limitations review by type is included below.

Financial Requirements

- YCCO reported the CCO did not make changes and did not apply any FRs or payments from members for services received that are in addition to payments made by the State (e.g., copayments, coinsurance, deductibles, or out-of-pocket maximums) for inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC) services for MH/SUD or M/S benefits.

Aggregate Lifetime and Annual Dollar Limits

- YCCO reported the CCO did not make any changes and did not apply any AL/ADLs on the total amount of a specified benefit over a lifetime or annually for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Quantitative Treatment Limitations

- YCCO reported the CCO did not make any changes and did not apply any QTLs or limits on the scope or duration of a benefit that are expressed numerically (e.g., day or visit limits) for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Non-Quantitative Treatment Limitations

Table P-1 highlights the overall ratings of compliance with parity requirements for the identified changes and 2023 findings for YCCO by NQTL domain and overall.

Table P-1—Compliance With Parity Requirements for YCCO by NQTL Domain and Overall

Organization Name	Medical Management	Provider Network	Pharmacy Management	Overall Compliance Rating
YCCO	Compliant	Compliant	Compliant	Compliant

Medical Management

- YCCO attested that no changes were implemented to the NQTLs that applied to MH/SUD or M/S benefits, which were evaluated during the calendar year (CY) 2023 MHP Evaluation and met parity requirements.

Provider Network

- YCCO attested that no changes were implemented to the NQTLs that applied to MH/SUD or M/S benefits, which were evaluated during the CY 2023 MHP Evaluation and met parity requirements.

Pharmacy Management

- YCCO attested that no changes were implemented to the NQTLs that applied to MH/SUD or M/S benefits, which were evaluated during the CY 2023 MHP Evaluation and met parity requirements.

Availability of Information

YCCO reported no changes were implemented regarding the mechanisms used to disseminate medical necessity information to members and/or providers.

Administrative Data Profile

Claims

Table P-2 presents a summary of the results from the analysis of paid claims by service type and benefit type. YCCO showed a moderate difference (5.0 percentage points) in the percentage of paid IP claims between MH/SUD (76.7 percent) and M/S (81.7 percent), where MH/SUD claims were paid less

frequently than M/S claims. A moderate difference (7.1 percent) was also noted between the percentage of IP OON MH/SUD (56.6 percent) and M/S (63.7 percent) claims, where MH/SUD claims were paid less frequently than M/S claims. However, the moderate difference (9.6 percent) noted between OP OON claims for MH/SUD (65.1 percent) and M/S (55.5 percent) showed OP OON MH/SUD claims paid at a higher rate.

Table P-2—Number and Percentage of Claims by Service Type and Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims		Out-of-Network Paid Claims	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	2,177	1,670	76.7%	398	56.6%
	M/S	24,245	19,814	81.7%	1,523	63.7%
OP	MH/SUD	124,944	112,748	90.2%	4,405	65.1%
	M/S	418,874	360,251	86.0%	19,472	55.5%
Total	**MH/SUD**	**127,121**	114,418	90.0%	4,803	64.3%
	M/S	**443,119**	380,065	85.8%	20,995	56.0%

Utilization Management

Table P-3 presents a summary of the results from the analysis of prior authorizations (PAs) by service type and benefit type. YCCO showed a moderate difference (8.5 percentage points) in the percentage of denied Rx claims between MH/SUD (66.9 percent) and M/S (58.4 percent), where MH/SUD Rx PAs were approved less frequently than M/S Rx PAs. Due to the low number of PA denials that were appealed, results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity. However, of the 13.5 percent of denied MH/SUD Rx PAs that were appealed, 100 percent were overturned.

Table P-3—PA Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals		Hearings	
		Total	Denied Number	Percent	Total Percent	Overturned Percent	Total Percent	Overturned Percent
IP	**MH/SUD**	13	1	7.7%	0.0%	NA	0.0%	N/A
	M/S	153	13	8.5%	100%	0.0%	0.0%	NA
OP	**MH/SUD**	574	24	4.2%	1.9%	0.0%	0.0%	NA
	M/S	7,100	963	13.6%	98.1%	20.8%	7.4%	50.0%
Rx	**MH/SUD**	387	259	66.9%	13.5%	100%	0.0%	NA
	M/S	2,109	1,231	58.4%	86.5%	60.0%	1.9%	0.0%

NA—indicates a denominator of zero; results could not be calculated.

Provider Enrollment

Table P-4 presents a summary of the results from the analysis of provider enrollment and terminations by benefit type. YCCO showed no difference in the percentage of provider applications approved in CY 2023. The CCO exhibited a moderate difference (6.9 percentage points) in the percentages of terminated providers, where M/S providers were terminated at higher rates (20.4 percent) than MH/SUD providers (13.5 percent).

Table P-4—CY 2023 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	934	100%	307	13.5%
M/S	7,128	100%	1,180	20.4%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table P-5 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Quarter 1 (Q1) 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

YCCO showed an increase in the overall provider network between Q1 2023 to Q1 2024 with a substantial increase (13.9 percent) in providers identified as MH. However, a substantial decrease (15.6 percent) was noted in the number of SUD providers. A comprehensive review of the CCO's provider network capacity was conducted through the annual Delivery System Network (DSN) Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table P-5—Number and Percentage of MH/SUD Providers by Quarter and Provider Type

Provider Type	Q1 2023			Q1 2024			Difference		
	All Providers (N)	MH/SUD Providers		All Providers (N)	MH/SUD Providers		MH/SUD Provider (N)	Percent Change	
		(N)	(%)		(N)	(%)			
MH	5,650	2,013	35.6%	6,835	2,292	33.5%	279	13.9%	▲
SUD		417	7.4%	6,835	352	5.1%	-65	-15.6%	▼

Provider-to-Member Ratios

Table P-6 presents the provider-to-member ratios for MH and SUD providers in Q1 2024 by provider type.

Table P-6—Provider-to-Member Ratios by Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	2,292	9,312	1:5
SUD	352	3,819	1:11

Time and Distance

Table P-7 presents the average time and distance to the nearest three MH and SUD providers by provider type and large urban and urban geographic settings. Table P-8 presents the average time and distance to the nearest three MH and SUD providers by provider type and rural geographic settings and counties with extreme access considerations (CEAC). Acceptable travel times and distances are 10 minutes/5 miles in large urban settings, 25 minutes/15 miles in urban settings, 30 minutes/20 miles in rural settings, and 40 minutes/30 miles in CEAC settings.

The average drive times and distances to the nearest three MH and SUD providers were within the acceptable travel times and distances set by OHA. The CCO had no CEAC settings within its service area as defined by state-established urbanicity parameters and is listed as *Not Applicable (NA)*. A comprehensive review of the CCO's provider network time and distance was conducted through the annual DSN Evaluation, which also included a review of factors that impact overall results (e.g., data quality, changes to study methodology, taxonomic transitions).

Table P-7—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Large Urban and Urban Geographic Settings

Provider Type	Large Urban						Urban					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	1.6	2.1	2.2	1.7	2.2	2.4	1.2	1.5	1.7	1.2	1.7	1.9
SUD	4.1	4.3	4.3	4.7	4.9	5.0	1.6	1.6	1.6	1.8	1.8	1.8

Table P-8—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Rural and CEAC Geographic Settings

Provider Type	Rural						CEAC					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	2.4	2.9	3.1	2.6	3.1	3.4	NA	NA	NA	NA	NA	NA
SUD	3.7	3.8	5.3	4.0	4.2	5.8	NA	NA	NA	NA	NA	NA

Table P-9 presents the percentages of CCO members with access to MH and SUD services by geographic setting. The results are aggregated across all members and not stratified by adult and pediatric populations. The CCO does not have a CEAC setting within its service area and is listed as *Not Applicable (NA)*. Results showing less than 95 percent of members meeting the acceptable times and distances are shaded red.[28] All YCCO members were within the acceptable travel times and distances except for members with a SUD diagnosis in large urban areas; however, more than 90 percent of those members were still within acceptable travel times and distances.

Table P-9—Time and Distance Results by Geographic Setting

MH				SUD			
Large Urban	Urban	Rural	CEAC	Large Urban	Urban	Rural	CEAC
100%	100%	100%	NA	90.1%	100%	100%	NA

Appointment Availability

The results from OHA's *CY 2023 Revealed Behavioral Health Telephone Survey Report* highlighting the accuracy of provider directory data and appointment availability for CCO members for behavioral health OP provider locations were incorporated into the *2024 Mental Health Parity Evaluation Summary*

[28] Although OHA has established time and distance standards, CCO compliance is not assessed as part of this evaluation. OHA assesses CCO compliance to time and distance standards based on adult and pediatric provider types comprising three tiers; 95 percent or more pediatric and adult members must meet the acceptable travel times and distances to the nearest adult and pediatric provider, regardless of urbanicity.

Report as well as the Oregon *2023 External Quality Review Technical Report*. OHA communicated and addressed individual CCO results from the surveys through established monitoring and oversight mechanisms.

Access-Related Grievances

Table P-10 presents the average percentage of access-related MH/SUD grievances compared to the overall number of MH/SUD grievances. The CCO showed a low percentage of grievances (2.0 percent) that were associated with MH/SUD services. Of those grievances, only one grievance was related to access issues. These low results should be interpreted with caution due to the overall low number of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.

Table P-10—Average Percentage of Access-Related MH/SUD Grievances

Total Grievances	MH/SUD Grievances		Access-Related MH/SUD Grievances	
	Number	Percent	Number	Percent
203	4	2.0%	1	25.0%

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2024 MHP Evaluation, the following strengths, weakness, and recommendations with respect to the quality, timeliness, and accessibility of health care services were identified. Strengths and weaknesses specific to the adequacy of MH/SUD provider networks and appointment availability were identified and communicated to the CCO through the *CY 2023 Revealed Behavioral Health Telephone Survey Report* and DSN Evaluation.

Strength/ Weakness	Description	Domain(s)*
⊕	**Strength:** No strengths were identified.	
⊖	**Weakness:** YCCO demonstrated 100 percent of MH/SUD Rx denial decisions were overturned at the appeal level. **Why the weakness exists:** Although the total number of appeals was low (i.e., seven), the fact that 100 percent of the denial decisions were overturned at the appeal level may highlight issues with potentially ineffective PA processes and/or individuals making inappropriate decisions. **Recommendations:** YCCO should review MH/SUD Rx appeals to understand the factors affecting the 100 percent overturn rate. The CCO should review PA criteria and/or decision-making processes and make	⏱️🔑

Strength/ Weakness	Description	Domain(s)*
	appropriate changes to ensure appropriate access to MH/SUD Rx services.	

*= Quality, = Timeliness, = Access

Appendix Q. MHP Results for Oregon Health Plan Fee-for-Service (OHP FFS)

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the coordinated care organization (CCO) to manage the administration of mental health (MH) and substance use disorder (SUD) and medical and surgical (M/S) covered benefits, and assess whether documentation demonstrated compliance with Mental Health Parity (MHP) requirements in how they were applied to MH/SUD and M/S services. Health Services Advisory Group, Inc. (HSAG) used the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant* to indicate the degree to which changes identified by the CCOs and Oregon Health Plan (OHP) fee-for-service (FFS) in the *MHP Treatment Limitation Attestation Tool* remained compliant with parity requirements or the degree to which the 2023 MHP finding(s) were addressed in the *MHP Treatment Limitation Supplemental Questionnaire* and demonstrated compliance with parity requirements. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency*. A *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both, or there was insufficient information or clear evidence of parity associated with implemented non-quantitative treatment limitations (NQTLs). A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria or no documentation was submitted to evaluate the consistency and stringency of NQTLs.

The *MHP Treatment Limitation Attestation Tool* along with the *MHP Treatment Limitation Supplemental Questionnaire,* as applicable, were used to collect information on the four types of treatment limitations (i.e., financial requirements [FRs], aggregate lifetime and annual dollar limits [AL/ADLs], quantitative treatment limitations [QTLs], and NQTLs). A summary of the treatment limitations review by type is included below.

Financial Requirements

- OHP FFS reported it did not make changes and did not apply any FRs or payments from members for services received that are in addition to payments made by the State (e.g., copayments, coinsurance, deductibles, or out-of-pocket maximums) for inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC) services for MH/SUD or M/S benefits.

Aggregate Lifetime and Annual Dollar Limits

- OHP FFS reported it did not make any changes and did not apply any AL/ADLs on the total amount of a specified benefit over a lifetime or annually for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Quantitative Treatment Limitations

- OHP FFS reported it did not make any changes and did not apply any QTLs or limits on the scope or duration of a benefit that are expressed numerically (e.g., day or visit limits) for IP, OP, Rx, or EC services for MH/SUD or M/S benefits.

Non-Quantitative Treatment Limitations

Table Q-1 highlights the overall ratings of compliance with parity requirements for the identified changes and 2023 findings for OHP FFS by NQTL domain and overall.

Table Q-1—Compliance With Parity Requirements for OHP FFS by NQTL Domain and Overall

Organization Name	Medical Management	Provider Network	Pharmacy Management	Overall Compliance Rating
OHP FFS	Partially Compliant	Partially Compliant	Partially Compliant	Partially Compliant

Medical Management

- OHP FFS completed the *MHP Treatment Limitation Supplemental Questionnaire*; however, it did not sufficiently address all calendar year (CY) 2023 findings related to the utilization management (UM) processes (i.e., prior authorization [PA], concurrent review [CR], and retrospective review [RR]), medical necessity criteria, and practice guideline selection/criteria NQTLs. OHP FFS indicated RR is not used to manage the administration of MH/SUD services thus addressing the finding related to the NQTL. Due to a lack of supporting documentation (e.g., internal policies, procedures, processes, standard operating procedures, and workflows) related to contractors/vendors, OHP FFS was unable to demonstrate how the treatment limitations for PA and CR were applied to MH/SUD and M/S benefits and that such NQTLs were comparable and not applied more stringently for MH/SUD benefits compared to M/S benefits. The information provided by OHP FFS related to medical necessity criteria and practice guidelines primarily addressed M/S services and was not sufficient to determine whether the processes, strategies, and evidentiary standards used in administering the NQTL to MH/SUD benefits were comparable to the processes, strategies, and evidentiary standards used in administering the NQTL to M/S benefits. This resulted in a *Partially Compliant* rating.

Provider Network

- OHP FFS completed the *MHP Treatment Limitation Supplemental Questionnaire*; however, it did not sufficiently address all CY 2023 findings related to the provider enrollment and credentialing and reimbursement rates NQTLs. OHP FFS provided information on specific reimbursement rates developed and implemented for primary care physicians and safety net clinics as they are paid using a Prospective Payment System (PPS), but documentation was limited to M/S services. Due to the absence of MH/SUD information, a comprehensive assessment of parity could not be performed. OHP FFS sufficiently addressed the geographic limitations NQTL. The rationale used by OHP FFS to determine assignment of geographic limitations was consistent between MH/SUD and M/S benefits, and the evidentiary standards used in administering the NQTL to MH/SUD benefits were

comparable to the evidentiary standards used in administering the NQTL to M/S benefits. However, for provider enrollment and credentialing, OHP FFS' documentation was limited and insufficient to evaluate whether the processes, strategies, evidentiary standards, and other factors used in provider enrollment and credentialing were not applied more stringently for MH/SUD benefits compared to M/S benefits. This resulted in a *Partially Compliant* rating.

Pharmacy Management

- OHP FFS completed the *MHP Treatment Limitation Supplemental Questionnaire*; however, it did not sufficiently address all CY 2023 findings related to the PA processes for Rx services, formulary design for prescription drugs, step therapy/fail-first strategies, and methods for determining usual, customary, and reasonable charges NQTLs. The formulary design for prescription drugs, step therapy/fail-first strategies, and methods for determining usual, customary, and reasonable charges NQTLs were sufficiently addressed by OHP FFS, and documentation demonstrated that the NQTLs were comparable and not applied more stringently for MH/SUD benefits compared to M/S benefits. However, the documentation provided by OHP FFS to address the PA process for prescription drugs lacked internal policies, procedures, processes, standard operating procedures, and workflows and, without sufficient supporting documentation, an evaluation of parity could not be completed. This resulted in a *Partially Compliant* rating.

Availability of Information

OHP FFS reported changes related to the way it makes criteria for medical necessity criteria information available to members. OHP FFS reported making the first FFS member handbook available to members online. While the handbook listed the services that require PA, it did not inform the member that OHP's covered benefits and treatments are based off a list of conditions and services named the Prioritized List of Health Services, which is ranked by the Health Evidence Review Commission. Since the OHP FFS member handbook did not inform members of the medical necessity criteria information, there was insufficient documentation demonstrating how medical necessity criteria were disseminated to all members, resulting in a *Partially Compliant* finding.

Administrative Data Profile

Claims

Table Q-2 presents a summary of the results from the analysis of paid claims by service type and benefit type. Overall, OHP FFS showed a substantial difference (13.3 percentage points) in the percentage of paid claims between MH/SUD (74.9 percent) and M/S (61.6 percent) services, with a greater percentage of MH/SUD claims being paid compared to M/S claims. However, a moderate difference between the percentage of paid MH/SUD claims and paid M/S claims was noted for IP claims (9.6 percentage points). Additionally, when compared to the CCOs, OHP FFS paid a substantially smaller percentage of submitted claims for both IP and OP services (i.e., 15.5 percentage points and 26.7 percentage points, respectively). However, caution should be used when interpreting these results as differences may be

due to alternative payors (e.g., Medicare and CCOs) responsible for primary payment. Due to the structure of OHP FFS' provider network, all enrolled providers are considered in network; as a result, claims analyses were not conducted by provider network status.

Table Q-2—Number and Percentage of Claims by Service Type and Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims		Out-of-Network Paid Claims		CCO Aggregate Paid Claims
		Number	Number	Percent	Number	Percent	
IP	MH/SUD	3,514	1,357	38.6%	NR	NR	87.6%
	M/S	48,399	23,306	48.2%	NR	NR	85.4%
OP	MH/SUD	1,252,891	940,170	75.0%	NR	NR	90.5%
	M/S	3,335,593	2,060,791	61.8%	NR	NR	88.4%
Total	**MH/SUD**	**1,256,405**	**941,527**	**74.9%**	**NR**	**NR**	90.4%
	M/S	**3,383,992**	**2,084,097**	**61.6%**	**NR**	**NR**	88.3%

NR—indicates appeals data were not reported by OHP FFS.

Utilization Management

Table Q-3 presents a summary of the results from the analysis of PAs by service type and benefit type. Across service types, a greater percentage of M/S PAs were denied compared to MH/SUD PAs for IP and OP service types. There was a substantial difference (10.8 percentage points) in the percentage of denied Rx PAs between MH/SUD (31.2 percent) and M/S (20.4 percent) benefits. Unlike the CCOs, OHP FFS did not have an appeals level for IP or OP PA denials; rather, all appeals to an adverse benefit determination were treated as a contested State hearing. Among Rx appeals, there was a minimal difference of 4.5 percentage points in the percentage of overturned Rx appeals between MH/SUD (72.2 percent) and M/S (76.7 percent) benefits. Moreover, although a low percentage of PA denials resulted in a hearing, there was a substantial difference (33.5 percentage points) in the percentage of OP denials overturned via hearing between MH/SUD (75.0 percent) and M/S (41.5 percent), suggesting that a higher percentage of MH/SUD PA requests may have been denied inappropriately compared to M/S PA requests. However, caution should be used when interpreting these results due to the small number of denials resulting in a hearing.

Table Q-3—PA Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals		Hearings	
		Total	Denied Number	Percent[1]	Total Percent	Overturned Percent	Total Percent	Overturned Percent
IP	**MH/SUD**	2,585	7	0.3%	NR	NR	0.0%	NA
	M/S	1,160	214	18.4%	NR	NR	0.0%	NA
OP	**MH/SUD**	6,231	120	1.9%	NR	NR	0.3%	75.0%
	M/S	6,906	1,337	19.4%	NR	NR	2.7%	41.5%

Service Type	Benefit Type	Prior Authorization			Appeals		Hearings	
		Total	Denied Number	Percent[1]	Total Percent	Overturned Percent	Total Percent	Overturned Percent
Rx	MH/SUD	8,837	2,758	31.2%	51.2%	72.2%	3.6%	20.0%
	M/S	12,206	2,493	20.4%	48.8%	76.7%	2.4%	28.6%

NA—indicates a denominator of zero; results could not be calculated.

NR—indicates appeals data were not reported by OHP FFS.

[1] Differences of 10 percentage points or more where a greater percentage of MH/SUD PA requests were denied compared to M/S PA requests are presented in red text.

Provider Enrollment

Table Q-4 presents a summary of the results from the analysis of provider enrollment and terminations by benefit type. OHP FFS did not report provider applications and/or terminations for CY 2023. Therefore, an analysis of provider enrollment data was not evaluated for parity.

Table Q-4—CY 2023 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	NR	NR	NR	NR
M/S	NR	NR	NR	NR

NR—indicates provider enrollment data (provider applications and/or terminations) were not reported by OHP FFS.

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table Q-5 presents the total number of providers in network, total number of MH/SUD providers contracted with the OHP FFS, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Quarter 1 (Q1) 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

OHP FFS showed a substantial increase (14.5 percent) in SUD providers and a substantial decrease (14.6 percent) in MH providers between Q1 2023 and Q1 2024.

Table Q-5—Number and Percentage of MH/SUD Providers by Quarter and Provider Type

Provider Type	Q1 2023			Q1 2024			Difference		
	All Providers (N)	MH/SUD Providers		All Providers (N)	MH/SUD Providers		MH/SUD Provider (N)	Percent Change	
		(N)	(%)		(N)	(%)			
MH	NR	6,933	—	NR	5,919	—	-1,014	-14.6%	▼
SUD		1,013	—	NR	1,160	—	147	14.5%	▲

NR—indicates provider data were not reported by OHP FFS.

— indicates the percentage of providers identified as MH/SUD was not able to be calculated. This was due to OHP FFS not reporting the total number of providers in the network. Provider counts are based on the number of enrolled providers active during the review period (i.e., MH claim in 2023).

Provider-to-Member Ratios

Table Q-6 presents the provider-to-member ratios for MH and SUD providers in Q1 2024 by provider type.

Table Q-6—Provider-to-Member Ratios by Benefit and Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	5,919	24,563	1:5
SUD	1,160	4,736	1:5

Time and Distance

Table Q-7 presents the average time and distance to the nearest three MH and SUD providers by provider type and large urban and urban geographic settings. Table Q-8 presents the average time and distance to the nearest three MH and SUD providers by provider type and rural geographic settings and counties with extreme access considerations (CEAC). Acceptable travel times and distances are 10 minutes/5 miles in large urban settings, 25 minutes/15 miles in urban settings, 30 minutes/20 miles in rural settings, and 40 minutes/30 miles in CEAC settings.

The average drive times and distances to the nearest three MH and SUD providers were within the acceptable travel times and distances set by OHA.

Table Q-7—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Large Urban and Urban Geographic Settings

Provider Type	Large Urban						Urban					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	0.7	0.9	1.0	1.1	1.4	1.6	1.0	1.3	1.4	1.2	1.5	1.7
SUD	1.2	1.5	1.6	2.0	2.4	2.6	1.7	2.0	2.2	2.1	2.5	2.7

Table Q-8—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Rural and CEAC Geographic Settings

Provider Type	Rural						CEAC					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	4.3	5.0	5.9	4.6	5.5	6.4	5.7	7.1	8.4	6.1	7.7	9.1
SUD	7.7	9.3	11.0	8.4	10.1	12.1	8.4	9.4	14.4	9.1	10.2	15.6

Table Q-9 presents the percentages of OHP FFS members with access to MH and SUD services by geographic setting. The results are aggregated across all members and not stratified by adult and pediatric populations. At least 95 percent of OHP FFS' members with an MH and/or SUD diagnosis were within the acceptable travel times and distances for all geographic settings.

Table Q-9—Time and Distance Results by Geographic Setting

MH				SUD			
Large Urban	Urban	Rural	CEAC	Large Urban	Urban	Rural	CEAC
100%	100%	98.6%	98.9%	99.8%	100%	95.4%	98.0%

Appointment Availability

OHP FFS did not monitor appointment availability for any provide types.

Access-Related Grievances

OHP FFS did not maintain a centralized repository of grievances, nor did it track and categorize the types of grievances received. As such, OHP FFS was unable to effectively monitor or extract grievances for reporting and monitoring.

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2024 MHP Evaluation, OHP FFS' results suggested several opportunities for improvement in the administration and monitoring of parity between MH/SUD and M/S benefits. Specifically, because of the lack of documented policies and procedures, along with limitations associated with information systems, OHP FFS was unable to fully demonstrate that treatment limitations for MH/SUD services were comparable to and were applied no more stringently than the limitations applied to M/S benefits. Due to the lack of information, a comprehensive assessment of parity could not be performed; however, when available, the results did not identify systemic issues that negatively affected parity between MH/SUD and M/S services. Rather, findings frequently highlighted general regulatory compliance issues affecting both MH/SUD and M/S benefits uniformly.

OHP FFS' results were used to identify the following strengths, weaknesses, and recommendations with respect to the quality, timeliness, and accessibility of healthcare services.

Strength/ Weakness	Description	Domain(s)*
+	**Strength:** No strengths were identified for OHP FFS.	
−	**Weakness:** OHP FFS received an overall NQTL compliant rating of *Partially Compliant*. **Why the weakness exists:** OHP FFS' tool responses and documentation for medical management, provider network, and pharmacy management were limited and did not include sufficient information related to its internal process or provide contractors/vendors processes to demonstrate how the treatment limitations were applied to MH/SUD benefits. **Recommendations:** OHP FFS should develop and maintain internal policies, procedures, processes, standard operating procedures, workflows, etc., and provide contractors/vendors policies, procedures, and processes that address the selection, implementation, and monitoring of all treatment limitations used by the organization to ensure they are comparable and applied no more stringently to MH/SUD benefits than to M/S benefits.	
−	**Weakness:** OHP FFS was unable to submit the required provider enrollment data for analysis of parity. MH/SUD and M/S provider enrollment practices and outcomes cannot be evaluated if relevant data are not collected, readily tracked, differentiated, and reported. This places inherent limitations on OHP FFS' ability to internally monitor and evaluate the parity of provider credentialing and/or contracting operations. **Why the weakness exists:** OHP FFS did not report any provider application or termination data. In addition, the provider count data were limited to only MH and SUD providers and did not include the total number of providers in the network. **Recommendations:** OHP FFS must update or modify its administrative systems to capture additional data elements (provider applications, terminations, provider counts, etc.) and/or processes to extract the data elements to allow the reporting of provider enrollment data by benefit type. Additionally, due to differences in provider enrollment processes, HSAG recommends that OHP FFS work with OHA and its contractor to map available data fields to required MHP evaluation data elements.	
−	**Weakness:** OHP FFS was unable to identify and submit all required grievance data for analysis of parity. Grievances cannot be evaluated if relevant data are not collected, readily tracked, differentiated, and reported. This places inherent limitations on OHP FFS' ability to	

Strength/ Weakness	Description	Domain(s)*
	internally monitor and evaluate grievances by benefit type and category (i.e., access-related). **Why the weakness exists:** OHP FFS did not maintain a centralized repository of grievances, nor did it track and categorize the types of grievances received. **Recommendations:** OHP FFS must update or modify its administrative systems to capture and distinguish both MH/SUD and M/S grievances, including the ability to define/categorize the type of grievances received regardless of department and/or vendor.	
−	**Weakness:** OHP FFS did not monitor the appointment availability of its contracted providers or their compliance with regulatory requirements. **Why the weakness exists:** OHP FFS had not established the mechanisms or methodology to collect, evaluate, and report on the availability of appointments for MH/SUD and/or M/S services. **Recommendations:** OHP FFS should implement mechanisms to capture and report on the availability of appointments by provider type in alignment with State administrative rules and federal standards.	
−	**Weakness:** OHP FFS showed a substantial difference in the percentage of MH/SUD Rx PA requests being denied compared to M/S Rx PA requests. Although differences in the percentage of Rx PA requests being denied may be legitimate, they may also highlight procedural differences that indicate potential barriers to members' access to MH/SUD Rx services. **Why the weakness exists:** The percentage of denied MH/SUD Rx PA requests was substantially higher than the percentage of denied M/S Rx PA requests. **Recommendations:** OHP FFS should review denied MH/SUD Rx PA requests to understand the factors affecting the higher percentage of MH/SUD Rx PA requests being denied compared to M/S Rx PA requests. OHP FFS should also review PA criteria and/or decision-making processes and make appropriate changes to ensure appropriate access to MH/SUD Rx services.	

*  = Quality,  = Timeliness,  = Access

Appendix R. MHP Community Partner Feedback

Salient points from multiple MHP CP feedback sessions are presented here and separated by CP group and date. HSAG has removed identifying information and revised feedback for clarity and pertinence to the MHP Evaluation.

Consumers

- April 10, 2024
  - Expressed the importance of peer support services (PSS) and noted appreciation for the focus on the utilization of these services.
  - Recognized the important role PSS have in engaging members and transitioning them into treatment services. However, members from this CP group reported that per OHP guidelines, PSS cannot be billed without an assessment and treatment plan thereby affecting access to these services.
  - Noted that In Lieu of Services (ILOS) used for PSS can be cumbersome for the CCOs to navigate.
- October 9, 2024
  - Recommended the MHP Evaluation include an assessment of the timeliness of PA decisions in addition to reviewing rates of denial.
  - Expressed the importance of accounting for the time required for providers to obtain approval to offer PSS.
  - Requested information on which CCOs have "turned on" the ILOS to pay for PSS since use of those funds could affect PSS utilization and the results.

CCOs

- April 23, 2024
  - Suggested collaborating with the THW (traditional health work) commission regarding OHA's evaluation of PSS, including leveraging the utilization/access data collected by the commission workgroup to avoid duplication of efforts.
  - Recommended OHA assess the feasibility of allowing the CCOs to pay for PSS at the outset of member outreach and treatment instead of only after a formal diagnosis and treatment plan have been developed.
  - Investigated the use of ILOS funds to support PSS, including at the outset of treatment prior to documentation of a formal diagnosis and treatment plan.
  - Noted that some CCOs indicated a preference for avoiding the use of ILOS funds when a service could be billable.

- CCOs were given an opportunity to provide written feedback on individual results between November 7, 2024, and November 25, 2024.

Providers

- April 4, 2024
  - Suggested that focusing on PSS claims data may not present a full picture of PSS utilization since providers and clinics may fund these services through funding streams other than claims and encounters.
  - Noted that PSS are often used before an assessment or a complete diagnosis is determined; as such, the utilization will not be captured through claims and encounters.
  - Requested clarification on the definition of timeliness—i.e., wait time for PSS versus the timeliness of payment.
  - Suggested evaluating the adequacy of the provider network based on the needs of different populations (e.g., age groups).
  - Interested in increased transparency into the clinical criteria used to determine the appropriate level of care.
  - Suggested collecting outcomes data in addition to utilization and payment rates.
  - Investigated network capacity issues that result in added travel time and distance to receive services and the associated burden to members.
  - Interested in more frequent updates on this project.
- October 9, 2024
  - Noted that the OON results for the percentage of paid claims makes sense since some CCOs contract with MH/SUD providers statewide while other CCOs have provider networks more limited to their service region.
  - Requested clarity on how payment rates associated with out-of-network claims reflect parity since the results may indicate an insufficient number of IN providers. HSAG confirmed parity is assessed through differences in the rate of payment of out-of-network MH/SUD and M/S claims.
  - Requested clarification on whether telehealth services were accounted for in the geographic distribution findings. HSAG noted that while OHA has begun to capture telehealth information, that information is not currently available for reporting.
  - Identified that the low number of appeals and grievances for MH/SUD services raises a red flag in relation to the number of denials and higher number of overturned decisions.
  - Requested that the revealed shopper survey results report use the term “mental health” as the more generic term, “behavioral health,” is equated with both MH and SUD services or treatment.
  - Stated that the use of “partially compliant” in the Treatment Limitation Review was too lenient and not in alignment with other audit activities. Some CP members noted that scoring should be “compliant” or “not compliant.”

BH Policy Advocates

- November 7, 2024
  - Suggested the network adequacy review report results by pediatric and adult providers to better understand the provider network in place to provide health care services to pediatric members.
  - Interested in exploring the adequacy of provider networks based on level of care instead of broad provider types.

Appendix S. Peer Support Services Results

Table S-1 shows the county-specific PSS utilization and timeliness results.

Table S-1—PSS Utilization Results by County

County	Members With MH Diagnosis				Members With SUD Diagnosis			
	Number of PSS Claims	PSS/ 1,000 MM	Paid PSS Claims (Percent)	Median Days From DOS to Payment	Number of PSS Claims	PSS/ 1,000 MM	Paid PSS Claims (Percent)	Median Days From DOS to Payment
Baker	77	1.009	99.0%	21	35	0.459	90.9%	38
Benton	58	0.221	72.6%	44	168	0.641	90.4%	43
Clackamas	252	0.196	89.6%	34	440	0.343	81.2%	41
Clatsop	61	0.352	92.4%	59	89	0.514	87.0%	45
Columbia	86	0.447	83.8%	120	179	0.929	62.5%	147
Coos	150	0.464	69.2%	35	167	0.517	76.3%	36
Crook	50	0.398	75.9%	57	67	0.533	92.0%	23
Curry	24	0.222	83.8%	36	54	0.501	88.4%	38
Deschutes	402	0.558	91.1%	27	529	0.734	95.5%	21
Douglas	156	0.278	82.5%	39	342	0.610	93.7%	28
Gilliam	6	0.717	100%	20	NA	NA	NA	NA
Grant	53	1.842	96.4%	38	33	1.147	95.4%	35
Harney	46	1.244	97.3%	48	24	0.649	70.8%	23
Hood River	33	0.329	90.9%	26	25	0.249	75.7%	30
Jackson	409	0.378	87.8%	76	984	0.910	93.4%	33
Jefferson	112	0.763	63.4%	70	92	0.627	70.1%	135
Josephine	135	0.266	96.9%	76	378	0.746	94.8%	62
Klamath	514	1.371	88.0%	56	212	0.565	81.4%	53
Lake	1	0.025	33.3%	42	8	0.204	77.4%	32
Lane	809	0.504	90.3%	26	542	0.338	89.1%	31
Lincoln	46	0.194	71.0%	58	449	1.892	93.3%	23
Linn	97	0.159	93.4%	48	158	0.259	95.4%	23
Malheur	140	0.746	99.2%	49	78	0.416	88.0%	40
Marion	749	0.457	95.4%	26	757	0.462	93.6%	21
Morrow	35	0.549	98.7%	33	33	0.518	94.7%	34
Multnomah	796	0.241	91.5%	41	1,924	0.582	84.5%	41
OON	48	0.365	92.9%	41	62	0.471	86.8%	48

County	Members With MH Diagnosis				Members With SUD Diagnosis			
	Number of PSS Claims	PSS/ 1,000 MM	Paid PSS Claims (Percent)	Median Days From DOS to Payment	Number of PSS Claims	PSS/ 1,000 MM	Paid PSS Claims (Percent)	Median Days From DOS to Payment
Polk	223	0.675	94.7%	28	203	0.614	94.2%	23
Sherman	3	0.360	100%	28	5	0.600	79.7%	327
Tillamook	70	0.588	80.7%	39	18	0.151	75.6%	36
Umatilla	226	0.593	96.4%	38	303	0.795	86.2%	35
Union	107	0.915	86.9%	41	170	1.454	94.3%	40
Wallowa	22	0.686	95.8%	18	51	1.590	77.6%	21
Wasco	70	0.545	94.5%	28	45	0.350	71.1%	63
Washington	263	0.144	85.3%	37	606	0.332	93.1%	40
Wheeler	7	1.293	97.8%	40	3	0.554	100%	53
Yamhill	243	0.609	94.7%	35	163	0.408	89.5%	30

NA (Not Applicable) indicates no PSS for members with SUD diagnosis in the county.

Appendix T. Statewide Denial Reasons

Table T-1 and Table T-2 show the statewide aggregate percentage of denial reasons for all service types (i.e., IP, OP, and Rx) and by benefit (i.e., MH/SUD and M/S) for all PA requests, including the distribution for total denials (i.e., MH/SUD and M/S combined). Results in the table are sorted in descending order from the most to least frequent denial reason.

Table T-1—Statewide PA Denial Reasons by Benefit

	Total		MH/SUD		M/S	
	N	%	N	%	N	%
Does Not Meet Criteria	60,741	45.0%	7,229	60.3%	53,512	43.5%
Not a Covered Service/ Benefit	29,458	21.8%	938	7.8%	28,520	23.2%
Service is *Below the Line*	17,672	13.1%	300	2.5%	17,372	14.1%
Treatment Limitation	16,531	12.2%	2,210	18.4%	14,321	11.6%
Out-of-Network Provider	5,243	3.9%	910	7.6%	4,333	3.5%
Administrative Denial	4,724	3.5%	370	3.1%	4,354	3.5%
Unknown	721	0.5%	31	0.3%	690	0.6%

Table T-2—Statewide PA Denial Reasons by Service Type and Benefit

Denial Reason	IP						OP						Rx					
	Total		MH/SUD		M/S		Total		MH/SUD		M/S		Total		MH/SUD		M/S	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Does Not Meet Criteria	**2,076**	**84.9%**	214	78.1%	1,862	85.8%	**29,263**	**45.6%**	987	43.9%	28,276	45.7%	**29,402**	**42.9%**	6,028	63.7%	23,374	39.6%
Not a Covered Service/Benefit	**183**	**7.5%**	31	11.3%	152	7.0%	**19,045**	**29.7%**	181	8.1%	18,864	30.5%	**10,230**	**14.9%**	726	7.7%	9,504	16.1%
Service is *Below the Line*	**27**	**1.1%**	0	0.0%	27	1.2%	**8,000**	**12.5%**	6	0.3%	7,994	12.9%	**9,645**	**14.1%**	294	3.1%	9,351	15.8%
Treatment Limitation	**4**	**0.2%**	0	0.0%	4	0.2%	**758**	**1.2%**	8	0.4%	750	1.2%	**15,769**	**23.0%**	2,202	23.3%	13,567	23.0%
Out-of-Network Provider	**29**	**1.2%**	4	1.5%	25	1.2%	**5,144**	**8.0%**	905	40.3%	4,239	6.8%	**70**	**0.1%**	1	0.0%	69	0.1%
Administrative Denial	**88**	**3.6%**	19	6.9%	69	3.2%	**1,432**	**2.2%**	138	6.1%	1,294	2.1%	**3,204**	**4.7%**	213	2.2%	2,991	5.1%
Unknown	**37**	**1.5%**	6	2.2%	31	1.4%	**504**	**0.8%**	21	0.9%	483	0.8%	**180**	**0.3%**	4	0.0%	176	0.3%