Oregon Health Authority

2020 Mental Health Parity Analysis Summary Report

March 2021

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Overview

To meet Mental Health Parity (MHP) requirements in 42 Code of Federal Regulations (CFR) §438 Subpart K, the Oregon Health Authority (OHA) conducted an initial MHP Analysis of OHP's full delivery system in 2018. OHA's 15 coordinated care organizations (CCOs) and Oregon Health Plan Fee-for-Service (OHP FFS) participated in the initial MHP Analysis, which included an inventory of all mental health (MH)/substance use disorder (SUD) and medical/surgical (M/S) benefits offered to OHP members. Limitations applied to benefits were analyzed to ensure that limitations (e.g., day limits, prior authorization [PA] requirements, or network admission standards) for MH/SUD services were comparable to and applied no more stringently than those for M/S services provided under OHP managed care benefit packages. Results of the initial analysis were reported in August 2018; and in 2019, the CCOs implemented corrective actions in areas lacking parity. For 2020, OHA tasked Health Services Advisory Group, Inc. (HSAG), with conducting a follow-up MHP Analysis across the CCOs and OHP FFS, in part due to each of the CCOs entering into new five-year contracts with the State, to determine if the existing benefits and any non-quantitative treatment limitations (NQTLs) remained compliant with the MHP regulations.

HSAG conducted the 2020 MHP Analysis based on August 2018 MHP analysis results, implemented corrective actions, and any additional changes to benefits design or operations that may have impacted parity. This report provides a summary of the 2020 MHP Analysis and results across all organizations for OHP managed care benefit packages.

2020 MHP Analysis Components

In accordance with 42 CFR §438 Subpart K, MHP applied to all OHP benefits delivered through OHA's managed care delivery system for benefit packages CCOA, CCOB, CCOE, and CCOG which includes benefits delivered through a combination of managed care and FFS delivery systems. HSAG developed a protocol and tools to carry out the 2020 MHP analysis activity based on the initial 2018 MHP Analysis and in alignment with guidance outlined in the toolkit provided by the Centers for Medicare & Medicaid Services (CMS): *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*.[1-1]

Because OHP benefits do not require financial limitations or quantitative limitations (e.g., day or visit limits), the 2020 MHP analysis focused on NQTLs such as prior authorization and provider admission processes. HSAG analyzed CCO and OHP FFS policies and operations to ensure that limitations applied

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

to MH/SUD benefits were comparable to and applied no more stringently to M/S benefits provided under each benefit package in the NQTL categories listed below.

- **Category I—Utilization Management Limits Applied to Inpatient Services:** Utilization management (UM) processes implemented through PA, concurrent review (CR), and retrospective review (RR) that may also be used to ensure medical necessity for MH/SUD and M/S services.
- **Category II—Utilization Management Limits Applied to Outpatient Services:** UM processes applied to OP MH/SUD and M/S services through PA, CR, and RR to ensure medical necessity.
- **Category III—Prior Authorization for Prescription Drug Limits:** PA as a means of determining whether particular medications will be dispensed. PA of prescription drugs limits the availability of specific medications.
- **Category IV—Provider Admission—Closed Network:** Closed networks as they impose limits to providers seeking to join a panel of approved providers.
- **Category V—Provider Admission—Network Credentialing:** Network enrollment/credentialing requirements imposed, including provider admission requirements such as state licensing requirements and exclusions of specific provider types, that may result in limitations.
- **Category VI—Out-of-Network/Out-of-State Limits:** Out-of-network (OON) and out-of-state (OOS) limits that affect how members access OON and OOS providers and address how OHA and the CCOs ensure necessary access to providers not eligible to be reimbursed or not in a CCO's network.

Additional MHP requirements related to the availability of criteria for medical necessity determinations and the reason for denial of reimbursement or payment for MH/SUD benefits was also analyzed. 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.

2020 MHP Analysis Results

The 2020 MHP Analysis evaluated CCO compliance in terms of comparability and stringency in the application of NQTLs to MH/SUD and M/S benefits. HSAG's analysis revealed that CCO policies included standardized processes that applied to both MH/SUD and M/S benefits, including UM and PA policies and service authorization handbooks. None of the CCOs had separate policies for the management of benefits based on benefit package, which ensured consistency in the analysis across the packages. While the overall OHP MHP analysis results showed non-compliance the majority of NQTL categories, the CCOs and OHP FFS were generally compliant with MHP requirements with four CCOs issued no findings and the remaining CCOs issued a minimal number of findings. The minimal number of findings were primarily due to operational differences in the CCOE and CCOG packages where the CCOs managed MH/SUD benefits and OHP FFS managed M/S benefits, which revealed greater

stringency in the CCOs' application of NQTLs. More detail on aggregated analysis results is provided in the body of this report.

Each CCO was instructed to complete and submit an improvement plan addressing corrective actions/interventions to resolve all MHP findings. HSAG will work with the CCOs and OHP FFS to implement corrective actions, providing technical assistance to the CCOs and OHP FFS to ensure full compliance with MHP requirements.

OHA MHP Analysis Recommendations

Based on the 2020 MHP analysis results across the CCOs and OHP FFS, HSAG developed recommendations for OHA to pursue to ensure continued compliance with MHP requirements. HSAG recommendations include the following:

- **General Activities:**
  - OHP FFS collaboration with CCOs on operational changes that could impact MHP.
  - Annual attestations of continued compliance with MHP regulations.
  - Development of material change criteria to identify what events trigger a MHP analysis.
- **Records Review Activities:**
  - 2021 MHP medical records reviews to further understand UM decision details and their impact on parity.
  - 2022 MHP Provider validation records reviews to fully assess the validation of unlicensed MH/SUD provider qualifications.
  - 2023 MHP claims denial records analysis to determine, in operation, whether parities exist in claims processing operations across the CCOs and within OHP FFS.

2. Introduction

Overview of Oregon's Mental Health Parity Analysis

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

To meet the requirements, the Oregon Health Authority (OHA) conducted an initial MHP Analysis of OHP's full delivery system in 2018. OHA's 15 coordinated care organizations (CCOs) and Oregon Health Plan Fee-for-Service (OHP FFS) participated in the initial MHP Analysis, which included an inventory of all MH/SUD and M/S benefits offered to OHP members and the limitations applied to those benefits to ensure that limitations (e.g., day limits, PA requirements, or network admission standards) for MH and SUD services were comparable to and applied no more stringently than those for M/S services provided under OHP. Results of the initial analysis were reported in August 2018; and in 2019, the CCOs implemented corrective actions in areas lacking parity.

For 2020, OHA tasked Health Services Advisory Group, Inc. (HSAG), with conducting a follow-up MHP Analysis across the CCOs and OHP FFS, in part due to each of the CCOs entering into new five-year contracts with the State, to determine if the existing benefits and any NQTLs remained compliant with the MHP regulations in 42 CFR §438 Subpart K. HSAG conducted the MHP Analysis in 2020 based on the August 2018 results, implemented corrective actions, and any additional changes to benefits design or operations that may impact parity. This report provides a summary of the 2020 MHP Analysis and results across all organizations for OHP managed care benefit packages.

Components of the 2020 MHP Analysis

In accordance with 42 CFR §438 Subpart K, MHP applied to all OHP benefits delivered through OHA's managed care delivery system, including those delivered through a combination of managed care and FFS delivery systems. HSAG developed a protocol and tools to carry out the analysis activity based on the initial 2018 MHP Analysis and in alignment with guidance outlined in the toolkit provided by the Centers for Medicare & Medicaid Services (CMS): *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*.[1-2] The 2020 MHP Analysis also referenced Oregon's Mapping Guide[1-3] that assigned benefits to MH/SUD and M/S groupings based on International Classification of Diseases, Tenth Revision (ICD-10) diagnoses and mapped into four prescribed classifications as published in the March 30, 2016, Federal Register, Vol. 81, No. 61[1-4] as illustrated in Figure 2-1.

Figure 2-1—MHP: Four Prescribed Classifications

OHP Benefit Packages

While all OHP benefit packages were delivered in accordance with the same Medicaid essential health benefits structure, the delivery of those benefits was categorized by OHP benefit package based on enrollment. Table 2-1 identifies the four OHP benefit packages evaluated in the 2020 MHP Analysis. Since each benefit package involves the delivery of Medicaid essential health benefits covered by both CCOs and OHP FFS, HSAG conducted an analysis of each CCO's NQTLs, and then against the OHP FFS NQTLs.

Table 2-1—OHP Benefit Packages

Benefit Package	Benefit Types Covered	Evaluation
CCOA	Physical Health, Behavioral Health, Dental Health	CCO MH/SUD and FFS MH/SUD compared to CCO M/S
CCOB	Physical Health, Behavioral Health	
CCOE	Behavioral Health	CCO MH/SUD and FFS MH/SUD compared to FFS M/S
CCOG	Behavioral Health, Dental Health	

[1-2] The CMS *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs* and additional CMS resources related to MHP can be accessed at: https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/parity/index.html.

[1-3] The Oregon Mapping Guide includes definitions, links, and resources important for the MHP Analysis. It also maps all Oregon Medicaid benefits to the classifications required for the MHP Analysis. It can be accessed on OHA's MHP webpage at: https://www.oregon.gov/OHA/HSD/OHP/Pages/MH-Parity.aspx.

[1-4] Federal Register. Volume 81, No. 61/Wednesday, March 30, 2016. Available at: https://www.govinfo.gov/content/pkg/FR-2016-03-30/pdf/FR-2016-03-30.pdf. Accessed on: Dec 4, 2020.

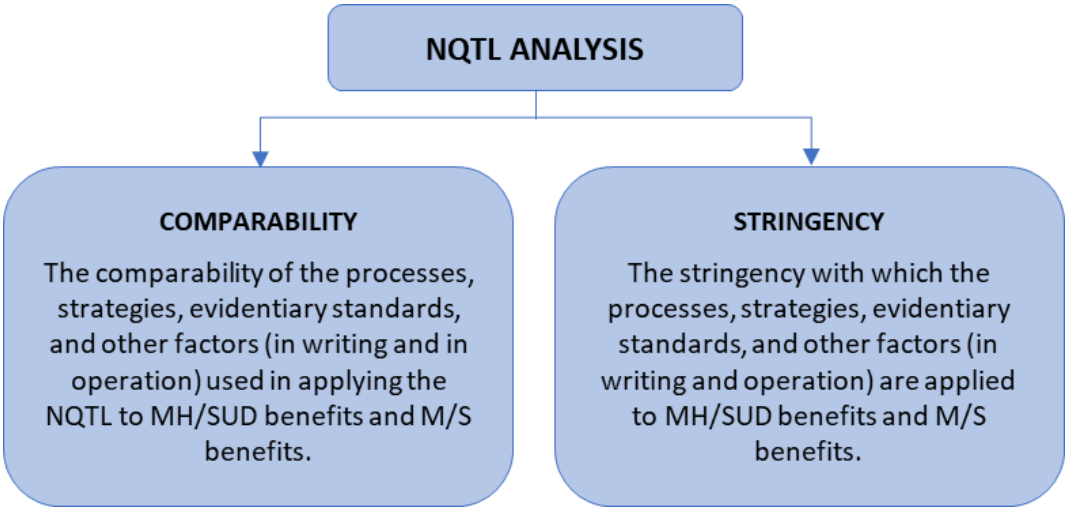
Non-Quantitative Treatment Limitations

Because Oregon Medicaid does not permit the use of QTLs (e.g., day and visit limits), HSAG's analysis focused on assessing NQTLs in the OHP delivery system. NQTLs are health care management limitations on the scope or duration of benefits through the use of managed care processes, such as PA or network admission standards. "Soft limits," benefit limits that allow for an individual to exceed limits or allow for limits to be "waived" based on medical necessity, are also considered NQTLs. Examples of NQTLs include:

- Medical management standards limiting or excluding benefits based on medical necessity or appropriateness criteria.
- Standards for provider admission to participate in a network and reimbursement rates.
- Restrictions based on geographic location, facility type, or provider specialty.
- Fail-first policies or step therapy protocols.
- Exclusions based on failure to complete a course of treatment prior to allowing authorization of a subsequent treatment.

MHP regulations hold that no NQTL can be applied to MH/SUD benefits and services that is not comparable to or is more stringent than those applied to M/S benefits and services in each benefit classification regarding processes, strategies, evidentiary standards, or other factors. HSAG assessed policies and procedures as written and operational processes for compliance with parity requirements by classification (e.g., inpatient [IP] and outpatient [OP]) of services. The 2018 MHP Analysis compared NQTLs for services that address MH/SUD diagnoses with services that address M/S diagnoses across the OHP benefit packages. Comparability was assessed as to the reason an NQTL was used, the evidence that supported its use, and the process for its implementation. The stringency criteria assessed the rigor with which the NQTLs were applied, the evidence for the level of stringency, and penalties and exceptions associated with limitations. Comparability and stringency are defined in Figure 2-2.

Figure 2-2—MHP Analysis Comparability and Stringency



NQTL Categories

Similar to the Initial 2018 MHP Analysis, HSAG assessed for comparability and stringency criteria across six specific NQTL categories in the OHP delivery system. The six categories are described below.

- **Category I—Utilization Management Limits Applied to Inpatient Services:** Utilization management (UM) processes implemented through PA, concurrent review (CR), and retrospective review (RR) that may also be used to ensure medical necessity for MH/SUD and M/S services.
- **Category II—Utilization Management Limits Applied to Outpatient Services:** UM processes applied to OP MH/SUD and M/S services through PA, CR, and RR to ensure medical necessity.
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- **Category VI—Out-of-Network/Out-of-State Limits:** Out-of-network (OON) and out-of-state (OOS) limits that affect how members access OON and OOS providers and address how OHA and the CCOs ensure necessary access to providers not eligible to be reimbursed or not in a CCO's network.

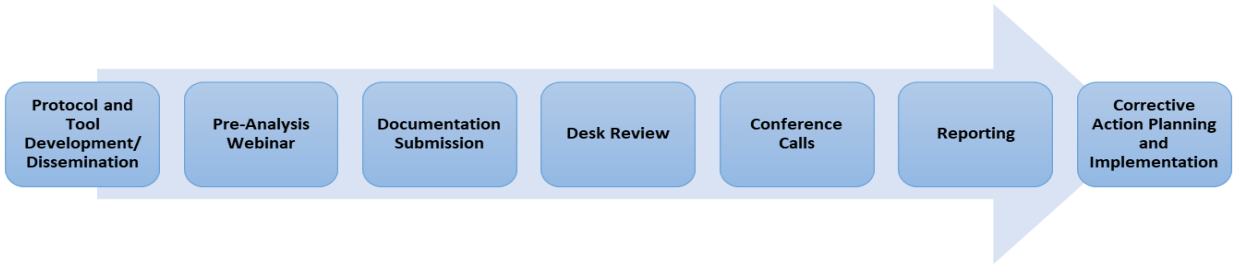
3. Process and Methodology

Building from the initial 2018 MHP Analysis, HSAG worked with OHA and the CCOs to conduct a follow-up MHP Analysis that evaluated changes to benefits design and operations that may impact parity. The 2020 MHP Analysis identified and addressed differences between the policies and standards governing limitations applied to MH/SUD services as compared to M/S services. 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.

Analysis Activities for 2020

The 2020 MHP Analysis activities are illustrated in Figure 3-1 and described below.

Figure 3-1—2020 MHP Analysis Activities



1. **Protocol and Tool Development and Dissemination:** HSAG developed and disseminated an MHP Analysis Protocol that presented details and guidance to OHA and the CCOs on the analysis process and included tools in which to conduct the 2020 MHP Analysis activity. The tools utilized for the analysis, identified below, were based on OHA's initial analysis of MHP and were developed using guidance outlined in the CMS *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*.
   - **MHP Evaluation Questionnaire**—Questions referencing the six NQTL categories, to identify changes that may impact parity.
   - **MHP Reporting Template**—Documentation of changes and additions to NQTLs previously reported in 2018, organized by the six NQTL categories.
   - **MHP Required Documentation Template**—UM and credentialing data across MH/SUD and M/S benefits and providers.

   Pre-Analysis Webinar: HSAG conducted a pre-analysis webinar on July 15, 2020, with OHA and the CCOs to provide an overview of MHP regulations, details of the protocol and tools, specifics of the analysis timeline, and examples of MHP scenarios for reference.
2. **Documentation Submission:** OHA and the CCOs were required to submit documentation that included responses to the MHP Evaluation Questionnaire and completed templates, along with supporting documentation, by August 31, 2020.

3. **Desk Review:** HSAG conducted a desk review of all submitted MHP Evaluation Questionnaires, the MHP Reporting Template, and required and supporting documentation (e.g., policies and procedures, benefit schedules, and delegate agreements) to analyze policies and operational practices that impact MHP and determine preliminary analysis findings.
4. **Conference Calls:** HSAG conducted conference calls to discuss preliminary analysis findings and areas in need of clarification. Additional information and documentation were requested at that time, as necessary to support the MHP Analysis.
5. **Reporting:** HSAG compiled analysis results and documented MHP determinations for each CCO and as compared to OHP FFS, identifying areas in which MHP had not been achieved and corrective actions were required to ensure future parity. OHA and each CCO had an opportunity to review report drafts prior to finalizing the reports.
6. **Corrective Action Planning and Implementation:** HSAG will work with OHA and the CCOs to develop and implement corrective action plans to achieve compliance with MHP requirements.

MHP Analysis Methodology

HSAG reviewers conducted a desk review of submitted MHP Analysis tools and supporting documentation to further clarify reported changes and additions to previously reported NQTLs from the initial MHP Analysis conducted in 2018. More specifically, HSAG evaluated responses to the MHP Evaluation Questionnaire to identify changes to benefits design and operations within OHA and each CCO that may impact MHP, cross-referenced questionnaire responses with changes and additions reported in the MHP Reporting Template, and reviewed supporting documentation submitted by OHA and the CCOs. Supporting documentation included, but was not limited to, UM policies, workflow diagrams, program descriptions, prescription drug formularies, and network admission/credentialing policies. HSAG conducted the 2020 MHP Analysis based on this information to determine compliance with parity guidelines, including ensuring that policies followed standard industry practice, allowed for little to no exception or variation, incorporated established State definitions and guidelines, included staff members qualified to make the decisions and complete the tasks assigned and appropriate oversight.

Information obtained via scheduled conference calls was also evaluated in relation to changes and additions reported. Differences in how limits were applied to MH/SUD services as compared to M/S services, in relation to comparability and stringency standards displayed in Table 3-1, were evaluated across the six NQTL categories for continued compliance with MHP regulations. Each CCO's NQTLs were additionally evaluated against OHP FFS MH/SUD and M/S NQTLs based on the structure of OHP benefit packages referenced in Section 1 of this report.

Table 3-1—Comparability and Stringency Standards

Comparability and Stringency Standard	Question Description
Benefits in Which NQTLs Apply	**1. To which benefits is an NQTL assigned?** *Purpose: To describe the NQTL assigned to MH/SUD and M/S benefits (e.g., PA, scope of services, and time frames).*
Comparability of Strategy	**2. Why is the NQTL assigned to these benefits?** *Purpose: To describe for what reasons or purpose the NQTL is assigned (e.g., ensure medical necessity, prevent overutilization, and comply with State and federal requirements).*
Comparability of Evidentiary Standard	**3. What evidence supports the rationale for the assignment?** *Purpose: To describe the evidence to support the rationale (e.g., benchmarks, standards that form the basis of the rationale, and State and federal requirements).*
Comparability of Processes	**4. What are the NQTL procedures?** *Purpose: To describe the NQTL process and evidence needed to support NQTL determinations (e.g., documentation requirements, timelines, and steps for the CCO and members/providers).*
Stringency of Strategy	**5. How frequently or strictly is the NQTL applied?** *Purpose: To describe the frequency of application, frequency of medical necessity and appropriateness reviews, level of discretion in how the NQTL is applied, triggers for review and re-review, etc.*
Stringency of Evidentiary Standard	**6. What standard supports the frequency or rigor with which the NQTL is applied?** *Purpose: To describe standards that the CCO uses to determine the frequency or rigor of NQTL procedures.*

Aggregated Analysis Results for 2020

Results of the MHP analyses were reported individually to OHP FFS and each CCO with limitations or other operational processes found to impact parity reported as findings. Required actions were also presented to each organization to support future compliance with MHP requirements as applicable. HSAG aggregated results from the MHP analyses as presented in Section 3.

4. MHP Analysis Results Summary

HSAG derived 2020 MHP Analysis results from the evaluation and observation of information obtained from the CCOs and OHP FFS, including:

- Responses to the 2020 MHP Evaluation Questionnaire.
- Reported data in the 2020 MHP Reporting Templates pertaining to NQTL categories.
- MHP data using the Required Documentation Template and supporting documentation as provided.
- Observations from conversations during conference calls conducted with CCOs and OHP FFS.

Results of the MHP Analysis are detailed below by each NQTL category. Specific details of each organization's analysis were reported separately in individual reports provided to OHA and CCOs.

Overall Analysis Results

Each CCO was responsible for delivering MH/SUD and M/S Medicaid benefits to members in CCOA and CCOB benefit packages. The CCOs additionally provided MH/SUD benefits to Medicaid members in CCOE and CCOG benefit packages, whereas OHP FFS fully managed M/S benefits for those two t packages. Most CCOs and OHP FFS delegated at least some UM functions to subcontractors including prior authorization and credentialing. All CCOs had agreements with community mental health programs (CMHPs) for delivering MH/SUD benefits with some CMHPs conducting UM on behalf of CCOs. HSAG evaluated the application of NQTLs to MH/SUD and M/S benefits in terms of comparability and stringency across the six NQTL categories.

Most CCO policies included standardized processes that applied to both MH/SUD and M/S benefits, including UM and PA policies and service authorization handbooks. None of the CCOs had separate policies for the management of benefits based on benefit package, which ensured consistency in the analysis across the packages. Overall, the CCOs and OHP FFS were compliant with MHP requirements with only a few areas identified as parity concerns.

For limits applied to IP and OP health benefits, CCOs and OHP FFS used UM processes to ensure coverage, medical necessity, appropriate treatment in the least restrictive environment that maintains the safety of the individual, compliance with federal and State requirements, and the prevention of overutilization. Evidence used to apply UM to MH/SUD and M/S benefits included Oregon Administrative Rules (OARs), Health Evidence Review Commission (HERC) Prioritized List (PL) and guidelines, InterQual guidelines, Milliman Care Guidelines (MCG), and American Society of Addiction Medicine guidelines, as well as guidelines developed by other medical professional entities.. NQTLs were managed by the CCOs and OHP FFS based on treatment guidelines, provider request, and member need.

All CCOs achieved parity for benefit packages CCOA and CCOB where they had full control over UM processes across both benefit types. However, many CCOs received findings for benefit packages CCOE and CCOG, where M/S benefits were being managed by OHP FFS. During 2019, OHP FFS established a 90-day retrospective review period for PA requests and an IRR process inclusive of an 80 percent testing standard. CCOs without a RR review period or a period of less than 90 days allowable for RR were issued findings of nonparity due to having more stringent processes for MH/SUD benefit authorizations as compared to M/S benefit authorizations administered by OHP FFS. Similarly, CCOs without an IRR process or a testing standard less than 80 percent were issued findings of nonparity related to the application of authorization decisions for IP and OP MH/SUD benefits which impacted the stringency of the application of NQTLs in that the method to promote consistency of IP and OP MH/SUD medical necessity determinations was not sufficiently structured as compared to IP and OP M/S processes. CCOs with the afore mentioned findings of nonparity in RR and IRR processes must make adjustments to promote consistency of medical necessity determinations in benefit packages CCOE and CCOG. Only one CCO had an inconclusive finding related to a higher denial rate for OP MH/SUD authorization requests as compared to OP M/S authorization requests, which will require the CCO to review its application of UM of OP PA requests to determine the basis for the higher rate of denials and to identify any parity concerns and opportunities for improvement.

HSAG's analysis of CCO and OHP FFS processes and operations did not reveal any explicit MHP concerns for the prior authorization of prescription drugs across the benefit packages. The application of PA for MH/SUD prescription drugs was comparable to PA for M/S prescription drugs and the organizations' authorization requirements, guidelines, procedures, and 24-hour responses were determined to be no more stringently applied to MH/SUD benefit requests when compared to M/S requests. Although there were data limitations in the ability to segregate data by benefit type, HSAG identified general concerns regarding the high rate of prescription drug denials for two CCOs. These concerns were identified as inconclusive findings with required actions for the CCOs to further assess pharmacy PA data for improvement opportunities.

For provider admission NQTL categories, the CCOs and OHP FFS fared well, with only three CCO analyses resulting in MHP findings. Regarding network closures, two affiliated CCOs reported that network closures occurred, but were unable to identify impacted providers due to the lack of a tracking mechanism. The inability to identify impacted providers due to network closures resulted in an inconclusive finding for both CCOs, requiring them to further analyze the impact of network closures to ensure issues related to parity do not exist. Network credentialing analyses across the CCOs did not reveal any findings related to comparability of processes, with all CCOs having an acceptable credentialing process; however, CCOs with credentialing data that revealed higher rates of denials or applications not accepted for MH/SUD providers seeking credentialing as compared to rates for M/S providers were issued inconclusive findings. While higher rates of MH/SUD providers not accepted for credentialing may not ultimately be a parity concern, the process of accepting applications should be further explored. Higher rates of denials that were consistent across both provider types were not called out in findings due to no impact on parity. OHP FFS was not analyzed against the CCOs due to the State not credentialing providers but instead enrolling them as Medicaid providers. This difference in process did not present a parity concern.

Finally, HSAG determined CCO and OHP FFS processes, strategies, and evidentiary standards for OON/OOS limits applied to MH/SUD to be comparable to and no more stringently applied, in writing and in operation, to M/S OON/OOS limits across all benefit packages. The same UM processes and evidentiary standards described in NQTL categories I, II, and III were applied to the management of OON/OOS benefits. All CCOs used some form of a single case agreement (or "letter of agreement") to contract with OON providers, which was consistent across both provider types. While OHP FFS's UM process for OOS requests was comparable across the two benefit types, the State did not use single case agreements for OON providers but instead enrolled the providers. The different processes employed by CCOs versus OHP FFS in utilizing OON providers did not present a parity concern.

HSAG summarized comparability and stringency compliance by organization in Table 4-1 below and data analysis results by organization in the areas of prior authorization for IP, OP, and prescription drugs, as well as credentialing and enrollment. Detailed findings and observations by organization were provided in MH Parity Reports developed for each organization.

Table 4-1—Overall MHP Analysis Results—Comparability and Stringency

C = Comparability; **S** = Stringency; √ = Compliant; X = Non-Compliant

Organization	Category I—UM Limits Applied to Inpatient Services		Category II—UM Limits Applied to Outpatient Services		Category III—Prior Authorization for Prescription Drug Limits		Category IV—Provider Admission—Closed Network		Category V—Provider Admission—Network Credentialing		Category VI—Out-of-Network/Out-of-State Limits	
	C	S	C	S	C	S	C	S	C	S	C	S
AH	√	X	√	X	√	√	√	√	√	√	√	√
AllCare	√	X	√	X	√	√	√	√	√	X	√	√
CHA	√	X	√	X	√	√	√	√	√	√	√	√
CPCCO	√	√	√	√	√	X	√	X	√	√	√	√
EOCCO	√	√	√	√	√	√	√	√	√	√	√	√
Health Share	√	√	√	√	√	√	√	√	√	√	√	√
IHN	√	√	√	√	√	√	√	√	√	√	√	√
JCC	√	√	√	√	√	X	√	X	√	√	√	√
PSCS-CG	√	X	√	X	√	√	√	√	√	√	√	√
PSCS-CO	√	X	√	X	√	√	√	√	√	√	√	√
PSCS-Lane	√	X	√	X	√	√	√	√	√	√	√	√
PSCS-MP	√	√	√	X	√	√	√	√	√	√	√	√
TCHP	√	√	√	X	√	√	√	√	√	√	√	√
UHA	√	√	√	√	√	√	√	√	√	√	√	√
YCCO	√	√	√	√	√	√	√	√	√	√	√	√
OHP FFS	√	X	√	X	√	√	N/A	N/A	N/A	N/A	√	√

Data Analysis Results

The CCOs and OHP FFS submitted UM data in the MHP Required Documentation Template, identifying PA counts and denial data for IP, OP, and prescription drug benefits. The reporting also included data on provider admission counts and terminations/denials, which includes data on applications accepted and not accepted. The completed templates included data from the period of January 1, 2020, through June 30, 2020. An analysis of the reported data and high-level observations is presented by organization in the subsections below.

Utilization Management for Inpatient/Outpatient Services

The CCOs and OHP FFS provided requested UM data for IP and OP services pertaining to authorization request counts and outcomes of requests. Table 4-2 presents each organization's counts for IP and OP PAs by benefit type, identifying the number of PA requests denied, appealed, and overturned.

Table 4-2—Prior Authorization Counts for Inpatient and Outpatient Services

IP and OP Prior Authorization Counts by Benefit Type								
Organization	Benefit Type	# of PA Requests	# of PA Requests Denied	% of PA Requests Denied	# of PA Denials Appealed	% of PA Denials Appealed	# of PA Denials Overtumed	% of PA Denials Overturned
AH	MH/SUD	374	45	12.03%	1	2.22%	0	0.00%
	M/S	7,492	2,074	27.68%	44	2.12%	6	0.29%
	Total	7,866	2,119	26.94%	45	2.12%	6	0.28%
AllCare	MH/SUD	907	51	5.62%	1	1.96%	1	1.96%
	M/S	20,356	1,164	5.72%	33	2.84%	8	0.69%
	Total	21,263	1,215	5.71%	34	2.80%	9	0.74%
CHA	MH/SUD	192	11	5.73%	0	0.00%	0	0.00%
	M/S	13,754	2,166	15.75%	72	3.32%	16	0.74%
	Total	13,946	2,177	15.61%	72	3.31%	16	0.73%
CPCCO	MH/SUD	394	11	2.79%	0	0.00%	0	0.00%
	M/S	5,966	516	8.65%	60	11.63%	31	6.01%
	Total	6,360	527	8.29%	60	11.39%	31	5.88%
EOCCO	MH/SUD	924	199	21.54%	33	16.58%	32	16.08%
	M/S	13,393	771	5.76%	26	3.37%	12	1.56%
	Total	14,317	970	6.78%	59	6.08%	44	4.54%

IP and OP Prior Authorization Counts by Benefit Type								
Organization	Benefit Type	# of PA Requests	# of PA Requests Denied	% of PA Requests Denied	# of PA Denials Appealed	% of PA Denials Appealed	# of PA Denials Overturned	% of PA Denials Overturned
Health Share	MH/SUD	66,036	106	0.16%	5	4.72%	2	1.89%
	M/S	89,989	6,940	7.71%	454	6.54%	182	2.62%
	Total	156,025	7,046	4.52%	459	6.51%	184	2.61%
IHN	MH/SUD	1,142	63	5.52%	3	4.76%	0	0.00%
	M/S	5,269	593	11.25%	57	9.61%	26	4.38%
	Total	6,411	656	10.23%	60	9.15%	26	3.96%
JCC	MH/SUD	1,608	26	1.62%	3	11.54%	0	0.00%
	M/S	13,462	1,403	10.42%	155	11.05%	77	5.49%
	Total	15,070	1,429	9.48%	158	11.06%	77	5.39%
PSCS-CG	MH/SUD	134	5	3.73%	0	0.00%	0	0.00%
	M/S	5,792	219	3.78%	16	7.31%	1	0.46%
	Total	5,926	224	3.78%	16	7.14%	1	0.45%
PSCS-CO	MH/SUD	1,284	57	4.44%	3	5.26%	1	1.75%
	M/S	34,815	1,567	4.50%	215	13.72%	42	2.68%
	Total	36,099	1,624	4.50%	218	13.42%	43	2.65%
PSCS-Lane	MH/SUD	787	15	1.91%	3	20.00%	1	6.67%
	M/S	36,190	1,373	3.79%	218	15.88%	50	3.64%
	Total	36,977	1,388	3.75%	221	15.92%	51	3.67%
PSCS-MP	MH/SUD	1,130	34	3.01%	6	17.65%	4	11.76%
	M/S	56,117	1,651	2.94%	209	12.66%	63	3.82%
	Total	57,247	1,685	2.94%	215	12.67%	67	3.98%
TCHP	MH/SUD	1,362	6	0.44%	0	0.00%	0	0.00%
	M/S	6,134	991	16.16%	24	2.42%	4	0.40%
	Total	7,496	997	13.30%	24	2.41%	4	0.40%
UHA	MH/SUD	970	75	7.73%	7	9.33%	1	1.33%
	M/S	13,250	1,567	11.83%	68	4.34%	11	0.70%
	Total	14,220	1,642	11.55%	75	4.57%	12	0.73%

IP and OP Prior Authorization Counts by Benefit Type								
Organization	Benefit Type	# of PA Requests	# of PA Requests Denied	% of PA Requests Denied	# of PA Denials Appealed	% of PA Denials Appealed	# of PA Denials Overturned	% of PA Denials Overturned
YCCO	MH/SUD	1,726	28	1.62%	1	3.57%	0	0.00%
	M/S	4,294	477	20.75%	99	20.75%	14	2.94%
	Total	6,020	505	19.80%	100	19.80%	14	2.77%
OHP FFS	MH/SUD	4,904	10	0.20%	0	0%	0	0%
	M/S	11,927	123	1.03%	0	0%	0	0%
	Total	16,831	133	0.80%	0	0%	0	0%

Observations

HSAG's analysis of PA data for IP and OP benefits revealed few concerns related to MHP, with only one CCO issued an inconclusive finding to be further assessed. The following data points were observed:

- The average denial rate across all organizations was 2.43 percent with MH/SUD PA denials representing only 3.05 percent of all denials.
- Of the 742 MH/SUD PA requests denied across all organizations, representing less than one percent of the 83,874 MH/SUD PA requests, 8.89 percent resulted in an appeal.
- Two CCOs had higher rates of denials for MH/SUD PA requests, but only one was issued a finding. The other CCO's high rate was based on a significantly small number of PA requests, which did not present a concern.
- The CCOs and OHP FFS reported varying denial reasons that HSAG organized into *medically necessary*, *not covered*, and *administrative issues* categories. Higher rates of denials were experienced for OP PA requests, with the primary categories of denials related to *medically necessary* and *not covered*.

Utilization Management for Prescription Drugs

The CCOs and OHP FFS provided requested data pertaining to prescription drug authorization request counts and outcomes. Table 4-3 presents each organization's PA counts for formulary and non-formulary prescription drug PA requests, identifying the number of requests overturned.

Table 4-3—Prior Authorization Counts for Prescription Drugs.

Prescription Dug Prior Authorization Counts (Formulary and Non-Formulary)							
Organization	# of PA Requests	# of PA Requests Denied	% of PA Requests Denied	# of PA Denials Appealed	% of PA Denials Appealed	# of PA Denials Overturned	% of PA Denials Overturned
AH	2,509	1,280	51.02%	12	0.94%	2	0.16%
AllCare	3,060	1,524	49.80%	20	1.31%	3	0.20%
CHA	7,521	1,723	22.91%	11	0.64%	2	0.12%
CPCCO	1,002	736	73.45%	7	0.95%	2	0.27%
EOCCO	2,416	1,118	46.27%	22	1.97%	12	1.07%
Health Share	10,402	5,120	49.22%	189	3.69%	94	1.84%
IHN	3,955	1,330	33.63%	50	3.76%	28	2.11%
JCC	1,788	1,269	70.97%	15	1.18%	4	0.32%
PSCS-CG	402	201	50.00%	34	16.92%	14	6.97%
PSCS-CO	2,203	1,203	54.61%	153	12.72%	65	5.40%
PSCS-Lane	2,321	562	24.21%	244	43.42%	106	18.86%
PSCS-MP	6,095	2,625	43.07%	376	14.32%	167	6.36%
TCHP	1,810	891	49.23%	31	3.48%	18	2.02%
UHA	3,558	1,688	47.44%	22	1.30%	4	0.24%
YCCO	1,046	348	33.27%	2	0.57%	2	0.57%
OHP FFS	16,499	2,587	15.68%	139	5.37%	92	3.56%

Observations

HSAG's analysis of CCO and OHP FFS counts for prescription drug PA requests did not reveal any direct concerns related to parity; however, the prescription drug PA data was not analyzed by benefit type due to limitations in the data analysis not including diagnosis code mapping. Two CCOs received inconclusive findings due to significantly high denial rates. The following data points were observed:

- Of the total 66,587 prescription drug PA requests reported across all organizations, 36.35 percent were denied.
- Only 5.48 percent of the 2,587 prescription drug PA request denials were appealed, with less than three percent of the total denials resulting in an overturned decision.
- The majority of the CCOs had denial rates between 40 and 50 percent, although the high denials rates can be attributed to coverage guidance that is generally more restrictive for prescription drugs than for health care services.
- Two CCOs received inconclusive findings due to significantly high denial rates that should be further explored; however, those CCOs had comparable processes and reported on efforts related to frequent formulary and PA request reviews.

- The CCOs and OHP FFS reported varying denial reasons that HSAG organized into *medically necessary*, *not covered*, *non-formulary*, and *administrative issues* categories. The majority of denied prescription drug PA requests were denied for *not covered* and *not medically necessary* categorical reasons.

Enrollment/Credentialing

OHP FFS and the CCOs provided requested data pertaining to provider enrollment/credentialing requests and outcomes. Table 4-4 presents each organization's enrollment/credentialing counts by provider type, identifying the number of terminations and denials, including applications not accepted.

Table 4-4—Enrollment/Credentialing Counts by Provider Type

Enrollment/Credentialing Counts by Provider Type							
Organization	**Provider Type**	**Avg. # Enrolled Providers**	**# Providers Terminated**	**% Terminated**	**# of Cred. Requests**	**# of Cred. Requests Denied/Not Accepted**	**% of Cred. Requests Denied/Not Accepted**
AH	MH/SUD	161	0	0.00%	24	0	0.00%
	M/S	274	0	0.00%	27	0	0.00%
	Total	**435**	**0**	**0.00%**	**51**	**0**	**0.00%**
AllCare	MH/SUD	210	NR*	--	15	7	46.67%
	M/S	1,475	NR	--	113	34	30.09%
	Total	**1,685**	**--**	**--**	**128**	**41**	**32.03%**
CHA	MH/SUD	127	0	0.00%	8	3	37.50%
	M/S	223	7	3.14%	53	5	9.43%
	Total	**350**	**7**	**2.00%**	**61**	**8**	**13.11%**
CPCCO	MH/SUD	978	NR	--	101	0	0.00%
	M/S	12,314	NR	--	375	2	0.53%
	Total	**13,292**	**--**	**--**	**476**	**2**	**0.42%**
EOCCO	MH/SUD	1,247	3	0.24%	51	0	0.00%
	M/S	7,020	5	0.07%	137	0	0.00%
	Total	**8,267**	**8**	**0.10%**	**188**	**0**	**0.00%**

Enrollment/Credentialing Counts by Provider Type							
Organization	Provider Type	Avg. # Enrolled Providers	# Providers Terminated	% Terminated	# of Cred. Requests	# of Cred. Requests Denied/Not Accepted	% of Cred. Requests Denied/Not Accepted
Health Share	MH/SUD	3,428	0	0.00%	326	0	0.00%
	M/S	21,451	111	0.52%	5,906	9	0.15%
	Total	**24,879**	**111**	**0.45%**	**6,232**	**9**	**0.14%**
IHN	MH/SUD	1,746	13	0.74%	51	13	25.49%
	M/S	10,157	113	1.11%	255	55	21.57%
	Total	**11,903**	**126**	**1.06%**	**306**	**68**	**22.22%**
JCC	MH/SUD	978	NR	--	101	0	0.00%
	M/S	12,314	NR	--	375	2	0.53%
	Total	**13,292**	**--**	**--**	**476**	**2**	**0.42%**
PSCS-CG	MH/SUD	3,661	13	0.36%	2,073	31	1.50%
	M/S	11,135	47	0.42%	3,119	9	0.29%
	Total	**14,796**	**60**	**0.41%**	**5,192**	**40**	**0.77%**
PSCS-CO	MH/SUD	3,661	13	0.36%	2,073	31	1.50%
	M/S	11,135	47	0.42%	3,119	9	0.29%
	Total	**14,796**	**60**	**0.41%**	**5,192**	**40**	**0.77%**
PSCS-Lane	MH/SUD	3,661	13	0.36%	2,073	31	1.50%
	M/S	11,135	47	0.42%	3,119	9	0.29%
	Total	**14,796**	**60**	**0.41%**	**5,192**	**40**	**0.77%**
PSCS-MP	MH/SUD	3,661	13	0.36%	2,073	31	1.50%
	M/S	11,135	47	0.42%	3,119	9	0.29%
	Total	**14,796**	**60**	**0.41%**	**5,192**	**40**	**0.77%**
TCHP	MH/SUD	2,030	392	19.31%	317	0	0.00%
	M/S	9,722	2,556	26.29%	662	1	0.15%
	Total	**11,752**	**2,948**	**25.09%**	**979**	**1**	**0.10%**
UHA	MH/SUD	60	6	10.00%	15	2	13.33%
	M/S	259	11	4.25%	33	8	24.24%

Enrollment/Credentialing Counts by Provider Type							
Organization	Provider Type	Avg. # Enrolled Providers	# Providers Terminated	% Terminated	# of Cred. Requests	# of Cred. Requests Denied/Not Accepted	% of Cred. Requests Denied/Not Accepted
	Total	**319**	**17**	**5.33%**	**48**	**10**	**20.83%**
YCCO	MH/SUD	209	0	0.00%	39	1	2.56%
	M/S	87	0	0.00%	436	0	0.00%
	Total	**296**	**0**	**0.00%**	**475**	**1**	**0.21%**
OHP FFS	MH/SUD	2,314	91	0.63%	NR	--	--
	M/S	9,569	5,337	6.81%	NR	-	--
	Total	**11,883**	**5,428**	**5.85%**	**--**	**--**	**--**

*NR refers to *Not Reported*.

Observations

HSAG's analysis of CCO and OHP FFS provider credentialing data revealed few direct parity concerns due to overall low denial rates reported for providers seeking credentialing during the reporting period. However, a few CCOs had higher rates of denials or applications not accepted during the enrollment period that resulted in inconclusive findings. The following data points were observed:

- Of the 157,537 reported average number of providers enrolled/credentialed during the reporting period, 17.86 percent were MH/SUD providers.
- The average denial rate for all provider types was 5.64 percent, with 1.98 percent of MH/SUD providers denied as compared to 6.44 percent of M/S providers denied.
- Two CCOs provided data revealing higher rates of denials or applications not accepted for MH/SUD providers than for M/S providers seeking credentialing, which should be further explored for barriers to provider participation or opportunities for improvement.

Additional Requirement Results

HSAG requested information from the CCOs and OHP FFS on the required availability of medical necessity determinations regarding MH/SUD benefits to members, potential members, and contracting providers upon request, and how reasons for denial of reimbursement or payment for MH/SUD benefits were made available to members. Each organization described its processes on notices of adverse benefit determination (NOABDs) and how the notices describe denial reasons for members. The CCOs and OHP FFS provided NOABD examples, confirming that denial reasons inclusive of medical necessity determinations were made available to members. A review of each organization's website

showed that resources were available for members that included information on MH/SUD benefits available, prior authorization grids, prescription drug formularies, and clinical practice guidelines. Based on the information reviewed, HSAG did not issue any findings related to the additional MHP administrative requirements.

5. OHA MHP Analysis Recommendations

Based on the 2020 MHP analysis results across the CCOs and OHP FFS, HSAG developed recommendations for OHA to pursue to ensure continued compliance with MHP requirements. HSAG recommendations are listed below.

General Activities

OHP FFS Collaboration with CCOs on Operational Changes that Could Impact MHP

Given that CCOs share responsibility with OHP FFS for the provision of benefits to Medicaid members under the CCOE and CCOG benefit packages, OHP FFS should develop a mechanism to track and communicate changes to OHP FFS processes that could impact MHP across the two benefit packages. Operational areas for which OHP FFS should track and communicate changes to CCOs include adjustments to UM processes for IP, OP, and prescription drug benefits, as well as adjustments to OON/OOS benefit management.

Annual Attestations

To ensure CCOs are regularly monitored for continued compliance with MHP regulations, OHA should require CCOs to submit an annual attestation certifying whether policies have changed in a way that could impact MHP. In addition, CCOs should be required to list any adjustments made over the previous year in support of providing enhanced quality services for MH/SUD benefits. This would additionally allow OHA to obtain information from CCOs on operational activities in support of MH/SUD benefit delivery that could be shared as best practices or implemented by the OHP FFS program.

Material Change Criteria

States are required to 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. HSAG recommends that OHA develop material change criteria that establishes triggering events for which a MHP Analysis should occur. This could include changes to CCO or OHP FFS delegation agreements involving the management of UM for MH/SUD or M/S benefits, substantive CCO Health Care Services Contract changes impacting UM, and changes to provider admission policies. Material changes triggers could be assessed via annual attestations as recommended above.

Records Review Activities

2021 MHP Medical Records Review

HSAG's 2020 analysis of IP, OP, and prescription drug UM data revealed various PA policies and procedures as well as various levels of denial categorization and reporting details. To further understand UM decision

details and their impact on parity, HSAG recommends a review of CCO and OHP FFS PA records encompassing both MH/SUD and M/S denials. The MHP records review should include the following:

- A sampling of MH/SUD and M/S records from each CCO that include denials.
- A review of the sampled records focusing on adherence to each CCO's UM policies and denial description detail.
- Record review tools to be completed by HSAG reviewers for each CCO and OHP FFS.
- An aggregate report documenting observations and results by CCO and for OHP FFS.

2022 MH/SUD Provider Validation Records Review

Provider credentialing is generally required for licensed providers, whereas validation of qualifications is required for unlicensed MH/SUD providers, of which there are many (e.g., Qualified Mental Health professionals, traditional health workers, substance use disorder counselors, etc.). The 2020 MHP analysis focused on credentialing data, and did not fully assess the validation of unlicensed MH/SUD provider qualifications. Because many of the CCOs delegate the validation of MH provider qualifications for the provision of MH/SUD services to Medicaid members, a randomized sample of MH/SUD provider validation documentation from both the CCOs and their delegates should be reviewed to ensure all validation components are validated and documented. The MH/SUD provider validation documentation review should include the following:

- A sampling of unlicensed MH/SUD provider validation records for each CCO.
- A review of the sampled MH/SUD provider validation records focusing on adherence to relevant federal and State requirements and each CCO's provider validation policies and procedures.
- Record review tools to be completed by HSAG reviewers for each CCO and OHP FFS.
- An aggregate report documenting observations and results by CCO and for OHP FFS.

2023 MHP Claims Denial Records Analysis

While further assessment should be done to determine the appropriateness and scope of a MH/SUD claims denial records analysis, HSAG recommends OHA consider conducting such an analysis. Claims level detail was not included in the 2020 MHP analysis but could help determine, in operation, whether parities exist in claims processing operations across the CCOs and within OHP FFS. HSAG will engage OHA in further discussions on this type of analysis.

6. Next Steps

Improvement Plan Implementation

To the extent MHP findings or concerns were found, each CCO was instructed to complete and submit an improvement plan addressing corrective actions/interventions to resolve all MHP findings. The improvement plan template must identify the following:

- Interventions planned by the organization to achieve MHP compliance.
- Individual(s) responsible for ensuring that the planned interventions are completed.
- Proposed timeline for completing each planned intervention with the understanding that most corrective actions/interventions can be completed within three months and no longer than six months. Corrective actions/interventions requiring additional time will need to include specific information to determine the appropriateness of the extended time frame.

CCO Improvement plans were due to HSAG by March 5, 2021 following the dissemination of the final 2020 MHP Analysis reports on February 5, 2021. HSAG will review the improvement plans to evaluate the sufficiency of each corrective action/interventions identified to bring CCO performance into compliance. HSAG will identify any discrepancies and require resubmission of improvement plans until they are approved. Quarterly reviews of improvement plan progress will be conducted with each CCO via desk reviews and conference calls as necessary to ensure that all planned corrective actions and interventions are completed.

OHA MHP Analysis Recommendations Implementation

Upon OHA's review of this aggregated 2020 MHP Analysis Summary and the individual CCO and OHP FFS reports, HSAG will work with OHA to implement approved recommendations and ongoing MHP monitoring activities. Each new and ongoing activity will be developed with an accompanying protocol for which to describe and carry out the activity. HSAG will be available to the CCOs and OHP FFS for technical assistance needed in support of MH Parity Activities.