Oregon Health Authority

2022 Mental Health Parity Analysis Summary Report

December 2022

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. New for the 2022 analysis, Oregon House Bill 3046 (HB 3046) outlines additional MHP reporting requirements for coordinated care organizations (CCOs) and the Oregon Health Plan fee-for-service (OHP FFS), evaluations of which are to be included in an annual comprehensive report to the Oregon Legislature by Oregon Health Authority (OHA).

To comply with federal and State requirements, 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.

The 2022 analysis included a review of each CCO's and OHP FFS' attestation of continued compliance with parity requirements for MH/SUD and M/S benefits as well as a comprehensive review of claims, utilization management (UM), and provider credentialing data. The 2022 MHP Analysis and report were designed to assess parity across MH/SUD and M/S benefits and support the work of OHA and its MHP community partners in developing parity-based network adequacy and timeliness measures to inform future studies.

Table 1-1 describes the organizations evaluated in the 2022 MHP Analysis and the associated organization abbreviations.

Table 1-1—List of Organization Names and Abbreviations

Organization Name	Organization Abbreviation
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	Health Share
InterCommunity Health Network	IHN
Jackson Care Connect	JCC
PacificSource Community Solutions–Central Oregon	PCS-CO
PacificSource Community Solutions–Columbia Gorge	PCS-CG
PacificSource Community Solutions–Lane	PCS-Lane
PacificSource Community Solutions–Marion Polk	PCS-MP
Trillium Community Health Plan, Inc.–North	TCHP-North
Trillium Community Health Plan, Inc.–South	TCHP-South
Umpqua Health Alliance, LLC	UHA
Yamhill Community Care Organization	YCCO
Oregon Health Plan Fee-for-Service	OHP FFS

Objectives

The primary objectives of the MHP activity were:

- Assess documentation submitted by each CCO and OHP FFS to determine compliance with MHP requirements outlined in 42 CFR §438 Subpart K and HB 3046.
- Evaluate CCO and OHP FFS parity of MH/SUD benefits as compared to M/S benefits provided under OHP managed care benefit packages.
- Identify areas for improvement and provide recommendations to ensure compliance with MHP requirements and improve MH/SUD services.
- Gather information and perspective regarding findings from the documentation review, data analysis, and compliance determinations during meetings with community partners.
- Identify potential areas of interest from community partners to inform the scope of the 2023 MHP activity.
- Prepare a comprehensive report inclusive of all 2022 MHP activity findings and input from community partners for OHA to submit to the Oregon Legislative Assembly as required by HB 3046.

2. Process and Methodology

The 2022 MHP Analysis identified and addressed differences between the policies and standards, implemented during calendar year (CY) 2021, governing limitations applied to MH/SUD services 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.

Technical Methods of Data Collection

The 2022 MHP activities are described below.

1. **Protocol Development and Dissemination:** HSAG developed the 2022 MHP Analysis Protocol, which presented details and guidance to OHA, the CCOs, and the OHP FFS on the process for conducting the 2022 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*.[2-1]
   - **2022 MHP Annual Attestation Form**—A standardized form inclusive of questions pertaining to delegation and operational changes that may impact parity and identify adjustments made over the previous year in support of providing enhanced quality services for MH/SUD benefits for the purposes of sharing best practices.
   - **2022 MHP Data Submission Template**—A Microsoft Excel file that provided requirements for the reporting of claims, UM, and provider credentialing data across MH/SUD and M/S benefits and providers.
2. **MHP Technical Assistance Webinar:** HSAG conducted a webinar with the CCOs and OHP FFS on March 10, 2022. The webinar provided an overview of MHP regulations, details of the 2022 MHP Analysis Protocol and tools, an overview of the MHP Analysis timeline, examples of operational changes that may impact parity, and an opportunity for questions and answers. HSAG and OHA produced a Questions & Answers 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 MHP documentation, including the completed annual attestation form, supporting documentation, and data submission template on or before June 1, 2022.

[2-1] Centers for Medicare & Medicaid Services. *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*, January 17, 2017. Available at: https://www.medicaid.gov/sites/default/files/2019-12/parity-toolkit.pdf. Accessed on July 15, 2022.

4. **Desk Review:** HSAG conducted a desk review of each CCO's and OHP FFS' submitted attestation form, supporting documentation, and data records to assess whether documentation submitted continued to comply with parity requirements and conduct an analysis of the administrative data.
5. **Follow-up Conferences:** HSAG conducted follow-up conferences with each CCO and OHP FFS as necessary to discuss any areas in need of clarification.
6. **Reporting:** HSAG compiled the preliminary results for each CCO and OHP FFS, including an analysis of the administrative data, and provided the information to OHA and its MHP community partners to perform the comparative analysis for final determination of parity. Each CCO and OHP FFS had an opportunity to review initial results and provide feedback prior to finalizing the reports. Information collected during OHA's meetings with community partners related to the adequacy of the provider network, timeliness of access to MH/SUD treatment and services, and services requested that the CCOs are not required to cover was included in this report. This information along with findings from the 2022 MHP activity were used to draw conclusions and inform decisions regarding the scope of the 2023 MHP activity.
7. **Coordination of Follow-Up Activities:** Based on documentation of findings, HSAG will work with OHA to coordinate follow-up activities (e.g., MHP activity development) and assist organizations in achieving compliance with MHP requirements.

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 completed and submitted by each organization, including, but not limited to:

- The 2022 Annual MHP Attestation Form, including narrative responses to all applicable questions and supplemental documentation.
- Detailed, member-level utilization data files.
- Reported rates for aggregated counts of claims, UM decisions, and provider enrollment and credentialing.

Additionally, OHA convened meetings with three groups of community partners (i.e., consumers, CCOs, and providers) to solicit community input on the MHP Analysis 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 during the 2022 MHP evaluation.

Annual MHP Attestation Analysis

For its review of the 2022 Annual MHP Attestation Form, 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 organizational structure and/or processes to managing 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 each CCO's and OHP FFS' performance was compliant with parity requirements based on whether the changes identified by the organization 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 specific element on the attestation form was not applicable to a CCO or OHP FFS during the period covered by HSAG's review. This scoring methodology aligned with CMS' Parity Compliance Toolkit.[2-2] HSAG reviewed all submitted documentation outlining regulatory and contractual provisions, each organization's website, and information available from the 2020 and 2021 MHP analyses. If a related operational change was reported in the 2022 Annual MHP Attestation Form, HSAG referenced the corresponding supporting documentation to determine compliance.

Table 2-1—Rating Definitions for Attestation 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*.
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*.

From the ratings assigned to each of the attestation elements, HSAG calculated a total compliance score for each applicable attestation 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)

[2-2] 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. Available at: https://www.apna.org/wp-content/uploads/2021/03/parity_toolkit_CMS.pdf. Accessed on: Oct 11, 2022.

elements, and the number of *Not Compliant* (0 points) elements. Elements *Not Applicable* to the organization are scored *NA* and are not included in the total score. Table 2-2 provides an example of the result tables used in the following report to display CCO and OHP FFS results.

Table 2-2—MHP Attestation Review Results

Oregon (OR) 2022 MHP Attestation Form Element	Total # of Change(s) Noted in 2021	Total # of Change(s) *Compliant* With Parity Standards	Compliance Score
General Questions—Delegation & Medical Guidelines/Evidence	# or NA	# or NA	% or NA
Utilization Management (Inpatient [IP], Outpatient [OP], and Pharmacy [Rx])	# or NA	# or NA	% or NA
Provider Admission Criteria	# or NA	# or NA	% or NA
Out-of-Network (OON)/Out-of-State (OOS) Limits	# or NA	# or NA	% or NA
Enhanced Quality Services MH/SUD Information	# or NA	# or NA	% or NA
Overall Compliance Score	**# or NA**	**# or NA**	**% or NA**

Administrative Data Profiles

To further understand the impact of CCO and OHP FFS policies and procedures on the management of MH/SUD and M/S benefits, HSAG evaluated CCO and OHP FFS data collected between January 1, 2021, and December 31, 2021, across three key domains. The data included aggregate counts for claims and UM decisions for MH/SUD and M/S services as well as MH/SUD and M/S provider enrollment data. 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 support the Administrative Data Profiles included services covered through four OHP benefit packages[2-3] (i.e., CCOA, CCOB, CCOE, and CCOB).

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 2-3, to

[2-3] Oregon Health Plan 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).

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

Table 2-3—Deviation Rating Definitions for Administrative Data Profile

Deviation Rating	Definition
None	Difference between MH/SUD and M/S profile metric is **less than** 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.

MHP Community Partner Input

In alignment with the requirements in HB 3046, OHA initiated meetings with three different community partner groups to solicit feedback from the community and provide input on both the assessment of parity as well as the direction of future MHP analyses. The community partner groups were composed of OHP members, CCOs, and providers and were initially convened between March and June of 2022. These discussion-oriented meetings served three key objectives:

1. Inform community partners of the 2022 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 community partner 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. Stakeholder Feedback.

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

- Evaluation results from the 2022 MHP Analysis, including a summary of findings from the Annual Attestation Analysis and Administrative Data Profile.
- Conclusions drawn from the CCO and OHP FFS findings.
- Recommendations for methodology changes in future MHP evaluations.

Table 2-4 contains a list of community partner groups and meeting dates in 2022. OHA coordinated meetings in fall 2022 to review preliminary findings and provide feedback on the proposed 2023 MHP Analysis study design. The consumer partner group opted to conduct closing meetings in October 2022 while the provider partner group met in November 2022. The CCO partners received preliminary copies of MHP findings in October 2022, and were provided an opportunity to review the results and submit written feedback. Additional meetings will be held with all MHP community partners to review and provide feedback on the proposed study design for the 2023 MHP Analysis.

Table 2-4—MHP Community Partner Groups and Meeting Dates

MHP Stakeholder	Initial Meeting	Closing Meeting(s)
Consumers	03/07/2022	10/12/2022 and 10/14/2022
CCOs	04/25/2022	11/10/2022
Providers	06/10/2022	11/18/2022

OHA then, in collaboration with its community partner groups, made final determinations regarding each CCO's and OHP FFS' compliance with parity requirements.

Reporting

Once feedback from OHA and the community partner 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.

Pursuant to 42 CFR §438.364, final MHP results will be aggregated across all CCOs and reported to CMS in the State's annual technical report that encompasses results from all external quality review (EQR) activities conducted in 2022, including the degree to which managed care entities (MCEs) have effectively addressed recommendations made by the EQRO during the previous year's activities.

3. Results

This section contains the results from the 2022 MHP Analysis and includes the qualitative and quantitative findings associated with the Annual Attestation Analysis and Administrative Data Profile, as well as key points derived from the MHP community partner meetings. 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.

Attestation Reviews

Based on HSAG's review of the 2022 Annual Attestation Forms and accompanying supplemental documentation, the CCOs and OHP FFS continued to demonstrate compliance with MHP requirements and parity standards. The annual attestations required the CCOs and OHP FFS to identify any operational areas where changes were implemented in CY 2021 that could potentially impact benefit parity. HSAG staff members reviewed the scope of these changes and assessed whether there was any impact on parity. Table 3-1 presents a summary of that review, including the number of operational changes identified by the CCOs, the number of changes compliant with parity standards, and the subsequent compliance score.

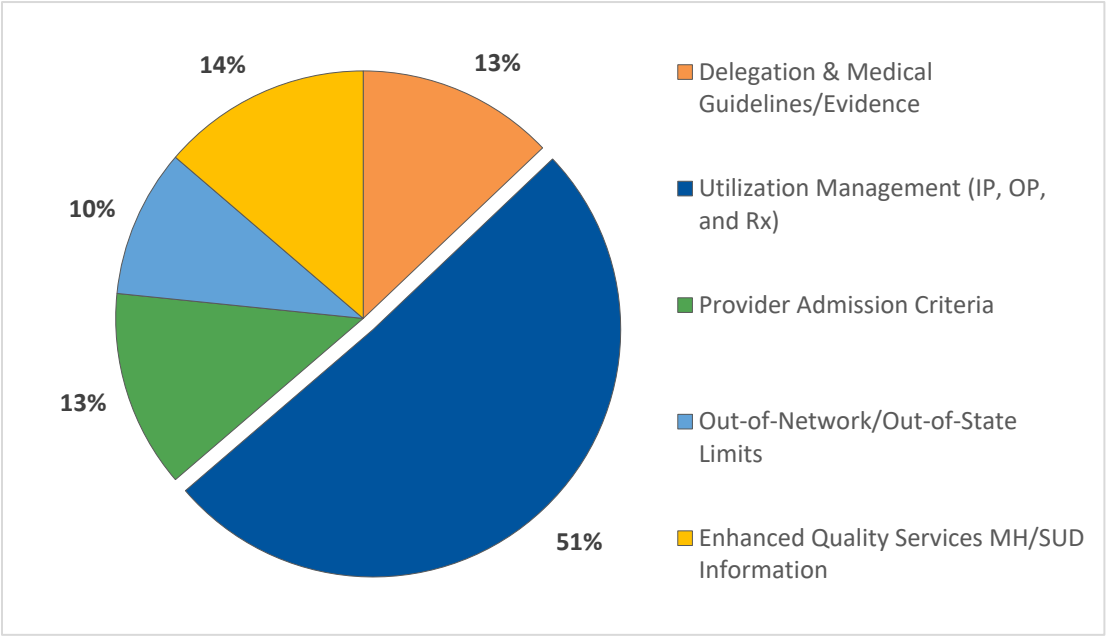
Table 3-1—Overall MHP Attestation Review Results

CCO Name	Total # of Change(s) Noted in 2021	Total # of Change(s) *Compliant* With Parity Standards	Compliance Score
AH	3	3	100%
AllCare	2	2	100%
CHA	8	8	100%
CPCCO	7	7	100%
EOCCO	3	3	100%
Health Share	12	12	100%
IHN	8	8	100%
JCC	7	7	100%
PCS-CG	13	13	100%
PCS-CO	13	13	100%
PCS-Lane	13	13	100%
PCS-MP	13	13	100%
TCHP-North	6	6	100%
TCHP-South	8	8	100%

CCO Name	Total # of Change(s) Noted in 2021	Total # of Change(s) *Compliant* With Parity Standards	Compliance Score
UHA	1	1	100%
YCCO	N/A	N/A	N/A
Overall CCO Performance	**117**	**117**	**100%**
OHP FFS	7	7	100%

In total, 117 operational changes were noted in CY 2021 across the 16 CCOs ranging from one program change (UHA) to 13 changes (PCS-CG, PCS-CO, PCS-Lane, and PCS-MP). YCCO was the only CCO that attested to making no operational changes affecting the administration of M/S and MH/SUD benefits. OHP FFS reported seven changes. However, none of the changes identified by the CCOs and OHP FFS during the attestation review negatively impacted parity; all organizations demonstrated continued parity between MH/SUD and M/S services. Figure 3-1 displays the percentage of changes associated with the five domains evaluated in the attestation analysis—Delegation and Medical Guidelines/Evidence; Utilization Management (IP, OP, and Rx); Provider Admission Criteria; Out-of-Network/Out-of-State Limits; and Enhanced Quality Services MH/SUD Information.

Figure 3-1—Operational Changes by MHP Attestation Form Element



Overall, the changes associated with utilization management accounted for just over half (51 percent) of the changes identified by the CCOs and FFS, while changes associated with OON/OOS limits represented the fewest (10 percent). However, none of the changes were identified as causing MH/SUD benefits to be more restrictive than M/S benefits offered, with respect to financial requirements, QTLs,

NQTLs, or annual/ lifetime dollar limits on benefit payments. The changes made during CY 2021 most often included:

- Updates to organizations' health information systems to support billing and claims, UM, case management, data collection and reporting, and monitoring operations.
- Revisions to policies and procedures to align health plan services with changes made to federal and State regulations or guidelines within the review period.
- Eliminating PA requirements for certain services, including:
  - Waiving PA requirements for the first seven days of OON skilled nursing facility stays.
  - Terminating temporary programs that had (1) waived all PA requirements for MH/SUD care and (2) allowed members to seek care from any provider, even OON.
  - Reduced the allowable time to respond to SUD service requests and eating disorder residential services.
- Changes and/or enhancements to organizations affecting delivery system networks, including:
  - Expanding access to and implementation of telehealth services.
  - Opening previously closed networks for MH/SUD providers in response to member needs.

The CCOs and OHP FFS noted that the updates incorporated into their policies, procedures, and systems were designed to:

- Improve patient outcomes.
- Increase oversight (e.g., internal quality reviews) of quality, timeliness, and access to MH/SUD services.
- Improve communication to members by standardizing language in member materials.
- Increase collaboration with community stakeholders.

The CCOs and OHP FFS were compliant with federal and State parity standards; there were no findings or recommendations associated with the attestation review.

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[3-1]
- UM, including IP, OP, and Rx coverage determinations
- Provider enrollment

[3-1] Claims data included dental and non-emergency medical transport (NEMT) claims, but excluded pharmacy claims.

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.[3-2] 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–Appendix Q.

Any partial denials (e.g., a claim with both paid and denied detail lines, or a PA decision that was partially denied) were classified as full denials.

Claims

To conduct the claims analysis, the CCOs and OHP FFS submitted claims counts that encompassed all covered services (except Rx[3-3]) by claim type (i.e., IP and OP) and provider network status (i.e., in-network [IN] and OON). The total number of IP and OP claims was counted at the header level and reported as the total number paid and denied overall and by network status. Since claim paid status is determined at the detail line level, claims were defined as *paid* if all detail lines were paid, while claims were defined as *denied* if at least one detail claim line was denied. 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 claims that were paid versus denied, moderate and substantial differences in rates identify areas where operational policies and procedures (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 identified greater rates of payment for MH/SUD services over M/S services.

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. Individual CCOs and OHP FFS exhibited considerable variation in payment rates across all stratifications. However, when individual CCO and OHP FFS differences were moderate or substantial, the deviation was generally due to a higher percentage of paid MH/SUD claims versus paid M/S claims. The following figures display the results of

[3-2] 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.

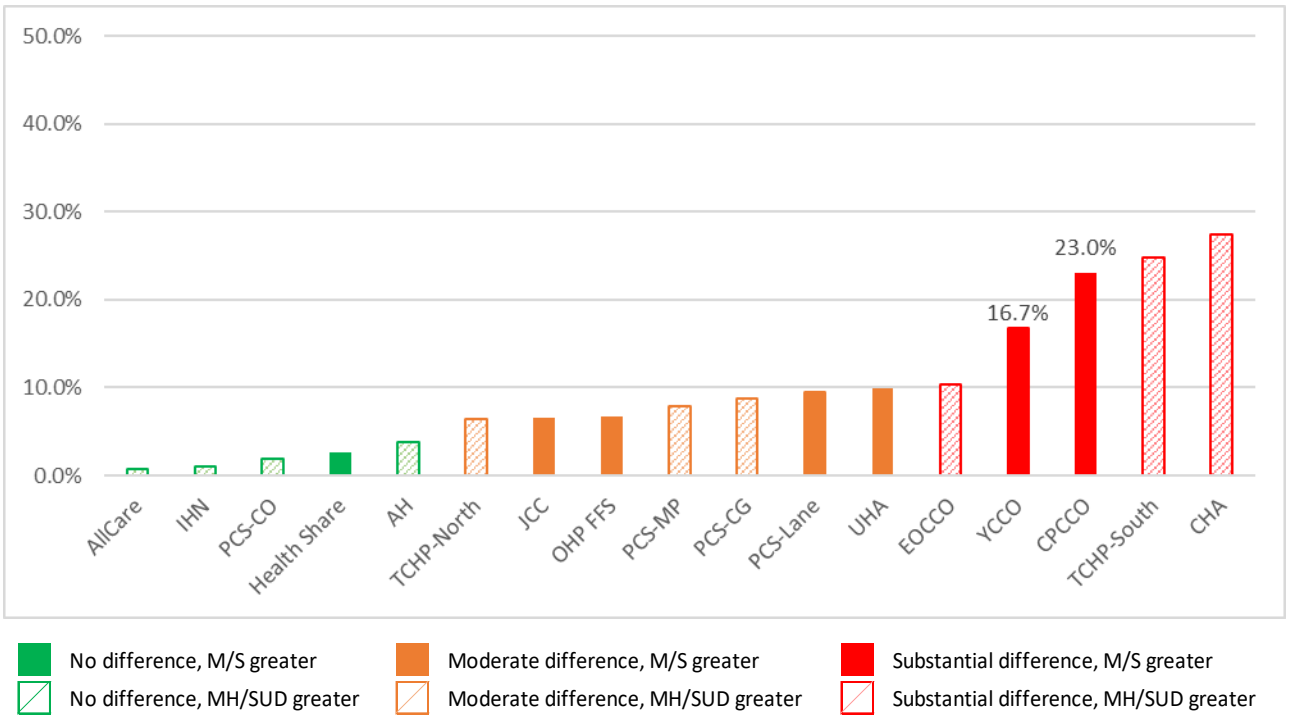
[3-3] Pharmacy claims were excluded from the analysis due to absence of diagnosis code on incoming claims. As a result, the CCOs and OHP FFS were unable to distinguish and classify individual claims as MH/SUD or M/S.

the comparisons in the percentage of paid MH/SUD and M/S claims for all CCOs and OHP FFS. The larger the number, the greater the difference between the percentage of paid claims 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 lower percentage of MH/SUD claims were compared to M/S claims.

Inpatient Claims

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

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

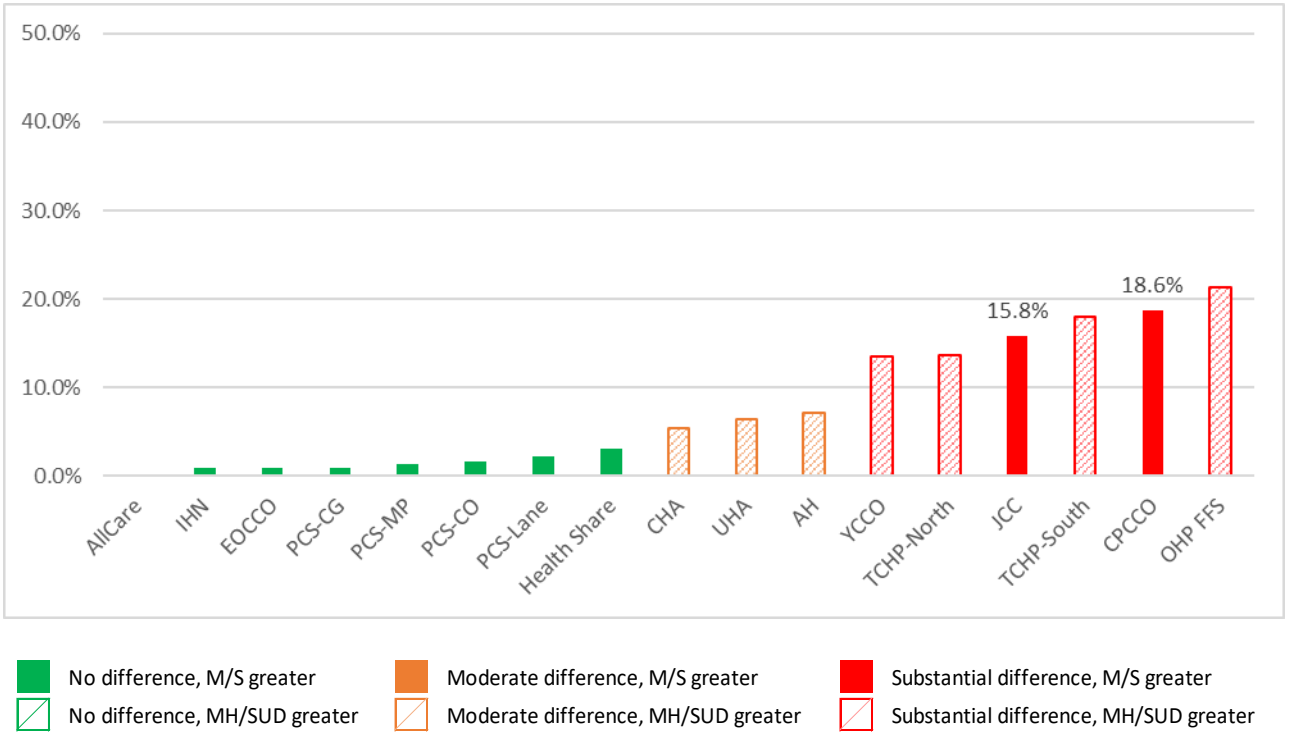


Overall, the difference in the statewide CCO percentage of IP paid claims for MH/SUD (79.4 percent) and M/S (81.0 percent) services was negligible at 1.5 percentage points, with individual CCO differences ranging from 0.8 percentage points (AllCare) to 27.5 percentage points (CHA). Five CCOs exhibited substantial differences in the percentage of paid IP claims; however, only two CCOs exhibited substantial differences where IP MH/SUD claims had a substantially lower paid rate than IP M/S claims (CPCCO [23.0 percentage points] and YCCO [16.7 percentage points]). Among the remaining CCOs, seven exhibited a moderate difference in the percentage of IP paid claims, as well as OHP FFS. The remaining five CCOs (AllCare, IHN, PCS-CO, Health Share, and AH) had less than a 5 percentage-point difference in IP paid claims rates.

Outpatient Claims

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

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

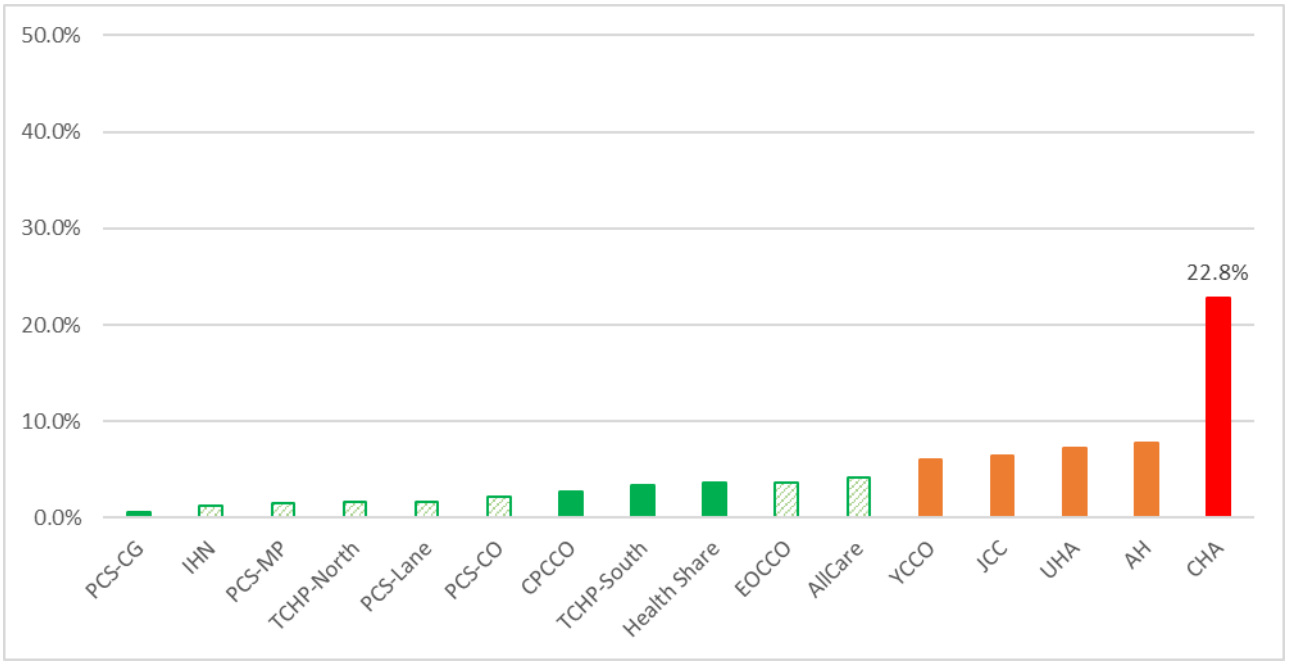


Similar to IP claims, the difference in the statewide CCO percentage of OP paid claims for MH/SUD (90.0 percent) and M/S (87.0 percent) services was negligible at 3.0 percentage points, with individual CCO differences ranging from 0.1 percentage points AllCare) to 18.6 percentage points (CPCCO); OHP FFS exhibited the greatest difference at 21.4 percentage points. Six CCOs exhibited substantial differences in the percentage of paid OP claims; however, only two CCOs exhibited substantial differences where OP MH/SUD claims had a substantially lower paid rate than OP M/S claims (CPCCO [18.6 percentage points] and JCC [15.8 percentage points]). Among the remaining CCOs, only three exhibited a moderate difference in the percentage of OP paid claims (CHA, UHA, and AH); however, the percentage of OP paid claims was higher for MH/SUD services in all cases. The remaining eight CCOs had less than a 5 percentage-point difference in OP paid claims rates.

Out-of-Network Paid Claims

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

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



Note: OHP FFS was unable to provide claims data stratified by IN and OON providers; therefore, OHP FFS was excluded from this analysis.

No difference, MH/SUD greater
No difference, M/S greater
Moderate difference, MH/SUD greater
Moderate difference, M/S greater
Substantial difference, MH/SUD greater
Substantial difference, M/S greater

Overall, the difference in the statewide CCO percentage of OON paid claims for MH/SUD (7.7 percent) and M/S (9.4 percent) services was negligible at 1.7 percentage points, with individual CCO differences ranging from 0.6 percentage points (PCS-CG) to 22.8 percentage points (CHA). Of the 16 CCOs, 11 exhibited minimal differences in the percentage of paid OON claims for MH/SUD and M/S services, while one CCO (CHA) exhibited a substantial difference of 22.8 percentage points. More importantly, OON M/S providers exhibited a higher percentage of paid claims than MH/SUD providers. Among the remaining CCOs, four exhibited a moderate difference in the percentage of OON paid claims (YCCO, JCC, UHA, and AH), while all exhibited a higher percentage of OON paid claims for M/S providers versus MH/SUD providers. It is important to note that more than 90 percent of both M/S and MH/SUD paid claims (90.6 percent and 92.3 percent, respectively) were attributed to IN providers, suggesting comprehensive coverage of M/S and MH/SUD providers within the CCOs' delivery system networks. However, caution should be used when interpreting these results, as this is only a proximate measure of network adequacy.

A secondary analysis was conducted to assess differences in the percentage of IN and OON paid claims rates for M/S and MH/SUD providers, separately. In general, the CCO statewide percentage of paid claims for IN providers was high for both M/S and MH/SUD (76.5 percent and 92.3 percent, respectively). However, substantial differences were identified in the CCO statewide percentage of paid claims for OON providers, where the percentage of OON paid MH/SUD claims was 19.8 percent

compared to 80.2 percent of OON paid M/S claims. The absolute difference in paid OON claims between MH/SUD and M/S providers ranged from 10.7 percentage points to 99.8 percentage points.

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 and 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 to10 percentage points). Aggregate data on appeals and administrative hearings are not presented in this report since the overall number of appeals and administrative hearings was too small to produce reliable statistics. This limitation is discussed in later sections of this report along with recommendations for future analysis. 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.

Overall, the difference in the percentage of denials for MH/SUD and M/S PA requests varied across all service types (i.e., IP, OP, and Rx), as illustrated by the CCO aggregate denial rates. While the difference in the CCO aggregate denial rate for IP MH/SUD services (2.0 percent) and IP M/S services (2.8 percent) was negligible, the percentage-point differences in the CCO aggregate OP and Rx denial rates were substantial (10.7 percentage points and 19.8 percentage points, respectively). However, the differences in OP and Rx MH/SUD and M/S denial rates for the CCO aggregate were driven by a lower denial rate for MH/SUD services compared to M/S services, suggesting no concerns with parity. Further, the difference in the percentage of OP denials for MH/SUD and M/S services dropped to 4.7 percentage points when excluding Health Share[3-4] due to the CCO's comparatively high volume of MH/SUD PA requests and corresponding low denial rate, both in absolute terms and compared to other

[3-4] Since Health Share's results did not directly impact the review of the other CCOs, its data were retained in the CCO aggregate denial calculations. Additional discussion of Health Share's data can be found in Appendix F.

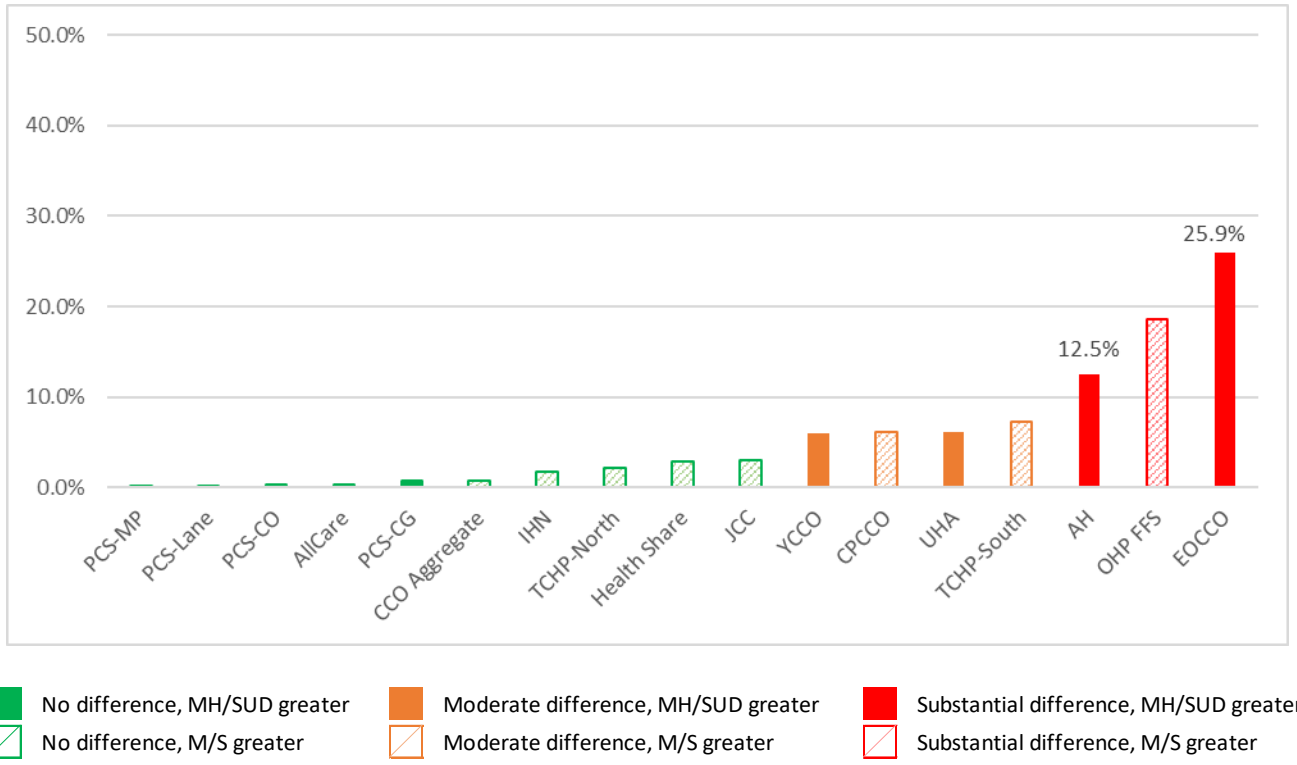
CCOs. In general, where absolute differences in the percentage of PA denials were *Moderate* or *Substantial*, MH/SUD PA requests were typically denied less frequently than M/S PA requests.

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 IP MH/SUD and M/S PA requests for all CCOs and OHP FFS. CHA reported no IP MH/SUD PA requests for CY 2021, and was therefore excluded from this comparative analysis.

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



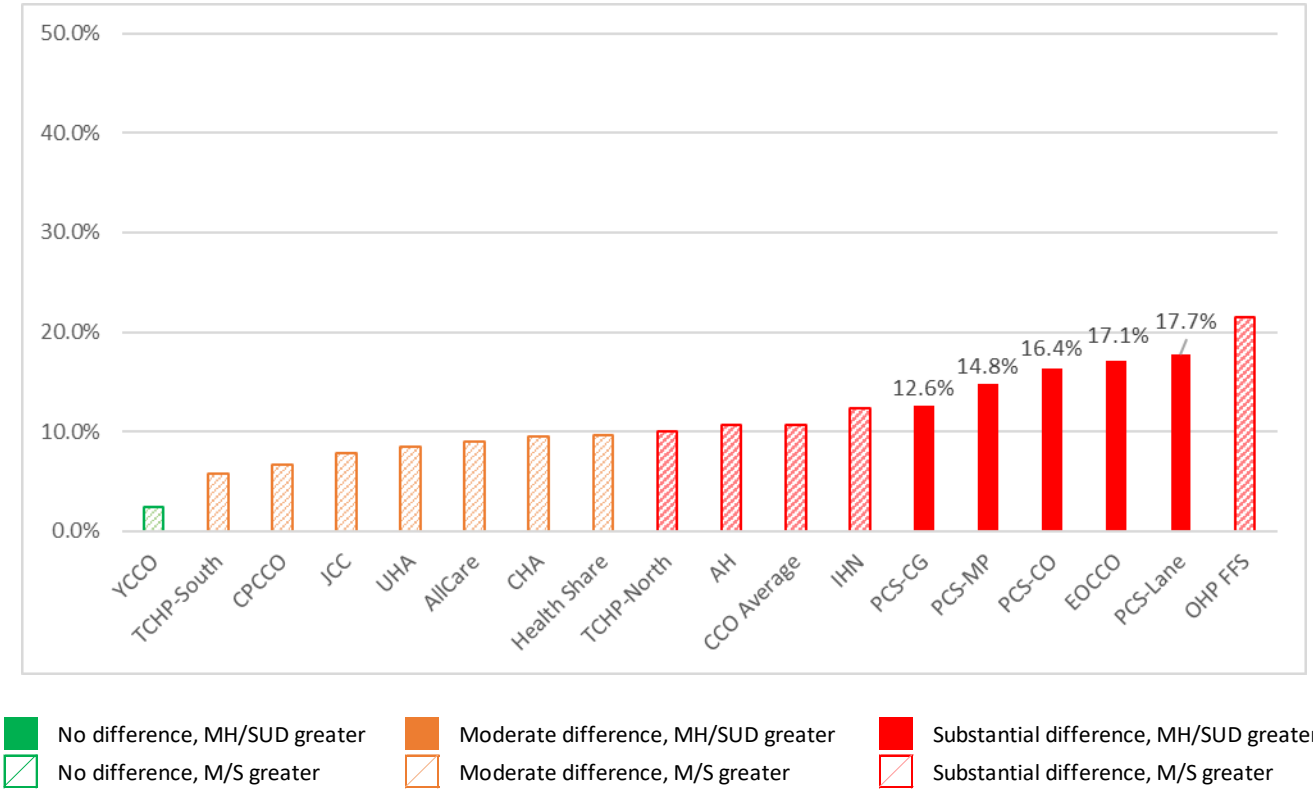
Overall, the difference in the statewide CCO percentage of denied IP PA requests for MH/SUD (2.0 percent) and M/S (2.8 percent) services was negligible at 0.8 percentage points, with individual CCO differences ranging from 0.1 percentage point (PCS-MP) to 25.9 percentage points (EOCCO). Two CCOs and OHP FFS exhibited substantial differences in the percentage of denied IP PA requests, with the two CCOs showing a substantially higher number of denials for IP MH/SUD PA requests than for IP

M/S PA requests (EOCCO [25.9 percentage points] and AH [12.5 percentage points]). However, both AH and EOCCO had relatively low numbers of IP MH/SUD denials (10 PA requests and 45 PA requests, respectively) as well as M/S denials (31 PA requests and 22 PA requests, respectively). As such, caution should be used when interpreting these results. OHP FFS also exhibited substantial differences in the number of denied IP PA requests; however, the rate of denial was lower for MH/SUD requests. Among the remaining CCOs, four exhibited a moderate difference (between 5 and 10 percentage points) in the percentage of denied IP PA requests, with two CCOs showing a higher number of IP MH/SUD PA request denials (YCCO and UHA). The remaining nine CCOs had less than a 5 percentage-point difference in IP PA denial rates.

Outpatient Authorization Denials

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

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



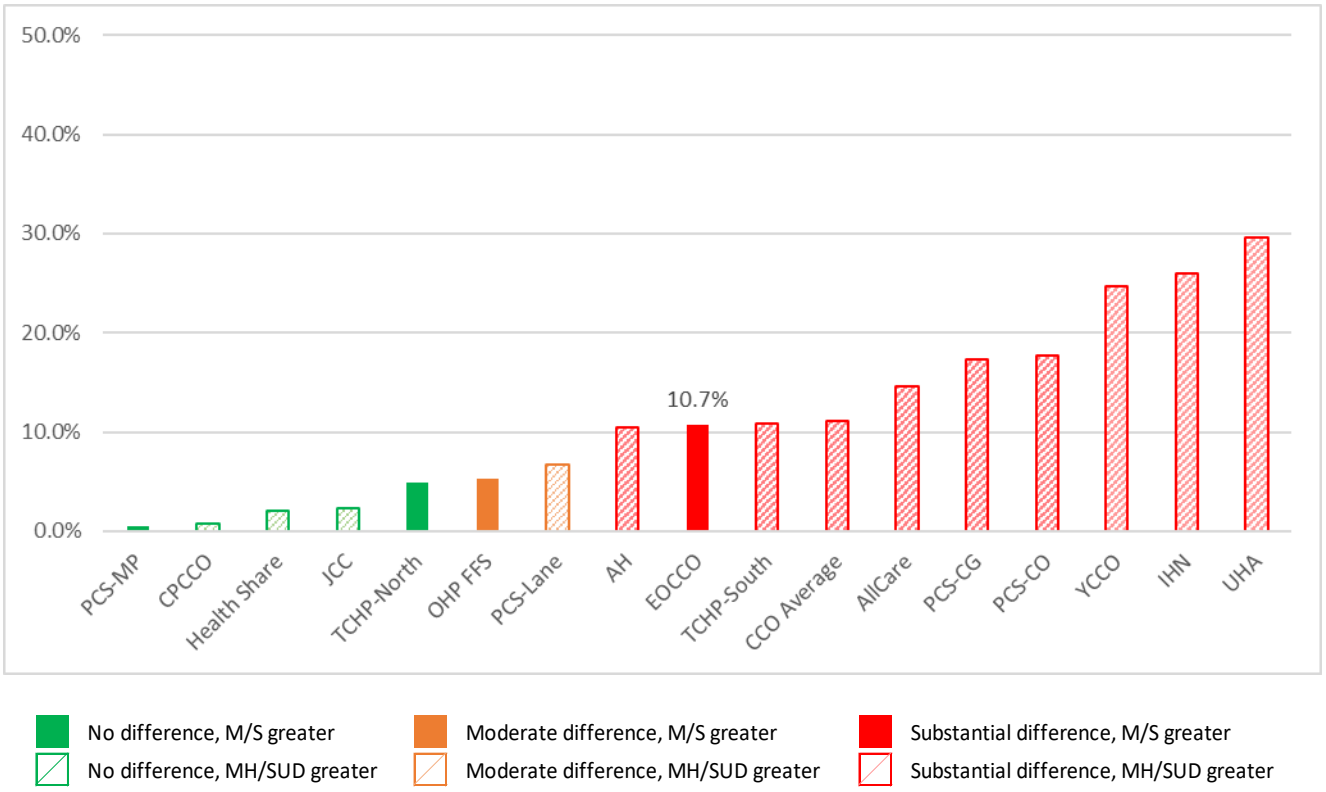
Overall, the difference in the statewide CCO percentage of denied OP PA requests for MH/SUD (1.2 percent) and M/S (11.9 percent) services was substantial at 10.7 percentage points, with individual CCO differences ranging from 2.5 percentage points (YCCO) to 17.7 percentage points (PCS-Lane); OHP FFS also exhibited a substantial difference (21.5 percentage points) in the percentage of OP denials. Half of the CCOs exhibited substantial differences in the percentage of denied OP PA requests, with five

CCOs showing a substantially higher number of denials for OP MH/SUD PA requests than for OP M/S PA requests (PCS-CG [12.6 percentage points], PCS-MP [14.8 percentage points], PCS-CO [16.4 percentage points], EOCCO [17.1 percentage points], and PCS-Lane [17.7 percentage points]). Among the remaining CCOs, seven (TCHP-South, CPCCO, JCC, UHA, AllCare, CHA, and Health Share) exhibited a moderate difference and all CCOs denied a lower percentage of MH/SUD OP PA requests compared to M/S OP PA requests. Only one CCO (YCCO) showed a negligible difference in MH/SUD and M/S OP PA denials.

Pharmacy Authorization Denials

Figure 3-7 shows the absolute difference in the percentage of denied Rx MH/SUD and M/S PA requests for all CCOs and OHP FFS. Since CHA was unable to differentiate MH/SUD and M/S Rx authorization requests in CY 2021, it was excluded from this comparative analysis.

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



Overall, the difference in the statewide CCO percentage of denied Rx PA requests for MH/SUD (44.1 percent) and M/S (55.2 percent) services was substantial at 11.1 percentage points, with individual CCO differences ranging from 0.5 percentage points (PCS-MP) to 29.6 percentage points (UHA). More than half of the CCOs exhibited substantial differences in the percentage of denied Rx PA requests; however, only one CCO showed a substantially higher number of denials for Rx MH/SUD PA requests than for Rx M/S PA requests (EOCCO [10.7 percentage points]). Among the remaining CCOs, one (PCS-Lane)

exhibited a moderate difference, though it denied a lower percentage of MH/SUD PA requests compared to M/S PA requests. Five CCOs (PCS-MP, CPCCO, Health Share, JCC, and TCHP-North) showed a negligible difference in MH/SUD and M/S Rx PA denials. OHP FFS exhibited a moderate difference in Rx PA denials (5.3 percentage points) in which MH/SUD PA requests were denied at a higher rate than M/S PA requests (23.9 percent versus 18.6 percent, respectively).

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 five key categories:

- Administrative Denial—denial due to administrative issues associated with the PA request (e.g., insufficient documentation)
- Below the Line (BTL)—service requested was below the line on the OHP Prioritized List[3-5]
- Not Medically Necessary—requested service does not meet clinical treatment guidelines
- Not a Covered Benefit—variety of noncoverage denials (e.g., service not found on OHP Prioritized List)
- Other—all other reasons

Table 3-2 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 3-2—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
Not Medically Necessary	41.8%	76.9%	81.7%	35.6%	48.1%	50.3%	32.0%
Not a Covered Benefit	31.9%	10.0%	5.8%	53.8%	30.7%	35.8%	33.0%
Service is *Below the Line*	21.7%	0.0%	3.1%	2.1%	17.3%	6.2%	30.0%
Administrative Denial	2.4%	10.6%	5.8%	2.6%	1.6%	3.7%	3.0%
Other	2.4%	2.5%	3.6%	5.8%	2.2%	0.2%	0.6%

Overall, across all CCOs and regardless of benefit, approximately four in 10 PA requests were denied for services determined to not be medically necessary (41.8 percent), followed by PA requests denied

[3-5] Oregon Health Authority. *Prioritized List of Health Services.* Available at: https://www.oregon.gov/oha/hsd/ohp/pages/prioritized-list.aspx. Accessed on Sept 14, 2022.

for the service not being a covered benefit (31.9 percent). Together, these two categories accounted for the majority of all PA denials (73.7 percent) as well as individually across IP (87.3 percent), OP (79.2 percent), and Rx (66.7 percent) services.[3-6] The next most frequent reason for a PA request across the CCOs was related to services being below the line (21.7 percent), followed by lack of documentation (administrative denial [2.4 percent]) and other reasons[3-7] (2.4 percent). Although variation was noted between CCOs, the distribution of denial reasons was generally consistent.

Please note that in the 2022 MHP Analysis, pharmacy denials included all CCO and OHP FFS denials, including mental health drugs (i.e., Standard Therapeutic Class (STC) 7 or STC 11) that are carved out and paid for by OHA on a fee-for-service basis. As such, some MH/SUD prescription authorizations may be reported as denials by the CCO, but subsequently approved and received by members. As such, differences in Rx denial rates between MH/SUD and M/S PA requests may inflate MH/SUD denials even though the request is ultimately approved. Therefore, caution should be used when interpreting differences between MH/SUD and M/S Rx PA denial rates.

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 processed, approved, and denied as well as terminated (including not being recredentialed) in CY 2021. All counts were stratified by benefit type to facilitate comparisons. These data points were collected to offer baseline information on parity of provider credentialing practices between MH/SUD and M/S. However, OHP FFS was not able to provide the required data elements needed to perform the assessment and was subsequently excluded from the following results. The aggregate counts from the CCOs were then used to generate the percentage of providers terminated and approved 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.

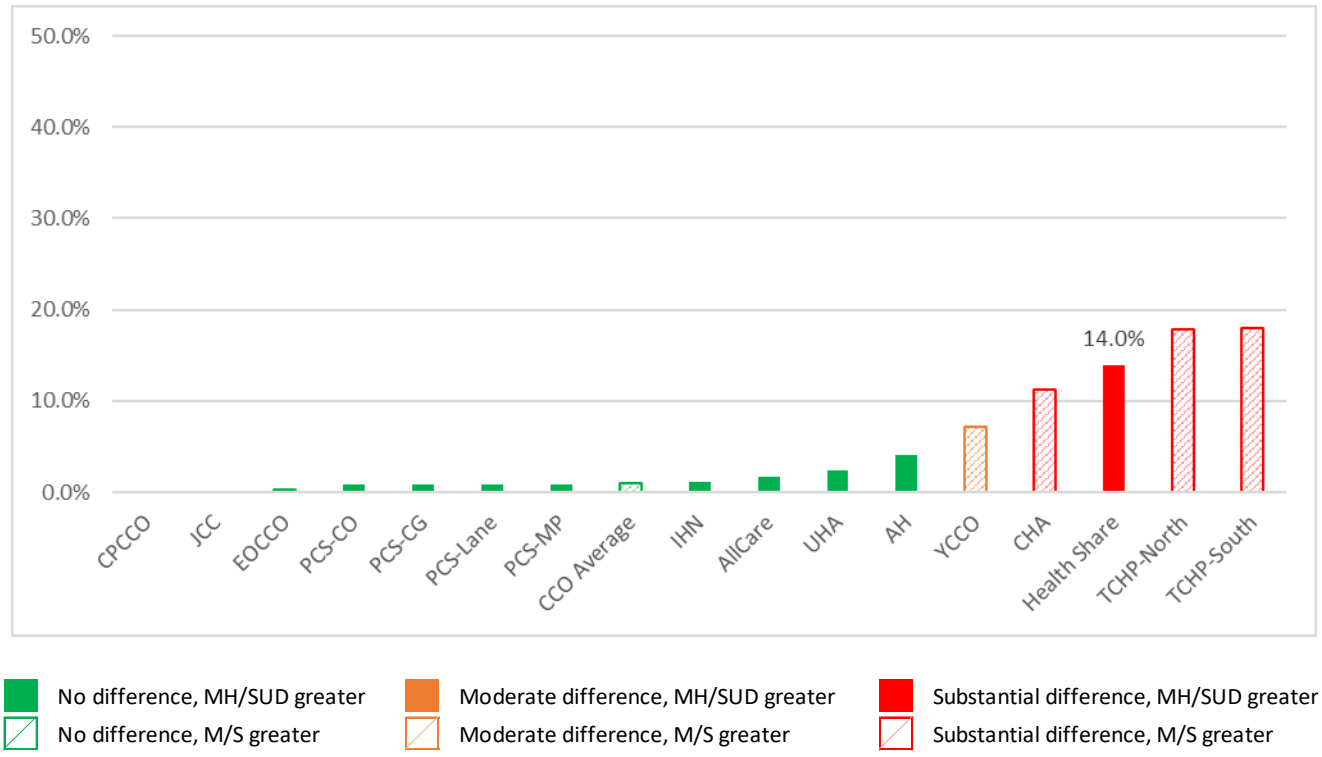
The following figures display the results of the comparisons in the percentage of terminated and approved applications for MH/SUD and M/S providers for all CCOs.

[3-6] The total service category rates (i.e., MH/SUD and M/S combined) are not presented in Table 3-2 but can be found in Appendix S.
[3-7] The rate for *Other* includes both denials categorized as *Other* and pharmacy denials related to *Partial Denials*.

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.

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

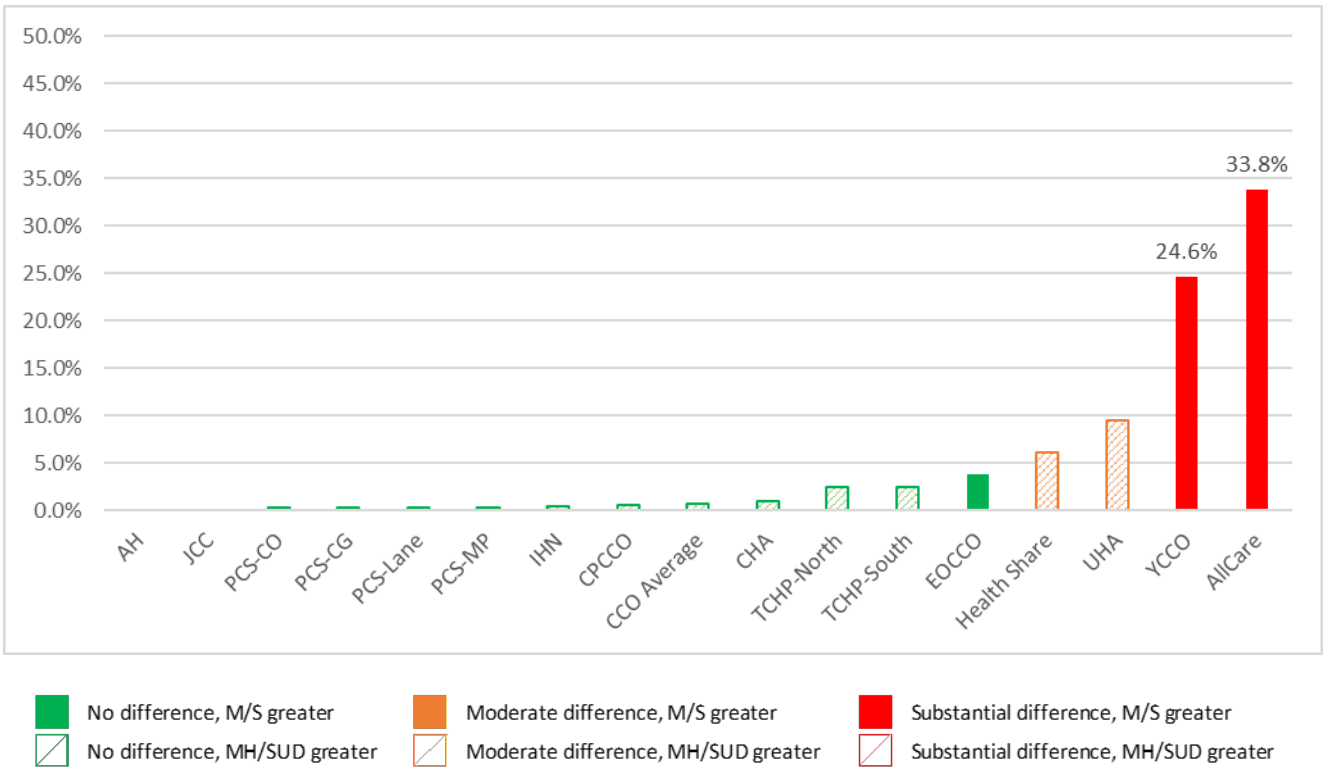


Overall, the difference in the statewide CCO percentage of terminated providers for MH/SUD (5.4 percent) and M/S (6.4 percent) was negligible at 1.0 percentage points, with individual CCO differences ranging from 0.0 percentage points (CPCCO and JCC, each) to 18.0 percentage points (TCHP-South). All but five CCOs exhibited little to no difference in the percentage of MH/SUD and M/S providers terminated or not recredentialed in CY 2021. Of the remaining CCOs, YCCO exhibited a moderate difference in termination rates (7.2 percentage points), while CHA, Health Share, TCHP-North, and TCHP-South exhibited substantial differences in the percentage of terminated providers. However, only Health Share showed a substantial difference where MH/SUD providers were terminated at higher rates (28.2 percent) than M/S providers (14.3 percent).

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 (95.3 percent) and M/S (94.6 percent) providers was negligible at 0.7 percentage points, with individual CCO differences ranging from 0.0 percentage points AH and JCC, each) to 33.8 percentage points (AllCare). Overall, all but four CCOs exhibited little to no difference in the percentage of MH/SUD and M/S provider applications approved in CY 2021. Of the remaining CCOs, Health Share and UHA exhibited moderate differences in MH/SUD and M/S rates of approval (6.1 percentage points and 9.5 percentage points, respectively), while YCCO and AllCare exhibited substantial differences in the percentage of approved provider applications. Moreover, both CCOs' substantial differences showed that lower percentages of provider applications were approved for MH/SUD providers compared to M/S providers.

Development of Network Adequacy and Timeliness of Access Measures

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. Although data to support a comprehensive assessment were not available at the time of the 2022 assessment, OHA, in collaboration with HSAG, assessed the current data collection activities and provider network-based studies to determine how existing data sources could be used to support future MHP analyses. Additionally, OHA sought and captured feedback from the community partner groups to further define future measures to assess parity within the CCOs' and OHP FFS' MHP/SUD provider networks.

To fully understand and measure access and availability, it is important to incorporate a multi-dimensional approach to assessing provider networks. Access represents a complex construct concerned with understanding whether members can obtain and use healthcare resources necessary to maintain and/or improve their health. To explore and understand OHP members' access to MH/SUD providers, the following subsections highlight the anticipated structure of network analyses based on available data sources. These analyses will focus on two access domains—network adequacy and timeliness of access.

Network Adequacy

Network adequacy addresses the underlying foundation of the provider network and refers to the supply of provider services available to OHP members. While no single set of measures can provide a full assessment of network adequacy, the use of multiple, intersecting measures can form a more comprehensive understanding of access.

To address network adequacy, it is recommended that future MHP analyses incorporate measures that evaluate two key dimensions of access—network capacity and geographic distribution. *Network capacity* addresses the underlying foundation of a provider network and identifies the supply of services available to OHP members. Using a variety of measures (e.g., provider-to-member ratios, provider counts, etc.), an assessment of the underlying capacity of a health plan's network can be obtained. *Geographic distribution* addresses whether the distribution of available providers is adequate to facilitate access to all OHP members. Key measures for assessing the geographic distribution of providers include time/distance analyses and compliance with network adequacy requirements. These analyses will determine the extent to which the supply of providers is distributed appropriately relative to members.

Currently, OHA contracts with its EQRO to conduct annual evaluations of the CCOs' delivery system network (DSN) to determine compliance with standards related to the adequacy of provider networks and access to care, and identify strengths, gaps in services, and opportunities for improvement. However, while none of these DSN evaluations focuses on parity with provider networks, data being collected from the CCOs could be used to support MHP analyses. Each year, CCOs are required to submit provider capacity data to OHA on a quarterly basis containing provider information on both practitioners and facility-based providers, including demographic information at the individual and site levels. Using these data, three measures will be used to support the analysis and reporting of MH/SUD providers and parity with M/S provider networks; these include:

- **Provider Counts**—A basic measure of capacity, provider counts for select MH/SUD and M/S provider specialties will be collected and reported to identify the contracted capacity to provide MH/SUD and M/S services. Provider counts will be measured over time to determine the stability of each network.
- **Provider-to-Member Ratios**—This measure offers a broad perspective of how many providers of a given type exist in a network in relation to the number of eligible members (e.g., pediatric MH providers for pediatric members). Such data will be used to evaluate and compare access to MH/SUD and M/S services.
- **Time and Distance Analysis**—Using address-level data, these analyses calculate the average driving distance and time between members and the nearest three providers. These analyses can be stratified by urbanicity (i.e., urban and rural), specific provider specialties, and member subpopulations. When possible, results will be compared to time and distance standards established by OHA.

While OHA's Provider Capacity data source is continually being refined and updated by OHA, the data source and subsequent results will allow for comparisons across MH/SUD and M/S provider types for multiple characteristics.

Timeliness of Access

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. *Timeliness of access* addresses how quickly OHP members are able to access services rendered by network providers. Using a variety of measures (e.g., secret or revealed shopper surveys, use of services, etc.), an assessment of the underlying availability and timeliness of services within a health plan's network can be obtained.

However, while federal and State regulations require CCOs to monitor the availability and timeliness of services, there is currently no coordinated collection of these data, nor a standard methodology for monitoring. Based on findings from current and prior DSN evaluations and other EQR activities, data on the timeliness of access are currently neither available nor comparable across health plans. In order to collect the data necessary to evaluate timeliness of access to support the MHP Analysis, OHA and/or its EQRO would need to plan for the collection and reporting of these data as defined in the following steps:

1. Identify appropriate metrics for assessing timeliness of access for both MH/SUD and M/S services.
2. Determine data elements needed to support the calculation of selected metrics.
3. Assess the capabilities of each CCO and OHP FFS to collect and report the required data elements.
4. Develop data collection and reporting tools to support the submission of data from the CCOs and OHP FFS.
5. Adjust the methodology within the constraints of federal, State, and contract requirements (e.g., 90-day deliverable notices, etc.) and conduct technical assistance as needed.
6. Collect the data elements and conduct the analysis.

4. Discussion

Unlike prior MHP analyses, the timing, methodology, and reporting of the 2022 MHP evaluation was driven by the passing of HB 3046, effective January 1, 2022. As such, several new data elements and measures (i.e., claims, UM decisions and outcomes, and provider enrollment) were collected and reported. Therefore, the results and findings from the 2022 report should be considered a baseline, and the conclusions taken from the analysis should be used to inform and refine future studies.

Conclusions

The overall findings from the two evaluation elements (i.e., attestation review and Administrative Data Profile) of the 2022 MHP Analysis are presented below.

Attestation Review

Overall, the CCOs and OHP FFS continued to demonstrate parity in their policies, procedures, and credentialing requirements across MH/SUD and M/S services. All the CCOs and OHP FFS noted a variety of operational changes; however, none of the changes were found to negatively impact parity.

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 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 was noted within each of the measures. However, the review of administrative data from the CCOs and OHP FFS raised concerns related to the quality and consistency of data and/or implementation of claims, UM, and provider enrollment processes, although this is not necessarily indicative of an impact on parity across benefit types.

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. However, when individual CCO and OHP FFS differences were *moderate* or *substantial*, the deviation was generally due to a higher percentage of paid claims among MH/SUD claims versus M/S claims.

Utilization Management

Overall, the difference in the percentage of denials for MH/SUD and M/S PA requests varied across all service types (i.e., IP, OP, and Rx). While the percentage-point difference in the CCO aggregate denial rate was negligible between IP MH/SUD and M/S services, the percentage-point difference in the CCO aggregate OP and Rx denial rates was substantial (greater than 10 percentage points). However, the difference in OP and Rx MH/SUD and M/S denial rates for the CCO aggregate was driven by a lower denial rate for MH/SUD services compared to M/S services, suggesting no concerns with parity. In general, where CCO and OHP FFS absolute differences in the percentage of PA denials were *moderate* or *substantial*, MH/SUD PA requests were typically denied less frequently than M/S PA requests.

In addition to CCO and OHP FFS performance for some data elements, HSAG identified issues with the data quality and completeness of UM data. For all CCOs and OHP FFS, denial reasons provided in member-level data were presented in a variety of formats, including plan-specific denial codes, abbreviations, full descriptions, and nonstandardized classifications. As a result, the reclassification of denial reasons into standardized categories was limited, reducing the ability to discern specific patterns within the UM data. This finding suggests the need for more refined data submission requirements in future studies. Other data issues identified during the review suggested data collection issues with CCO and OHP FFS systems. In one case, a CCO was unable to provide Rx PA data stratified by MH/SUD and M/S PA requests, while OHP FFS was unable to submit complete provider enrollment data. Both cases identified inherent limitations in the respective organizations' ability to internally monitor and evaluate operational parity across benefit types.

While all required PA data are reported in the CCO- and OHP FFS-specific appendices, the review for UM, at the aggregate level, was limited to the small number of appeals and administrative hearings reported in CY 2021. As such, future MHP analyses should incorporate file reviews of appeals and hearings to support the parity assessment of appeals and administrative hearings.

Provider Enrollment

Overall, the difference in the statewide CCO percentage of terminated providers for MH/SUD and M/S providers was negligible. All but five CCOs exhibited little to no difference in the percentage of MH/SUD and M/S providers terminated or not recredentialed in CY 2021. Of the remaining CCOs exhibiting moderate and substantial differences, only one CCO had differences where MH/SUD providers were terminated at higher rates than M/S providers. Similarly, the difference in the statewide CCO percentage of provider applications approved for MH/SUD and M/S providers was also negligible, with all but four CCOs exhibiting little to no difference in the percentage of MH/SUD and M/S provider applications approved in CY 2021.

Network Adequacy

Although data to support a comprehensive assessment were not available at the time of the 2022 assessment, OHA, in collaboration with HSAG, assessed the current data collection activities and provider network-based studies to determine how existing data sources could be used to support future

MHP analyses. OHA sought and captured feedback from the community partner groups to further define future measures to assess parity within the CCOs' and OHP FFS' MHP/SUD provider networks, leading to the recommendation of three measures:

- Provider capacity counts
- Provider-to-member ratios
- Time and distance analysis

Additionally, although required by HB 3046, the data needed to assess the timeliness of access are currently neither available nor comparable across health plans. In order to collect the data necessary to evaluate the timeliness of access to support the MHP Analysis, OHA will need to develop both data collection and measurement protocols.

MHP Community Partner Input

OHA initiated meetings with three different community partner groups (i.e., consumers, CCOs, and providers) 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 community partners (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. Specifically, the community partner groups will be used to support the direction and development of both network adequacy and timeliness of access measures, and the selection of special topics for single-year (i.e., deep dive) reviews. Topics identified for future consideration included but were not limited to the following:

- Implementation and utilization of telehealth services
- MH/SUD reimbursement rates
- Evaluating differences between MH and SUD benefits
- Wait times for inpatient and outpatient services

Finally, community partners strongly emphasized the need to include not only quantitative assessment of parity, but also qualitative assessments that center on the "individuals behind the numbers."

Parity Determination

Based on a review of the Annual Attestation Analysis and Administrative Data Profiles, in collaboration with the community partner groups, the administration of MH/SUD and M/S benefits were found to be in parity for the CCOs and OHP FFS, although individual differences in performance are reviewed for each organization in the appendices. These differences should be reviewed by each respective organization to support and ensure continued compliance with parity standards.

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:

- The CY 2023 MHP activity should include a full review of the CCOs' and OHP FFS' policies and procedures supporting the administration of MH/SUD and M/S benefits. This review should include a review the financial requirements (e.g., copays, deductibles, etc.); QTLs (e.g., day limits, visit limits, etc.); NQTLs (e.g., scope and duration of treatment, medical management, authorization standards, etc.); and annual and lifetime dollar limits. The last full review was conducted by HSAG in CY 2020 with the recommendation to conduct a comprehensive review every three years, with an attestation-based review during the intervening years. In order to align with this recommendation and ensure continued parity across policies and procedures, a full review should be conducted in accordance with the Medicaid Parity Final Rule, 42 CFR §438 Subpart K.
- Beginning in CY 2023, the annual MHP evaluation should include a file review targeting coverage determinations, appeals, and administrative hearings. Based on the results from the 2022 MHP Analysis, while UM data were reported by the CCOs and OHP FFS, there was insufficient volume to support a comprehensive analysis of parity at the aggregate level. Further, an evaluation of UM files is important to ensure accurate implementation of policies and procedures.
- Although the 2022 MHP Analysis incorporated quantitative evaluation of claims, UM, and provider enrollment resulting in baseline measurement, the data were often insufficient to fully identify patterns within the data. To improve the quality and amount of detail available to the analysis, it is recommended that the administrative data profile data submission tool and instructions be updated to (1) incorporate lessons learned from 2022 technical assistance sessions with the CCOs and OHP FFS, and (2) enhance the collection of data elements. These changes would include, but not be limited to, the following:
  - Reporting of aggregate claim counts at both the header and detail level
  - Incorporating claim denial codes
  - Modifying stratification definitions for MH/SUD and M/S services, claim and UM denials, and provider enrollment terminations and approval
  - Enhancing data submission formatting to standardize member-level data collection
- OHA should work with HSAG to review current CCO DSN reporting requirements to incorporate the data elements needed to support the assessment of network adequacy and timeliness of access for the CCOs and OHP FFS as it relates to parity within the MH/SUD and M/S provider networks.
- OHA, in collaboration with community partners and HSAG, should develop and select special investigation topics for future single-year analyses to be conducted in 2024 and 2025.
- Per community partner feedback, OHA should ensure that future MHP evaluations meaningfully incorporate community partners in the evaluation process in alignment with HB 3046.
- OHA, in collaboration with MHP stakeholders and HSAG, should ensure that qualitative assessments and frameworks are incorporated alongside quantitative assessments as necessary and appropriate for MHP evaluation.

Improvement Plan

Organizations that received a finding associated with the 2022 MHP Analysis will be required to implement corrective actions to address the deficiency. Implementation of interventions identified in the improvement plan should begin immediately to resolve findings and bring the organization into compliance with federal and State requirements. All findings must be fully addressed before the next MHP submission date of June 1, 2023, as mandated by HB 3046. The CCOs and OHP FFS are encouraged to contact HSAG to schedule a technical assistance call to review findings and ensure the proposed interventions will successfully resolve areas of noncompliance.

Appendix A. Detailed MHP Results for Advanced Health

MHP Attestation Review

Table A-1 presents a summary of the attestation review and highlights the number of operational changes identified by the CCO, the number of changes compliant with parity standards, and the subsequent compliance score.

Table A-1—MHP Attestation Review Results: AH

OR 2022 MHP Attestation Form Element	Total # of Change(s) Noted in 2021	Total # of Change(s) *Compliant* With Parity Standards	CCO Compliance Score
General Questions—Delegation & Medical Guidelines/Evidence	2	2	100%
Utilization Management (IP, OP, and Rx)	1	1	100%
Provider Admission Criteria	NA	NA	NA
Out-of-Network/Out-of-State Limits	NA	NA	NA
Enhanced Quality Services MH/SUD Information	NA	NA	NA
Overall Compliance Score	**3**	**3**	**100%**

Overall, the CCO demonstrated compliance with MHP requirements and standards when changes were identified in key operational areas. These changes included:

- Updates to information technology (IT) systems relevant to claims, billing, and UM.
- Staffing changes related to behavioral health leadership.
- Updates to PA criteria for pharmaceuticals related to opioid or opiate withdrawal management.

Administrative Data Profile

Table A-2 presents a summary of the results from the analysis of paid claims by service and benefit type. In general, AH showed a moderate difference 7.5 percentage points) in the percentage of paid claims between MH/SUD (86.1 percent) and M/S (78.6 percent) services. This difference was driven primarily by differences exhibited in OP claims. Similar differences were noted among IN paid claims, although data were not available to address IN differences by service type for AH.

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

Service Type	Benefit Type	Total Claims	Paid Claims[1]		In-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	2,341	1,686	72.0%	NA	NA
	M/S	22,643	15,454	68.3%	NA	NA
OP	MH/SUD	99,809	86,245	86.4%	NA	NA
	M/S	324,785	257,468	79.3%	NA	NA
Total	**MH/SUD**	**102,150**	**87,931**	**86.1%**	**79,680**	**90.6%**
	M/S	**347,428**	**272,922**	**78.6%**	**225,948**	**82.8%**

Note: NA indicates that in- and out-of-network counts were not collected separately for IP and OP claims.

[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.

Table A-3 presents a summary of the results from the analysis of PAs by service and benefit type. Due to the low number of PA denials that were appealed, results associated with the percentage of PA denials appealed, appeals upheld, and appeals overturned should be interpreted with caution, including any assessment of parity. Future studies may regularly incorporate a file review of MH/SUD and M/S appeals as a more effective measure of parity across services.

Table A-3—Prior Authorization Results by Benefit Type for AH

Service Type	Benefit Type	Total PA Requests	Requests Denied		Denied Requests Appealed[1]		
			Number	Percent[2]	Total Percent[2]	Percent Upheld	Percent Overturned
IP	**MH/SUD**	69	10	14.5%	0%	NA	NA
	M/S	1,518	31	2.0%	3.2%	100%	0%
OP	**MH/SUD**	975	96	9.9%	0%	NA	NA
	M/S	26,128	5,348	20.5%	2.7%	97.2%	2.8%
Rx	**MH/SUD**	684	374	54.7%	0.5%	50.0%	50.0%
	M/S	3,974	2,589	65.2%	0.9%	79.2%	20.8%

[1] Due to the small number of appeals, caution should be used when interpreting these results. NA indicates a denominator of zero, or no requests were appealed.

[2] 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.

Overall, AH exhibited substantial differences (greater than 10 percentage points) in the percentage of PA requests denied across IP, OP, and Rx coverage determinations (12.5 percentage points, 10.6 percentage points, and 10.5 percentage points, respectively). However, only PA denials for IP services were higher among MH/SUD services compared to M/S services (14.5 percent versus 2.0 percent). Additionally, AH reported in its summary data that 33 IP PA requests were denied because they were below the line of coverage on the OHP Prioritized List of Services. However, AH's member-level data

showed no BTL denial reasons. AH should review its IP PA denials to confirm the accuracy of reported data and update any necessary processes or systems.

Summary of Overall Strengths and Areas Requiring Improvement

Upon review of its Annual MHP Attestation and submitted claims and UM data, no findings were noted for AH related to the parity of MH/SUD and M/S services.

Performance Strengths	**Strength:** No strengths were identified following review of the 2022 MHP Analysis findings.
Area(s) Requiring Improvement	**Area(s) requiring improvement:** No areas requiring improvement were identified based on the 2022 MHP Analysis findings.

Appendix B. Detailed MHP Results for AllCare CCO, Inc.

MHP Attestation Review

Table B-1 presents a summary of the attestation review and highlights the number of operational changes identified by the CCO, the number of changes compliant with parity standards, and the subsequent compliance score.

Table B-1—MHP Attestation Review Results: AllCare

OR 2022 MHP Attestation Form Element	Total # of Change(s) Noted in 2021	Total # of Change(s) *Compliant* With Parity Standards	CCO Compliance Score
General Questions—Delegation & Medical Guidelines/Evidence	NA	NA	NA
Utilization Management (IP, OP, and Rx)	1	1	100%
Provider Admission Criteria	1	1	100%
Out-of-Network/Out-of-State Limits	NA	NA	NA
Enhanced Quality Services MH/SUD Information	NA	NA	NA
Overall Compliance Score	**2**	**2**	**100%**

Overall, the CCO demonstrated compliance with MHP requirements and standards when changes were identified in key operational areas. These changes included:

- Updates to the pharmaceutical formulary.
- Updates to PA criteria for pharmaceuticals related to opioid or opiate withdrawal management.
- Restoration of MH provider capacity following the dissolution of a significant MH subcontractor. After obtaining feedback from providers, the CCO began contracting directly with in-county providers and expanding telehealth MH services in neighboring counties.

Administrative Data Profile

Table B-2 presents a summary of the results from the analysis of paid claims by service and benefit type. In general, AllCare showed minimal to no difference (less than 1 percentage point) in the percentage of paid claims between MH/SUD (96.6 percent) and M/S (96.9 percent) services.

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

Service Type	Benefit Type	Total Claims	Paid Claims[1]		In-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	12,292	11,777	95.8%	NA	NA
	M/S	53,596	50,939	95.0%	NA	NA
OP	MH/SUD	206,361	200,199	97.0%	NA	NA
	M/S	724,275	703,011	97.1%	NA	NA
Total	**MH/SUD**	**218,653**	**211,976**	**97.0%**	**121,323**	**57.2%**
	M/S	**777,871**	**753,950**	**96.9%**	**463,103**	**61.4%**

Note: NA indicates that in- and out-of-network counts were not collected separately for IP and OP claims.

[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.

Table B-3 presents a summary of the results from the analysis of PAs by service and benefit type. Due to the low number of PA denials that were appealed, results associated with the percentage of PA denials appealed, appeals upheld, and appeals overturned should be interpreted with caution, including any assessment of parity. Future studies may regularly incorporate a file review of MH/SUD and M/S appeals as a more effective measure of parity across services.

Table B-3—Prior Authorization Results by Benefit Type for AllCare

Service Type	Benefit Type	Total PA Requests	Requests Denied		Denied Requests Appealed[1]		
			Number	Percent[2]	Total Percent[2]	Percent Upheld	Percent Overturned
IP	**MH/SUD**	259	0	0%	NA	NA	NA
	M/S	4,545	17	0.4%	NA	NA	NA
OP	**MH/SUD**	245	10	4.1%	NA	NA	NA
	M/S	6,997	914	13.1%	7.3%	43.3%	56.7%
Rx	**MH/SUD**	463	167	36.1%	3.0%	40.0%	60.0%
	M/S	5,573	2,821	50.6%	1.1%	70.0%	30.0%

[1] Due to the small number of appeals, caution should be used when interpreting these results. NA indicates a denominator of zero, or no requests were appealed.

[2] 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.

Overall, AllCare exhibited a minimal difference (less than 1 percentage point) for PA requests denied for IP, a moderate difference 9.0 percentage points) for OP PA requests, and a substantial difference (14.5 percentage points) for Rx coverage determinations. However, for both OP and Rx PA denials, PA denials were higher among M/S services compared to MH/SUD services.

AllCare had the lowest percentage of MH/SUD paid claims for IN providers of any CCO and one of the lowest for IN M/S providers. These results suggest the need for further investigation into the factors

contributing to lower IN paid claims, including the adequacy of AllCare's MH/SUD provider network. AllCare also reported a substantially lower percentage of approved MH/SUD provider applications than M/S provider application approvals. It is recommended that AllCare investigate the nature of its low IN percentage of paid claims for MH/SUD and M/S services and comparatively low provider application approval rate for MH/SUD providers to identify the root causes. As appropriate, the CCO should then take steps to correct any potential errors in its data, network adequacy, and operational processes.

Summary of Overall Strengths and Areas Requiring Improvement

Upon review of its Annual MHP Attestation and submitted claims and UM data, no findings were noted for AllCare related to the parity of MH/SUD and M/S services.

Performance Strengths	**Strength:** Following the dissolution of a key subcontracted Community Mental Health Program in one of its counties, AllCare obtained feedback from community providers and increased both its direct contracting efforts and telehealth modalities for MH services. These actions contributed to increases in MH provider satisfaction and reduced administrative barriers to care. **[Access]**
Area(s) Requiring Improvement	**Area(s) requiring improvement:** No areas requiring improvement were identified based on the 2022 MHP Analysis findings.

Appendix C. Detailed MHP Results for Cascade Health Alliance, LLC

MHP Attestation Review

Table C-1 presents a summary of the attestation review and highlights the number of operational changes identified by the CCO, the number of changes compliant with parity standards, and the subsequent compliance score.

Table C-1—MHP Attestation Review Results: CHA

OR 2022 MHP Attestation Form Element	Total # of Change(s) Noted in 2021	Total # of Change(s) *Compliant* With Parity Standards	CCO Compliance Score
General Questions—Delegation & Medical Guidelines/Evidence	1	1	100%
Utilization Management (IP, OP, and Rx)	1	1	100%
Provider Admission Criteria	1	1	100%
Out-of-Network/Out-of-State Limits	NA	NA	NA
Enhanced Quality Services MH/SUD Information	5	5	100%
Overall Compliance Score	**8**	**8**	**100%**

Overall, the CCO demonstrated compliance with MHP requirements and standards when changes were identified in key operational areas. These changes included:

- Updates to PA criteria related to Intensive In-Home Behavioral Health Treatment and pharmaceutical criteria related to opioid or opiate withdrawal management.
- Updates to IT systems relevant to UM, case management, tracking, and reporting.

Administrative Data Profile

Table C-2 presents a summary of the results from the analysis of paid claims by service and benefit type. In general, CHA showed a minimal difference (4.7 percentage points) in the percentage of paid claims between MH/SUD (79.1 percent) and M/S (74.4 percent) services. However, when evaluating IN paid claims, a substantial difference was noted between MH/SUD (66.4 percent) and M/S services (43.6 percent), though the percentage of paid IN claims was higher for MH/SUD. Data were not available to address IN differences by service type. Interestingly, while CHA exhibited the greatest difference in IP paid claims between MH/SUD and M/S services, the percentages of paid claims for MH/SUD (37.6 percent) and M/S (10.1 percent) were the lowest of any CCO.

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

Service Type	Benefit Type	Total Claims	Paid Claims[1]		In-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	11,340	4,267	37.6%	NA	NA
	M/S	23,797	2,414	10.1%	NA	NA
OP	MH/SUD	170,793	139,754	81.8%	NA	NA
	M/S	702,025	537,315	76.5%	NA	NA
Total	**MH/SUD**	**182,133**	**144,021**	**79.1%**	**95,688**	**66.4%**
	M/S	**725,822**	**539,729**	**74.4%**	**235,510**	**43.6%**

Note: NA indicates that in- and out-of-network counts were not collected separately for IP and OP claims.

[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.

Table C-3 presents a summary of the results from the analysis of PAs by service and benefit type. Due to the low number of PA denials that were appealed, results associated with the percentage of PA denials appealed, appeals upheld, and appeals overturned should be interpreted with caution, including any assessment of parity. Future studies may regularly incorporate a file review of MH/SUD and M/S appeals as a more effective measure of parity across services.

Table C-3—Prior Authorization Results by Benefit Type for CHA

Service Type	Benefit Type	Total PA Requests	Requests Denied		Denied Requests Appealed[1]		
			Number	Percent[2]	Total Percent[2]	Percent Upheld	Percent Overturned
IP	**MH/SUD**	0	0	NA	NA	NA	NA
	M/S	30	0	0%	NA	NA	NA
OP	**MH/SUD**	180	18	10.0%	5.6%	100%	0%
	M/S	13,697	2,667	19.5%	3.3%	58.4%	41.6%
Rx	**MH/SUD**	-	16	-	0%	NA	NA
	M/S	-	2,812	-	0.4%	91.7%	8.3%

[1] Due to the small number of appeals, caution should be used when interpreting these results. NA indicates a denominator of zero, or no requests were appealed.

[2] 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.

Overall, CHA exhibited a moderate difference (9.5 percent) in the percentage of OP PA requests denied; however, the percentage of PA denials for OP services was higher for M/S services. For IP services, no PA requests were documented for MH/SUD services, and only 30 PA requests for M/S services. Moreover, CHA was the only CCO unable to distinguish Rx PA requests by benefit type (i.e., MH/SUD versus M/S), indicating that the organization had a limited capacity to monitor parity within its Rx benefits.

Summary of Overall Strengths and Areas Requiring Improvement

Upon review of its Annual MHP Attestation and submitted claims and UM data, no findings were noted for CHA related to the parity of MH/SUD and M/S services; however, one finding was noted related to the quality of Rx PA data captured and reported as part of the 2022 MHP Analysis.

Performance Strengths	**Strength:** CHA identified barriers for youth and families in the community related to MH services and worked to improve systems of care through the development of policies and procedures to include wraparound services and supports. **[Quality and Access]**
Area(s) Requiring Improvement	**Area(s) requiring improvement:** CHA was unable to separate its Rx PA data by benefit type (i.e., MH/SUD and M/S). **[Quality and Access]** **Rationale:** MH/SUD and M/S benefit PA practices and outcomes cannot be comparatively evaluated if the relevant data are unavailable. This finding places inherent limitations on CHA's ability to internally monitor and evaluate the parity of Rx benefit utilization across benefit types. **Required action(s):** CHA must update its administrative systems, or work with delegate Rx benefit managers, to capture the necessary data elements to allow the reporting of Rx PA data by benefit type. CHA must implement these changes in order to support future MHP reporting requirements.

Appendix D. Detailed MHP Results for Columbia Pacific CCO, LLC

MHP Attestation Review

Table D-1 presents a summary of the attestation review and highlights the number of operational changes identified by the CCO, the number of changes compliant with parity standards, and the subsequent compliance score.

Table D-1—MHP Attestation Review Results: CPCCO

OR 2022 MHP Attestation Form Element	Total # of Change(s) Noted in 2021	Total # of Change(s) *Compliant* With Parity Standards	CCO Compliance Score
General Questions—Delegation & Medical Guidelines/Evidence	NA	NA	NA
Utilization Management (IP, OP, and Rx)	4	4	100%
Provider Admission Criteria	2	2	100%
Out-of-Network/Out-of-State Limits	1	1	100%
Enhanced Quality Services MH/SUD Information	NA	NA	NA
Overall Compliance Score	**7**	**7**	**100%**

Overall, the CCO demonstrated compliance with MHP requirements and standards when changes were identified in key operational areas. These changes included:

- A decreased timeline for responding to SUD service requests and PA requests for eating disorder residential services to align with other residential services.
- A modified scope of utilization review to include approval for additional IP services for members experiencing discharge barriers.
- Opening its provider network to additional MH/SUD providers in response to network deficiencies.
- Updating its policies and procedures to align with the State requirement that all pharmacy prescribers are required have an Oregon State ID number.

Administrative Data Profile

Table D-2 presents a summary of the results from the analysis of paid claims by service and benefit type. In general, CPCCO showed a substantial difference (19.1 percentage points) in the percentage of paid claims between MH/SUD (67.4 percent) and M/S (86.5 percent) services, with a lower percentage of MH/SUD claims being paid compared to M/S claims. The substantial differences in the percentage of

paid claims were exhibited for both IP and OP claims (23.0 percent and 18.7 percent, respectively). However, when evaluating differences in paid claims for IN providers, the difference between MH/SUD claims (93.2 percent) and M/S claims (90.5 percent) was minimal.

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

Service Type	Benefit Type	Total Claims	Paid Claims[1]		In-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	381	225	59.1%	NA	NA
	M/S	43,510	35,713	82.1%	NA	NA
OP	MH/SUD	3,856	2,630	68.2%	NA	NA
	M/S	596,504	518,044	86.9%	NA	NA
Total	**MH/SUD**	**4,237**	**2,855**	**67.4%**	**2,662**	**93.2%**
	M/S	**640,014**	**553,757**	**86.5%**	**500,968**	**90.5%**

Note: NA indicates that in- and out-of-network counts were not collected separately for IP and OP claims.

[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.

Table D-3 presents a summary of the results from the analysis of PAs by service and benefit type. Due to the low number of PA denials that were appealed, results associated with the percentage of PA denials appealed, appeals upheld, and appeals overturned should be interpreted with caution, including any assessment of parity. Future studies may regularly incorporate a file review of MH/SUD and M/S appeals as a more effective measure of parity across services.

Table D-3—Prior Authorization Results by Benefit Type for CPCCO

Service Type	Benefit Type	Total PA Requests	Requests Denied		Denied Requests Appealed[1]		
			Number	Percent[2]	Total Percent[2]	Percent Upheld	Percent Overturned
IP	**MH/SUD**	138	0	0%	NA	NA	NA
	M/S	1,892	116	6.1%	1.7%	50.0%	50.0%
OP	**MH/SUD**	600	1	0.2%	0%	NA	NA
	M/S	13,858	946	6.8%	9.6%	49.5%	50.6%
Rx	**MH/SUD**	213	152	71.4%	1.3%	100%	0%
	M/S	2,143	1,546	72.1%	0.6%	55.6%	44.4%

[1] Due to the small number of appeals, caution should be used when interpreting these results. NA indicates a denominator of zero, or no requests were appealed.

[2] 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.

Overall, CPCCO exhibited moderate differences in the percentage of PA requests denied across MH/SUD and M/S IP and OP denials (6.1 percent and 6.6 percent, respectively), and only a minimal difference between MH/SUD and M/S Rx PA denials (0.7 percent). However, for all service types, PA

denials were higher among M/S services compared to MH/SUD services. In general, CPCCO's percentage of denied MH/SUD and M/S PA requests for Rx services was among the highest across all CCOs, and substantially higher than the statewide CCO aggregate rate despite having some of the lowest percentages for IP and OP PA denials. CPCCO should investigate its Rx PA process for potential opportunities for improvement.

Summary of Overall Strengths and Areas Requiring Improvement

Upon review of its Annual MHP Attestation and submitted claims and UM data, no findings were noted for CPCCO related to the parity of MH/SUD and M/S services.

Performance Strengths	**Strength:** The CCO's Behavioral Health UM team implemented monthly internal quality audits to align with the Physical Health UM team's practices. **[Quality]**
Area(s) Requiring Improvement	**Area(s) requiring improvement:** No areas requiring improvement were identified based on the 2022 MHP Analysis findings.

Appendix E. Detailed MHP Results for Eastern Oregon CCO, LLC

MHP Attestation Review

Table E-1 presents a summary of the attestation review and highlights the number of operational changes identified by the CCO, the number of changes compliant with parity standards, and the subsequent compliance score.

Table E-1—MHP Attestation Review Results: EOCCO

OR 2022 MHP Attestation Form Element	Total # of Change(s) Noted in 2021	Total # of Change(s) *Compliant* With Parity Standards	CCO Compliance Score
General Questions—Delegation & Medical Guidelines/Evidence	1	1	100%
Utilization Management (IP, OP, and Rx)	2	2	100%
Provider Admission Criteria	NA	NA	NA
Out-of-Network/Out-of-State Limits	NA	NA	NA
Enhanced Quality Services MH/SUD Information	NA	NA	NA
Overall Compliance Score	**3**	**3**	**100%**

Overall, the CCO demonstrated compliance with MHP requirements and standards when changes were identified in key operational areas. These changes included:

- Updated PA requirements to reflect the addition of new M/S codes.
- Adjusted provider payment arrangements from an FFS basis to primary care capitation.

Administrative Data Profile

Table E-2 presents a summary of the results from the analysis of paid claims by service and benefit type. In general, EOCCO showed a minimal difference (percentage points) in the percentage of paid claims between MH/SUD (86.5 percent) and M/S (85.7 percent) services. This difference was driven primarily by percentages and differences exhibited in OP claims. A minimal difference (3.7 percent) was also noted between MH/SUD and M/S IN paid claims, although the percentage of paid M/S claims was higher than MH/SUD claims. Data were not available to address IN differences by service type for EOCCO.

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

Service Type	Benefit Type	Total Claims	Paid Claims[1]		In-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	6,334	5,111	80.7%	NA	NA
	M/S	8,301	5,837	70.3%	NA	NA
OP	MH/SUD	224,856	194,952	86.7%	NA	NA
	M/S	848,947	729,033	85.9%	NA	NA
Total	**MH/SUD**	**231,190**	**200,063**	**86.5%**	**173,249**	**86.60%**
	M/S	**857,248**	**734,870**	**85.7%**	**663,397**	**90.27%**

Note: NA indicates that in- and out-of-network counts were not collected separately for IP and OP claims.

[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.

Table E-3 presents a summary of the results from the analysis of PAs by service and benefit type. Due to the low number of PA denials that were appealed, results associated with the percentage of PA denials appealed, appeals upheld, and appeals overturned should be interpreted with caution, including any assessment of parity. Future studies may regularly incorporate a file review of MH/SUD and M/S appeals as a more effective measure of parity across services.

Table E-3—Prior Authorization Results by Benefit Type for EOCCO

Service Type	Benefit Type	Total PA Requests	Requests Denied		Denied Requests Appealed[1]		
			Number	Percent[2]	Total Percent[2]	Percent Upheld	Percent Overturned
IP	**MH/SUD**	168	45	26.8%	40.0%	55.6%	44.4%
	M/S	2,511	22	0.9%	22.7%	60.0%	40.0%
OP	**MH/SUD**	167	43	25.8%	39.5%	23.5%	76.5%
	M/S	33,895	2,937	8.7%	4.4%	66.4%	33.6%
Rx	**MH/SUD**	381	255	66.9%	0%	NA	NA
	M/S	5,081	2,855	56.2%	0.1%	0%	100%

[1] Due to the small number of appeals, caution should be used when interpreting these results. NA indicates a denominator of zero, or no requests were appealed.

[2] 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.

Overall, EOCCO exhibited substantial differences (greater than 10 percentage points) in the percentage of PA requests denied across IP, OP, and Rx coverage determinations (25.9 percentage points, 17.1 percentage points, and 10.7 percentage points, respectively). Moreover, PA denials for all three service types were higher among MH/SUD services compared to M/S services. It is recommended that EOCCO investigate the nature of these differences to determine the reason(s) and take steps to correct any potential errors in either its data, UM procedures, or other operations.

Summary of Overall Strengths and Areas Requiring Improvement

Upon review of its Annual MHP Attestation and submitted claims and UM data, no findings were noted for EOCCO related to the parity of MH/SUD and M/S services.

Performance Strengths	**Strength:** No strengths were identified following review of the 2022 MHP Analysis findings.
Area(s) Requiring Improvement	**Area(s) requiring improvement:** No areas requiring improvement were identified based on the 2022 MHP Analysis findings.

Appendix F. Detailed MHP Results for Health Share of Oregon

MHP Attestation Review

Table F-1 presents a summary of the attestation review and highlights the number of operational changes identified by the CCO, the number of changes compliant with parity standards, and the subsequent compliance score.

Table F-1—MHP Attestation Review Results: Health Share

OR 2022 MHP Attestation Form Element	Total # of Change(s) Noted in 2021	Total # of Change(s) *Compliant* With Parity Standards	CCO Compliance Score
General Questions—Delegation & Medical Guidelines/Evidence	2	2	100%
Utilization Management (IP, OP, and Rx)	5	5	100%
Provider Admission Criteria	2	2	100%
Out-of-Network/Out-of-State Limits	2	2	100%
Enhanced Quality Services MH/SUD Information	1	1	100%
Overall Compliance Score	**12**	**12**	**100%**

Overall, the CCO demonstrated compliance with MHP requirements and standards when changes were identified in key operational areas. These changes included:

- Removing PA and UM requirements from MH/SUD OP services to align with the Oregon Medicaid COVID-19 Provider Guide.
- Ending notification requirements for initial admissions to skilled nursing facilities, inpatient rehabilitation centers, and long-term acute hospitals.
- Updating prescription criteria for treatments related to gender dysphoria.
- Decreasing the timeline for responding to SUD service requests and PA requests for eating disorder residential services to align with other residential services.
- Modifying utilization review criteria to include approval for additional IP services for members experiencing discharge barriers.
- Opening its network to additional MH/SUD providers in response to network deficiencies.

Administrative Data Profile

Table F-2 presents a summary of the results from the analysis of paid claims by service and benefit type. In general, Health Share showed a minimal difference (2.9 percentage points) in the percentage of paid claims between MH/SUD (89.4 percent) and M/S (86.5 percent) services. Minimal differences were also reflected in the individual IP and OP results, as well as among IN paid claims. Data were not available to address IN differences by service type for Health Share.

Table F-2—Number and Percentage of Claims by Benefit Type for Health Share

Service Type	Benefit Type	Total Claims	Paid Claims[1]		In-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	66,766	54,750	82.0%	NA	NA
	M/S	332,076	280,975	84.6%	NA	NA
OP	MH/SUD	2,290,445	2,052,496	89.6%	NA	NA
	M/S	5,275,909	4,568,857	86.6%	NA	NA
Total	**MH/SUD**	**2,357,211**	**2,107,246**	**89.4%**	**1,974,777**	**93.7%**
	M/S	**5,607,985**	**4,849,832**	**86.5%**	**4,367,498**	**90.1%**

Note: NA indicates that in- and out-of-network counts were not collected separately for IP and OP claims.

[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.

Table F-3 presents a summary of the results from the analysis of PAs by service and benefit type. Due to the low number of PA denials that were appealed, results associated with the percentage of PA denials appealed, appeals upheld, and appeals overturned should be interpreted with caution, including any assessment of parity. Future studies may regularly incorporate a file review of MH/SUD and M/S appeals as a more effective measure of parity across services.

Table F-3—Prior Authorization Results by Benefit Type for Health Share

Service Type	Benefit Type	Total PA Requests	Requests Denied		Denied Requests Appealed[1]		
			Number	Percent[2]	Total Percent[2]	Percent Upheld	Percent Overturned
IP	**MH/SUD**	3,529	9	0.3%	11.1%	100%	0%
	M/S	20,131	628	3.1%	2.2%	50.0%	50.0%
OP	**MH/SUD**	140,216	284	0.2%	2.8%	75.0%	25.0%
	M/S	165,374	16,277	9.8%	6.7%	66.1%	33.9%
Rx	**MH/SUD**	2,579	1,406	54.5%	1.6%	40.9%	59.1%
	M/S	19,044	10,769	56.6%	2.2%	54.1%	45.9%

[1] Due to the small number of appeals, caution should be used when interpreting these results.

[2] 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.

Overall, Health Share exhibited minimal differences (less than 5 percentage points) in the percentage of PA requests denied across IP and Rx coverage determinations (2.8 percent points and 2.1 percentage points, respectively). However, the difference in the percentage of denied OP PA requests between MH/SUD and M/S (9.6 percentage points) was moderate, although the overall number of denials was less than 1 percent. Across all service types, the number of PA denials among MH/SUD services was lower than PA denials for M/S services.

Compared to other CCOs, Health Share's overall volume of PA requests (i.e., higher) and percentage of MH/SUD denials (i.e., lower) represented an outlier in the analysis. While Health Share had 140,216 OP MH/SUD PA requests with a denial rate of 0.2 percent, the average number of OP MH/SUD PA requests (excluding Health Share) was 1,278 requests, and the average denial rate was 8.21 percent. Health Share relies on subcontractors to provide all direct care and subcontracts all MH/SUD care to CareOregon. One of CareOregon's operational practices includes the reduction or removal most PA requirements for OP MH/SUD services. While this practice provides context for Health Share's low denial rate, it does not fully account for the high volume of OP MH/SUD PA requests. It is recommended that Health Share investigate the nature of its high volume of OP MH/SUD requests in relation its member population to determine the reason(s) and take steps to correct any errors or explain any anomalies in either its data, network adequacy, PA processes, or other operations.

Additionally, Health Share reported the lowest number of MH/SUD contracted providers and the highest percentage of terminated or nonrecredentialed MH/SUD providers compared to other CCOs. It is recommended that Health Share continue to assess the status of its MH/SUD network to identify further needs.

Summary of Overall Strengths and Areas Requiring Improvement

Upon review of its Annual MHP Attestation and submitted claims and UM data, no findings were noted for Health Share related to the parity of MH/SUD and M/S services.

Performance Strengths	**Strength:** Health Share has increased its oversight of the authorization review process by modifying the methodology used for quarterly denial reviews per its 2021 Improvement Plan. This will help the CCO ensure that its delegate's reviews and member notification standards for MH/SUD services are congruent with M/S services. **[Quality]**
Area(s) Requiring Improvement	**Area(s) requiring improvement:** No areas requiring improvement were identified based on the 2022 MHP Analysis findings.

Appendix G. Detailed MHP Results for InterCommunity Health Network

MHP Attestation Review

Table G-1 presents a summary of the attestation review and highlights the number of operational changes identified by the CCO, the number of changes compliant with parity standards, and the subsequent compliance score.

Table G-1—MHP Attestation Review Results: IHN

OR 2022 MHP Attestation Form Element	Total # of Change(s) Noted in 2021	Total # of Change(s) *Compliant* With Parity Standards	CCO Compliance Score
General Questions—Delegation & Medical Guidelines/Evidence	2	2	100%
Utilization Management (IP, OP, and Rx)	4	4	100%
Provider Admission Criteria	2	2	100%
Out-of-Network/Out-of-State Limits	NA	NA	NA
Enhanced Quality Services MH/SUD Information	NA	NA	NA
Overall Compliance Score	**8**	**8**	**100%**

Overall, the CCO demonstrated compliance with MHP requirements and standards when changes were identified in key operational areas. These changes included:

- Modifications to its provider selection process to address pandemic-related increases in demand and to implement process improvements.
- Updates to and alignment across pharmaceutical formulary and PA requirements related to MH/SUD and M/S benefit types.
- Waiving PA requirements for the first seven days of OON skilled nursing facility stays related to the pandemic.

Administrative Data Profile

Table G-2 presents a summary of the results from the analysis of paid claims by service and benefit type. In general, IHN showed a minimal difference (1.0 percentage point) in the percentage of paid claims between MH/SUD (94.9 percent) and M/S (93.9 percent) services. Minimal differences were also reflected in the individual IP and OP results, as well as among IN paid claims. Data were not available to address IN differences by service type.

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

Service Type	Benefit Type	Total Claims	Paid Claims[1]		In-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	9,903	9,025	91.1%	NA	NA
	M/S	57,020	51,405	90.2%	NA	NA
OP	MH/SUD	317,783	301,953	95.0%	NA	NA
	M/S	784,629	739,220	94.2%	NA	NA
Total	**MH/SUD**	**327,686**	**310,978**	**94.9%**	**295,029**	**94.9%**
	M/S	**841,649**	**790,625**	**93.9%**	**759,758**	**96.1%**

Note: NA indicates that in- and out-of-network counts were not collected separately for IP and OP claims.

[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.

Table G-3 presents a summary of the results from the analysis of PAs by service and benefit type. Due to the low number of PA denials that were appealed, results associated with the percentage of PA denials appealed, appeals upheld, and appeals overturned should be interpreted with caution, including any assessment of parity. Future studies may regularly incorporate a file review of MH/SUD and M/S appeals as a more effective measure of parity across services.

Table G-3—Prior Authorization Results by Benefit Type for IHN

Service Type	Benefit Type	Total PA Requests	Requests Denied		Denied Requests Appealed[1]		
			Number	Percent[2]	Total Percent[2]	Percent Upheld	Percent Overturned
IP	**MH/SUD**	30	1	3.3%	0%	NA	NA
	M/S	952	48	5.0%	60.4%	13.8%	86.2%
OP	**MH/SUD**	6,272	135	2.2%	14.1%	100%	0%
	M/S	34,402	4,999	14.5%	28.5%	24.3%	75.7%
Rx	**MH/SUD**	452	43	9.5%	2.3%	0%	100%
	M/S	9,945	3,526	35.5%	3.9%	51.1%	48.9%

[1] Due to the small number of appeals, caution should be used when interpreting these results. NA indicates a denominator of zero, or no requests were appealed.

[2] 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.

Overall, IHN exhibited substantial differences (greater than 10 percentage points) in the percentage of PA requests denied across MH/SUD and M/S OP and Rx requests (12.3 percent and 26.0 percent, respectively), and only a minimal difference between MH/SUD and M/S IP PA denials (1.7 percent). However, for all service types, PA denials were higher among M/S services compared to MH/SUD services.

Summary of Overall Strengths and Areas Requiring Improvement

Upon review of its Annual MHP Attestation and submitted claims and UM data, no findings were noted for IHN related to the parity of MH/SUD and M/S services.

Performance Strengths	**Strength:** No strengths were identified following review of the 2022 MHP Analysis findings.
Area(s) Requiring Improvement	**Area(s) requiring improvement:** No areas requiring improvement were identified based on the 2022 MHP Analysis findings.

Appendix H. Detailed MHP Results for Jackson Care Connect

MHP Attestation Review

Table H-1 presents a summary of the attestation review and highlights the number of operational changes identified by the CCO, the number of changes compliant with parity standards, and the subsequent compliance score.

Table H-1—MHP Attestation Review Results: JCC

OR 2022 MHP Attestation Form Element	Total # of Change(s) Noted in 2021	Total # of Change(s) *Compliant* With Parity Standards	CCO Compliance Score
General Questions—Delegation & Medical Guidelines/Evidence	NA	NA	NA
Utilization Management (IP, OP, and Rx)	4	4	100%
Provider Admission Criteria	2	2	100%
Out-of-Network/Out-of-State Limits	1	1	100%
Enhanced Quality Services MH/SUD Information	NA	NA	NA
Overall Compliance Score	**7**	**7**	**100%**

Overall, the CCO demonstrated compliance with MHP requirements and standards when changes were identified in key operational areas. These changes included:

- Decreasing the timeline for responding to SUD service requests and PA requests for eating disorder residential services to align with other residential services.
- Modifying utilization review criteria to include approval of additional IP services for members experiencing discharge barriers.
- Expanding the provider network to incorporate additional MH/SUD providers in response to network deficiencies.
- Updating policies and procedures to align with State requirements that require all pharmacy prescribers to have an Oregon State ID number.

Administrative Data Profile

Table H-2 presents a summary of the results from the analysis of paid claims by service and benefit type. In general, JCC showed a substantial difference (14.8 percentage points) in the percentage of paid claims between MH/SUD (72.9 percent) and M/S (87.7 percent) services. The overall difference was

driven primarily by the substantial difference exhibited in the percentage of paid OP claims (percentage points). Moreover, the percentage of paid claims overall and for OP claims was higher for M/S compared to MH/SUD claims. However, among IP claims, the difference in the percentage of paid MH/SUD claims (80.4 percent) and M/S claims (86.9 percent) was moderate at 6.5 percentage points. Similar differences were noted among IN paid claims, although data were not available to address IN differences by service type.

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

Service Type	Benefit Type	Total Claims	Paid Claims[1]		In-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	464	373	80.4%	NA	NA
	M/S	86,478	75,149	86.9%	NA	NA
OP	MH/SUD	4,091	2,946	72.0%	NA	NA
	M/S	1,134,445	995,968	87.8%	NA	NA
Total	**MH/SUD**	**4,555**	**3,319**	**72.9%**	**3,215**	**96.9%**
	M/S	**1,220,923**	**1,071,117**	**87.7%**	**968,338**	**90.4%**

Note: NA indicates that in- and out-of-network counts were not collected separately for IP and OP claims.

[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.

Table H-3 presents a summary of the results from the analysis of PAs by service and benefit type. Due to the low number of PA denials that were appealed, results associated with the percentage of PA denials appealed, appeals upheld, and appeals overturned should be interpreted with caution, including any assessment of parity. Future studies may regularly incorporate a file review of MH/SUD and M/S appeals as a more effective measure of parity across services.

Table H-3—Prior Authorization Results by Benefit Type for JCC

Service Type	Benefit Type	Total PA Requests	Requests Denied		Denied Requests Appealed[1]		
			Number	Percent[2]	Total Percent[2]	Percent Upheld	Percent Overturned
IP	MH/SUD	265	0	0%	NA	NA	NA
	M/S	3,343	101	3.0%	7.9%	25.0%	75.0%
OP	MH/SUD	821	1	0.1%	0%	NA	NA
	M/S	33,963	2,694	7.9%	7.8%	52.4%	47.6%
Rx	MH/SUD	333	241	72.4%	1.2%	66.7%	33.3%
	M/S	3,487	2,604	74.7%	1.0%	68.0%	32.0%

[1] Due to the small number of appeals, caution should be used when interpreting these results. NA indicates a denominator of zero, or no requests were appealed.

[2] 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.

Overall, JCC exhibited minimal differences (less than 5 percentage points) in the percentage of PA requests denied across IP and Rx coverage determinations (3.0 percent points and 2.3 percentage points, respectively). However, the difference in the percentage of denied OP PA requests between MH/SUD and M/S (7.8 percentage points) was moderate, although the overall number of MH/SUD denials was less than 1 percent. Across all service types, the number of PA denials among MH/SUD services was lower than PA denials for M/S services.

Compared to other CCOs, JCC's percentage of denied Rx PA requests was among the highest, and was substantially higher than the average for CCOs. At the same time, JCC reported some of the lowest percentages for IP and OP MH/SUD PA denials. It is recommended that JCC investigate the nature of its high volume of Rx MH/SUD requests in relation its member population to determine the reason(s) and take steps to correct any errors or explain any anomalies in either its data, network adequacy, PA processes, or other operations.

Summary of Overall Strengths and Areas Requiring Improvement

Upon review of its Annual MHP Attestation and submitted claims and UM data, no findings were noted for JCC related to the parity of MH/SUD and M/S services.

Performance Strengths	**Strength:** The CCO's Behavioral Health UM team implemented monthly internal quality audits to align with its Physical Health UM team's practices. **[Quality]**
Area(s) Requiring Improvement	**Area(s) requiring improvement:** No areas requiring improvement were identified based on the 2022 MHP Analysis findings.

Appendix I. Detailed MHP Results for PacificSource Community Solutions–Central Oregon

MHP Attestation Review

Table I-1 presents a summary of the attestation review and highlights the number of operational changes identified by the CCO, the number of changes compliant with parity standards, and the subsequent compliance score.

Table I-1—MHP Attestation Review Results: PCS-CO

OR 2022 MHP Attestation Form Element	Total # of Change(s) Noted in 2021	Total # of Change(s) *Compliant* With Parity Standards	CCO Compliance Score
General Questions—Delegation & Medical Guidelines/Evidence	1	1	100%
Utilization Management (IP, OP, and Rx)	7	7	100%
Provider Admission Criteria	1	1	100%
Out-of-Network/Out-of-State Limits	2	2	100%
Enhanced Quality Services MH/SUD Information	2	2	100%
Overall Compliance Score	**13**	**13**	**100%**

Overall, the CCO demonstrated compliance with MHP requirements and standards when changes were identified in key operational areas. These changes included:

- Updates to and alignment across pharmaceutical formulary and PA requirements related to MH/SUD and M/S benefit types.
- Updates to prescription criteria for treatments related to gender dysphoria.
- Removing PA requirements for transfers to skilled nursing facilities, inpatient rehabilitation centers, and long-term acute hospitals.
- Retroactive MH/SUD and M/S authorizations were extended to 90 days post-service.

Administrative Data Profile

Table I-2 presents a summary of the results from the analysis of paid claims by service and benefit type. In general, PCS-CO showed a minimal difference (1.7 percentage points) in the percentage of paid claims between MH/SUD (91.3 percent) and M/S (89.6 percent) services. Minimal differences were also

reflected in the individual IP and OP results, as well as among IN paid claims. Data were not available to address IN differences by service type.

Table I-2—Number and Percentage of Claims by Benefit Type for PCS-CO

Service Type	Benefit Type	Total Claims	Paid Claims[1]		In-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	1,699	1,498	88.17	NA	NA
	M/S	8,914	7,688	86.3%	NA	NA
OP	MH/SUD	386,346	352,640	91.3%	NA	NA
	M/S	1,513,763	1,357,063	89.7%	NA	NA
Total	**MH/SUD**	**388,045**	**354,138**	**91.3%**	**342,722**	**96.8%**
	M/S	**1,522,677**	**1,364,751**	**89.6%**	**1,350,610**	**99.0%**

Note: NA indicates that in- and out-of-network counts were not collected separately for IP and OP claims.

[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.

Table I-3 presents a summary of the results from the analysis of PAs by service and benefit type. Due to the low number of PA denials that were appealed, results associated with the percentage of PA denials appealed, appeals upheld, and appeals overturned should be interpreted with caution, including any assessment of parity. Future studies may regularly incorporate a file review of MH/SUD and M/S appeals as a more effective measure of parity across services.

Table I-3—Prior Authorization Results by Benefit Type for PCS-CO

Service Type	Benefit Type	Total PA Requests	Requests Denied		Denied Requests Appealed[1]		
			Number	Percent[2]	Total Percent[2]	Percent Upheld	Percent Overturned
IP	**MH/SUD**	2,277	13	0.6%	0%	NA	NA
	M/S	3,217	7	0.2%	0%	NA	NA
OP	**MH/SUD**	899	242	26.9%	2.5%	83.3%	16.7%
	M/S	29,827	3,144	10.5%	4.8%	100%	0%
Rx	**MH/SUD**	443	191	43.1%	1.1%	50.0%	50.0%
	M/S	4,554	2,767	60.8%	1.1%	80.0%	20.0%

[1] Due to the small number of appeals, caution should be used when interpreting these results. NA indicates a denominator of zero, or no requests were appealed.

[2] 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.

Overall, PCS-CO exhibited substantial differences (greater than 10 percentage points) in the percentage of PA requests denied across OP and Rx coverage determinations (16.4 percentage points and 17.7 percentage points, respectively). However, only PA denials for OP services were higher among MH/SUD services compared to M/S services (26.9 percent versus 10.5 percent). It is recommended that

PCS-CO investigate the nature of its OP UM differences to determine the reason(s) and take steps to correct any potential errors in either its data, UM practices, or other operations. There was a minimal difference in the percentage of MH/SUD and M/S PA denials for IP services (0.4 percentage points), with less than 1 percent of all PA requests being denied.

Summary of Overall Strengths and Areas Requiring Improvement

Upon review of its Annual MHP Attestation and submitted claims and UM data, no findings were noted for PCS-CO related to the parity of MH/SUD and M/S services.

Performance Strengths	**Strength:** PCS-CO created a clinician desktop reference to increase alignment in PA decisions across teams within the UM department. **[Quality]**
Area(s) Requiring Improvement	**Area(s) requiring improvement:** No areas requiring improvement were identified based on the 2022 MHP Analysis findings.

Appendix J. Detailed MHP Results for PacificSource Community Solutions–Columbia Gorge

MHP Attestation Review

Table J-1 presents a summary of the attestation review and highlights the number of operational changes identified by the CCO, the number of changes compliant with parity standards, and the subsequent compliance score.

Table J-1—MHP Attestation Review Results: PCS-CG

OR 2022 MHP Attestation Form Element	Total # of Change(s) Noted in 2021	Total # of Change(s) *Compliant* With Parity Standards	CCO Compliance Score
General Questions—Delegation & Medical Guidelines/Evidence	1	1	100%
Utilization Management (IP, OP, and Rx)	7	7	100%
Provider Admission Criteria	1	1	100%
Out-of-Network/Out-of-State Limits	2	2	100%
Enhanced Quality Services MH/SUD Information	2	2	100%
Overall Compliance Score	**13**	**13**	**100%**

Overall, the CCO demonstrated compliance with MHP requirements and standards when changes were identified in key operational areas. These changes included:

- Updates to and alignment across pharmaceutical formulary and PA requirements related to MH/SUD and M/S benefit types.
- Updates to prescription criteria for treatments related to gender dysphoria.
- Removing PA requirements for transfers to skilled nursing facilities, inpatient rehabilitation centers, and long-term acute hospitals.
- Retroactive MH/SUD and M/S authorizations extended to 90 days post-service.

Administrative Data Profile

Table J-2 presents a summary of the results from the analysis of paid claims by service and benefit type. In general, PCS-CG showed a minimal difference (0.9 percentage points) in the percentage of paid claims between MH/SUD (88.9 percent) and M/S (88.0 percent) services. Minimal differences were also

reflected in the individual IP and OP results, as well as among IN paid claims. Data were not available to address IN differences by service type.

Table J-2—Number and Percentage of Claims by Benefit Type for PCS-CG

Service Type	Benefit Type	Total Claims	Paid Claims[1]		In-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	186	148	79.6%	NA	NA
	M/S	2,136	1,512	70.8%	NA	NA
OP	MH/SUD	55,178	49,089	89.0%	NA	NA
	M/S	320,473	282,237	88.1%	NA	NA
Total	**MH/SUD**	**55,364**	**49,237**	**88.9%**	**47,865**	**97.3%**
	M/S	**322,609**	**283,749**	**88.0%**	**274,368**	**96.7%**

Note: NA indicates that in- and out-of-network counts were not collected separately for IP and OP claims.

[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.

Table J-3 presents a summary of the results from the analysis of PAs by service and benefit type. Due to the low number of PA denials that were appealed, results associated with the percentage of PA denials appealed, appeals upheld, and appeals overturned should be interpreted with caution, including any assessment of parity. Future studies may regularly incorporate a file review of MH/SUD and M/S appeals as a more effective measure of parity across services.

Table J-3—Prior Authorization Results by Benefit Type for PCS-CG

Service Type	Benefit Type	Total PA Requests	Requests Denied		Denied Requests Appealed[1]		
			Number	Percent[2]	Total Percent[2]	Percent Upheld	Percent Overturned
IP	**MH/SUD**	312	3	1.0%	0%	NA	NA
	M/S	801	2	0.3%	0%	NA	NA
OP	**MH/SUD**	166	39	23.5%	5.1%	0%	100%
	M/S	5,165	561	10.9%	3.4%	100%	0%
Rx	**MH/SUD**	79	36	45.6%	0%	NA	NA
	M/S	1,014	637	62.8%	0.8%	60.0%	40.0%

[1] Due to the small number of appeals, caution should be used when interpreting these results. NA indicates a denominator of zero, or no requests were appealed.

[2] 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.

Overall, PCS-CG exhibited substantial differences (greater than 10 percentage points) in the percentage of PA requests denied across OP and Rx coverage determinations (12.6 percentage points and 17.2 percentage points, respectively). However, only PA denials for OP services were higher among MH/SUD services compared to M/S services (23.5 percent versus 10.9 percent). It is recommended that

PCS-CG investigate the nature of its OP UM differences to determine the reason(s) and take steps to correct any potential errors in either its data, UM practices, or other operations. There was a minimal difference in the percentage of MH/SUD and M/S PA denials for IP services (0.7 percentage points), with just 1 percent or less of all PA requests being denied.

Summary of Overall Strengths and Areas Requiring Improvement

Upon review of its Annual MHP Attestation and submitted claims and UM data, no findings were noted for PCS-CG related to the parity of MH/SUD and M/S services.

Performance Strengths	**Strength:** PCS-CG created a clinician desktop reference to increase alignment in decisions across teams within the UM department. **[Quality]**
Area(s) Requiring Improvement	**Area(s) requiring improvement:** No areas requiring improvement were identified based on the 2022 MHP Analysis findings.

Appendix K. Detailed MHP Results for PacificSource Community Solutions–Lane

MHP Attestation Review

Table K-1 presents a summary of the attestation review and highlights the number of operational changes identified by the CCO, the number of changes compliant with parity standards, and the subsequent compliance score.

Table K-1—MHP Attestation Review Results: PCS-Lane

OR 2022 MHP Attestation Form Element	Total # of Change(s) Noted in 2021	Total # of Change(s) *Compliant* With Parity Standards	CCO Compliance Score
General Questions—Delegation & Medical Guidelines/Evidence	1	1	100%
Utilization Management (IP, OP, and Rx)	7	7	100%
Provider Admission Criteria	1	1	100%
Out-of-Network/Out-of-State Limits	2	2	100%
Enhanced Quality Services MH/SUD Information	2	2	100%
Overall Compliance Score	**13**	**13**	**100%**

Overall, the CCO demonstrated compliance with MHP requirements and standards when changes were identified in key operational areas. These changes included:

- Updates to and alignment across pharmaceutical formulary and PA requirements related to MH/SUD and M/S benefit types.
- Updates to prescription criteria for treatments related to gender dysphoria.
- Removing PA requirements for transfers to skilled nursing facilities, inpatient rehabilitation centers, and long-term acute hospitals.
- Retroactive MH/SUD and M/S authorizations were extended to 90 days post-service.

Administrative Data Profile

Table K-2 presents a summary of the results from the analysis of paid claims by service and benefit type. In general, PCS-Lane showed a minimal difference (2.1 percentage points) in the percentage of paid claims between MH/SUD (92.1 percent) and M/S (90.0 percent) services. Minimal differences were

also reflected in the individual IP and OP results, as well as among IN paid claims. Data were not available to address IN differences by service type.

Table K-2—Number and Percentage of Claims by Benefit Type for PCS-Lane

Service Type	Benefit Type	Total Claims	Paid Claims[1]		In-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	3,585	2,788	77.8%	NA	NA
	M/S	12,252	10,687	87.2%	NA	NA
OP	MH/SUD	507,995	468,141	92.2%	NA	NA
	M/S	2,064,448	1,857,838	90.0%	NA	NA
Total	**MH/SUD**	**511,580**	**470,929**	**92.1%**	**455,313**	**96.7%**
	M/S	**2,076,700**	**1,868,525**	**90.0%**	**1,838,471**	**98.4%**

Note: NA indicates that in- and out-of-network counts were not collected separately for IP and OP claims.

[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.

Table K-3 presents a summary of the results from the analysis of PAs by service and benefit type. Due to the low number of PA denials that were appealed, results associated with the percentage of PA denials appealed, appeals upheld, and appeals overturned should be interpreted with caution, including any assessment of parity. Future studies may regularly incorporate a file review of MH/SUD and M/S appeals as a more effective measure of parity across services.

Table K-3—Prior Authorization Results by Benefit Type for PCS-Lane

Service Type	Benefit Type	Total PA Requests	Requests Denied		Denied Requests Appealed[1]		
			Number	Percent[2]	Total Percent[2]	Percent Upheld	Percent Overturned
IP	**MH/SUD**	3,648	3	0.1%	0%	NA	NA
	M/S	5,134	16	0.3%	0%	NA	NA
OP	**MH/SUD**	729	228	31.3%	3.5%	37.5%	62.5%
	M/S	25,203	3,412	13.5%	5.5%	98.9%	1.1%
Rx	**MH/SUD**	836	474	56.7%	1.1%	20.0%	80.0%
	M/S	7,392	4,686	63.4%	1.3%	74.6%	25.4%

[1] Due to the small number of appeals, caution should be used when interpreting these results. NA indicates a denominator of zero, or no requests were appealed.

[2] 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.

Overall, PCS-Lane exhibited a substantial difference (greater than 10 percentage points) in the percentage of PA requests denied across OP coverage determinations (17.8 percentage points), and a moderate difference among Rx PA denials (6.7 percentage points). However, only PA denials for OP services were higher among MH/SUD services compared to M/S services (31.3 percent versus 13.5

percent). It is recommended that PCS-Lane investigate the nature of its OP UM differences to determine the reason(s) and take steps to correct any potential errors in either its data, UM practices, or other operations. There was a minimal difference in the percentage of MH/SUD and M/S PA denials for IP services (0.2 percentage points), with less than 1 percent of all PA requests being denied.

Summary of Overall Strengths and Areas Requiring Improvement

Upon review of its Annual MHP Attestation and submitted claims and UM data, no findings were noted for PCS-Lane related to the parity of MH/SUD and M/S services.

Performance Strengths	**Strength:** PCS-Lane created a clinician desktop reference to increase alignment in PA decisions across teams within the UM department. **[Quality]**
Area(s) Requiring Improvement	**Area(s) requiring improvement:** No areas requiring improvement were identified based on the 2022 MHP Analysis findings.

Appendix L. Detailed MHP Results for PacificSource Community Solutions–Marion Polk

MHP Attestation Review

Table L-1 presents a summary of the attestation review and highlights the number of operational changes identified by the CCO, the number of changes compliant with parity standards, and the subsequent compliance score.

Table L-1—MHP Attestation Review Results: PCS-MP

OR 2022 MHP Attestation Form Element	Total # of Change(s) Noted in 2021	Total # of Change(s) *Compliant* With Parity Standards	CCO Compliance Score
General Questions—Delegation & Medical Guidelines/Evidence	1	1	100%
Utilization Management (IP, OP, and Rx)	7	7	100%
Provider Admission Criteria	1	1	100%
Out-of-Network/Out-of-State Limits	2	2	100%
Enhanced Quality Services MH/SUD Information	2	2	100%
Overall Compliance Score	**13**	**13**	**100%**

Overall, the CCO demonstrated compliance with MHP requirements and standards when changes were identified in key operational areas. These changes included:

- Updates to and alignment across pharmaceutical formulary and PA requirements related to MH/SUD and M/S benefit types.
- Updates to prescription criteria for treatments related to gender dysphoria.
- Removing PA requirements for transfers to skilled nursing facilities, inpatient rehabilitation centers, and long-term acute hospitals.
- Retroactive MH/SUD and M/S authorizations extended to 90 days post-service.

Administrative Data Profile

Table L-2 presents a summary of the results from the analysis of paid claims by service and benefit type. Overall, PCS-MP showed a minimal difference (1.3 percentage points) in the percentage of paid claims between MH/SUD (89.5 percent) and M/S (88.2 percent) services. Minimal differences were also reflected in the individual OP results, while the difference in the percentage of paid IP claims for

MH/SUD (90.2 percent) and M/S (82.3 percent) was moderate (7.9 percentage points). The difference in the percentage of IN MH/SUD (96.5 percent) and M/S (98.1 percent) claims was also minimal. Data were not available to address IN differences by service type.

Table L-2—Number and Percentage of Claims by Benefit Type for PCS-MP

Service Type	Benefit Type	Total Claims	Paid Claims[1]		In-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	4,410	3,978	90.2%	NA	NA
	M/S	18,262	15,023	82.3%	NA	NA
OP	MH/SUD	696,344	623,112	89.5%	NA	NA
	M/S	2,860,838	2,523,802	88.2%	NA	NA
Total	**MH/SUD**	**700,754**	**627,090**	**89.5%**	**605,323**	**96.5%**
	M/S	**2,879,100**	**2,538,825**	**88.2%**	**2,490,313**	**98.1%**

Note: NA indicates that in- and out-of-network counts were not collected separately for IP and OP claims.

[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.

Table L-3 presents a summary of the results from the analysis of PAs by service and benefit type. Due to the low number of PA denials that were appealed, results associated with the percentage of PA denials appealed, appeals upheld, and appeals overturned should be interpreted with caution, including any assessment of parity. Future studies may regularly incorporate a file review of MH/SUD and M/S appeals as a more effective measure of parity across services.

Table L-3—Prior Authorization Results by Benefit Type for PCS-MP

Service Type	Benefit Type	Total PA Requests	Requests Denied		Denied Requests Appealed[1]		
			Number	Percent[2]	Total Percent[2]	Percent Upheld	Percent Overturned
IP	**MH/SUD**	2,819	7	0.3%	0%	NA	NA
	M/S	6,967	25	0.4%	0%	NA	NA
OP	**MH/SUD**	1,013	294	29.0%	0.7%	100%	0%
	M/S	35,176	5,014	14.3%	4.6%	98.3%	1.7%
Rx	**MH/SUD**	579	361	62.4%	1.4%	40.0%	60.0%
	M/S	8,299	5,132	61.8%	1.0%	79.6%	20.4%

[1] Due to the small number of appeals, caution should be used when interpreting these results. NA indicates a denominator of zero, or no requests were appealed.

[2] 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.

Overall, PCS-MP exhibited a substantial difference (greater than 10 percentage points) in the percentage of PA requests denied for OP coverage determinations (14.7 percentage points), and minimal differences among IP and Rx PA denials (0.1 percentage points and 0.6 percentage points, respectively). Moreover,

PA denials for OP services were higher among MH/SUD services compared to M/S services (29.0 percent versus 14.3 percent). It is recommended that PCS-MP investigate the nature of its OP UM differences to determine the reason(s) and take steps to correct any potential errors in either its data, UM practices, or other operations.

Summary of Overall Strengths and Areas Requiring Improvement

Upon review of its Annual MHP Attestation and submitted claims and UM data, no findings were noted for PCS-MP related to the parity of MH/SUD and M/S services.

Performance Strengths	**Strength:** PCS-MP created a clinician desktop reference to increase alignment in PA decisions across teams within the UM department. **[Quality]**
Area(s) Requiring Improvement	**Area(s) requiring improvement:** No areas requiring improvement were identified based on the 2022 MHP Analysis findings.

Appendix M. Detailed MHP Results for Trillium Community Health Plan, Inc.–North

MHP Attestation Review

Table M-1 presents a summary of the attestation review and highlights the number of operational changes identified by the CCO, the number of changes compliant with parity standards, and the subsequent compliance score.

Table M-1—MHP Attestation Review Results: TCHP-North

OR 2022 MHP Attestation Form Element	Total # of Change(s) Noted in 2021	Total # of Change(s) *Compliant* With Parity Standards	CCO Compliance Score
General Questions—Delegation & Medical Guidelines/Evidence	1	1	100%
Utilization Management (IP, OP, and Rx)	3	3	100%
Provider Admission Criteria	1	1	100%
Out-of-Network/Out-of-State Limits	NA	NA	NA
Enhanced Quality Services MH/SUD Information	1	1	100%
Overall Compliance Score	**6**	**6**	**100%**

Overall, the CCO demonstrated compliance with MHP requirements and standards when changes were identified in key operational areas. These changes included:

- Updates to MH/SUD policies and procedures to better align across benefit types and to ensure compliance with federal, State, and contract requirements.
- Removing PA requirements from behavioral health OP therapy services and for pharmaceuticals related to opioid or opiate withdrawal management.
- Updates to M/S QTL requirements related to speech, occupational, and physical therapy.

Administrative Data Profile

Table M-2 presents a summary of the results from the analysis of paid claims by service and benefit type. Overall, TCHP-North showed a substantial difference (13.4 percentage points) in the percentage of paid claims between MH/SUD (85.5 percent) and M/S (72.1 percent) services. This difference was driven primarily by differences exhibited in OP claims. The difference in the percentage of paid IP claims between MH/SUD and M/S services was moderate (6.4 percentage points). Across all service

types, a greater percentage of MH/SUD claims were paid compared to M/S claims. Similar differences were noted among IN paid claims, although data were not available to address IN differences by service type.

Table M-2—Number and Percentage of Claims by Benefit Type for TCHP-North

Service Type	Benefit Type	Total Claims	Paid Claims[1]		In-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	2,309	1,749	75.8%	NA	NA
	M/S	11,533	8,002	69.4%	NA	NA
OP	MH/SUD	42,069	36,207	86.1%	NA	NA
	M/S	103,437	74,926	72.4%	NA	NA
Total	**MH/SUD**	**44,378**	**37,956**	**85.5%**	**32,080**	**84.5%**
	M/S	**114,970**	**82,928**	**72.1%**	**71,437**	**86.1%**

Note: NA indicates that in- and out-of-network counts were not collected separately for IP and OP claims.

[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.

Table M-3 presents a summary of the results from the analysis of PAs by service and benefit type. Due to the low number of PA denials that were appealed, results associated with the percentage of PA denials appealed, appeals upheld, and appeals overturned should be interpreted with caution, including any assessment of parity. Future studies may regularly incorporate a file review of MH/SUD and M/S appeals as a more effective measure of parity across services.

Table M-3—Prior Authorization Results by Benefit Type for TCHP-North

Service Type	Benefit Type	Total PA Requests	Requests Denied		Denied Requests Appealed[1]		
			Number	Percent[2]	Total Percent[2]	Percent Upheld	Percent Overturned
IP	**MH/SUD**	184	21	11.4%	19.1%	25.0%	75.0%
	M/S	899	122	13.6%	4.1%	100%	0%
OP	**MH/SUD**	1,324	71	5.4%	11.3%	75.0%	25.0%
	M/S	3,333	515	15.5%	12.8%	57.6%	42.4%
Rx	**MH/SUD**	125	84	67.2%	8.3%	57.1%	42.9%
	M/S	954	594	62.3%	4.9%	34.5%	65.5%

[1] Due to the small number of appeals, caution should be used when interpreting these results. NA indicates a denominator of zero, or no requests were appealed.

[2] 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.

Overall, TCHP-North exhibited a substantial difference (greater than 10 percentage points) in the percentage of PA requests denied for OP coverage determinations 10.1 percentage points); however, the percentage of OP MH/SUD PA denials was lower than the PA denials for M/S services (5.4 percent

versus 15.5 percent). The difference between denied MH/SUD and M/S PA requests for IP services was minimal (2.2 percentage points), while the difference for Rx PA requests was moderate (4.9 percentage points); however, the percentage of denied MH/SUD PA requests (67.2 percent) was higher than for M/S PA requests (62.3 percent).

Summary of Overall Strengths and Areas Requiring Improvement

Upon review of its Annual MHP Attestation and submitted claims and UM data, no findings were noted for TCHP-North related to the parity of MH/SUD and M/S services.

Performance Strengths	**Strength:** No strengths were identified following review of the 2022 MHP Analysis findings.
Area(s) Requiring Improvement	**Area(s) requiring improvement:** No areas requiring improvement were identified based on the 2022 MHP Analysis findings.

Appendix N. Detailed MHP Results for Trillium Community Health Plan, Inc.–South

MHP Attestation Review

Table N-1 presents a summary of the attestation review and highlights the number of operational changes identified by the CCO, the number of changes compliant with parity standards, and the subsequent compliance score.

Table N-1—MHP Attestation Review Results: TCHP-South

OR 2022 MHP Attestation Form Element	Total # of Change(s) Noted in 2021	Total # of Change(s) *Compliant* With Parity Standards	CCO Compliance Score
General Questions—Delegation & Medical Guidelines/Evidence	2	2	100%
Utilization Management (IP, OP, and Rx)	3	3	100%
Provider Admission Criteria	1	1	100%
Out-of-Network/Out-of-State Limits	NA	NA	NA
Enhanced Quality Services MH/SUD Information	2	2	100%
Overall Compliance Score	**8**	**8**	**100%**

Overall, the CCO demonstrated compliance with MHP requirements and standards when changes were identified in key operational areas. These changes included:

- Updates to MH/SUD policies to better align across benefit type and to ensure compliance with federal, State, and contract requirements.
- Transferring MH/SUD UM clinical and administrative functions to internal Trillium staff members from a subcontractor.
- Removing PA requirements for behavioral health OP therapy services and pharmaceuticals related to opioid or opiate withdrawal management.
- Updates to M/S QTL requirements related to speech, occupational, and physical therapy.

Administrative Data Profile

Table N-2 presents a summary of the results from the analysis of paid claims by service and benefit type. Overall, TCHP-South showed a substantial difference (18.8 percentage points) in the percentage of paid claims between MH/SUD (87.5 percent) and M/S (68.7 percent) services, as well as individually

for IP and OP claims (24.7 percentage points and 18.1 percent). Across all service types, a greater percentage of MH/SUD claims were paid compared to M/S claims. Similar differences were noted among IN paid claims, although the difference was minimal (percentage points.)

Table N-2—Number and Percentage of Claims by Benefit Type for TCHP-South

Service Type	Benefit Type	Total Claims	Paid Claims[1]		In-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	12,157	9,835	80.9%	NA	NA
	M/S	42,560	23,911	56.2%	NA	NA
OP	MH/SUD	227,534	199,971	87.9%	NA	NA
	M/S	453,144	316,622	69.8%	NA	NA
Total	**MH/SUD**	**239,691**	**209,806**	**87.5%**	**201,462**	**96.0%**
	M/S	**495,704**	**340,533**	**68.7%**	**315,313**	**92.6%**

Note: NA indicates that in- and out-of-network counts were not collected separately for IP and OP claims.

[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.

Table N-3 presents a summary of the results from the analysis of PAs by service and benefit type. Due to the low number of PA denials that were appealed, results associated with the percentage of PA denials appealed, appeals upheld, and appeals overturned should be interpreted with caution, including any assessment of parity. Future studies may regularly incorporate a file review of MH/SUD and M/S appeals as a more effective measure of parity across services.

Table N-3—Prior Authorization Results by Benefit Type for TCHP-South

Service Type	Benefit Type	Total PA Requests	Requests Denied		Denied Requests Appealed[1]		
			Number	Percent[2]	Total Percent[2]	Percent Upheld	Percent Overturned
IP	**MH/SUD**	309	22	7.1%	4.6%	100%	0%
	M/S	2,282	329	14.4%	1.2%	50.0%	50.0%
OP	**MH/SUD**	2,524	167	6.6%	9.0%	53.3%	46.7%
	M/S	8,600	1,067	12.4%	13.9%	65.5%	34.5%
Rx	**MH/SUD**	319	119	37.3%	2.5%	33.3%	66.7%
	M/S	2,454	1,183	48.2%	3.8%	48.9%	51.1%

[1] Due to the small number of appeals, caution should be used when interpreting these results. NA indicates a denominator of zero, or no requests were appealed.

[2] 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.

Overall, TCHP-South exhibited moderate differences in the percentage of PA requests denied for IP and OP coverage determinations (7.3 percentage points and 5.8 percentage points, respectively), while the difference in denied Rx PA requests between MH/SUD and M/S was substantial (10.9 percentage

points). However, the percentage of MH/SUD Rx PA denials was lower than the PA denials for M/S services (37.3 percent versus 48.2 percent).

Summary of Overall Strengths and Areas Requiring Improvement

Upon review of its Annual MHP Attestation and submitted claims and UM data, no findings were noted for TCHP-South related to the parity of MH/SUD and M/S services.

Performance Strengths	**Strength:** No strengths were identified following review of the 2022 MHP Analysis findings.
Area(s) Requiring Improvement	**Area(s) requiring improvement:** No areas requiring improvement were identified based on the 2022 MHP Analysis findings.

Appendix O. Detailed MHP Results for Umpqua Health Alliance, LLC

MHP Attestation Review

Table O-1 presents a summary of the attestation review and highlights the number of operational changes identified by the CCO, the number of changes compliant with parity standards, and the subsequent compliance score.

Table O-1—MHP Attestation Review Results: UHA

OR 2022 MHP Attestation Form Element	Total # of Change(s) Noted in 2021	Total # of Change(s) *Compliant* With Parity Standards	CCO Compliance Score
General Questions—Delegation & Medical Guidelines/Evidence	NA	NA	100%
Utilization Management (IP, OP, and Rx)	1	1	100%
Provider Admission Criteria	NA	NA	100%
Out-of-Network/Out-of-State Limits	NA	NA	100%
Enhanced Quality Services MH/SUD Information	NA	NA	NA
Overall Compliance Score	**1**	**1**	**100%**

Overall, the CCO demonstrated compliance with MHP requirements and standards when changes were identified in key operational areas. One change was identified related to:

- Updates to its pharmaceutical formulary and PA requirements to better align the administration of MH/SUD and M/S benefit types.

Administrative Data Profile

Table O-2 presents a summary of the results from the analysis of paid claims by service and benefit type. Overall, UHA exhibited a moderate difference (5.6 percentage points) in the percentage of paid claims between MH/SUD (86.4 percent) and M/S (80.8 percent) services, as well as for IP and OP claims individually (9.7 percentage points and 6.3 percentage points, respectively). However, the percentage of paid claims was lower among MH/SUD IP claims compared to M/S IP claims. The percentage of paid IN MH/SUD claims (97.5 percent) and M/S claims (90.3 percent) was also moderate.

Table O-2—Number and Percentage of Claims by Benefit Type for UHA

Service Type	Benefit Type	Total Claims	Paid Claims[1]		In-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	5,862	4,146	70.7%	NA	NA
	M/S	3,575	2,882	80.6%	NA	NA
OP	MH/SUD	125,466	109,320	87.1%	NA	NA
	M/S	595,827	481,124	80.8%	NA	NA
Total	**MH/SUD**	**131,328**	**113,466**	**86.4%**	**110,066**	**97.5%**
	M/S	**599,402**	**484,006**	**80.8%**	**386,553**	**90.3%**

Note: NA indicates that in- and out-of-network counts were not collected separately for IP and OP claims.

[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.

Table O-3 presents a summary of the results from the analysis of PAs by service and benefit type. Due to the low number of PA denials that were appealed, results associated with the percentage of PA denials appealed, appeals upheld, and appeals overturned should be interpreted with caution, including any assessment of parity. Future studies may regularly incorporate a file review of MH/SUD and M/S appeals as a more effective measure of parity across services.

Table O-3—Prior Authorization Results by Benefit Type for UHA

Service Type	Benefit Type	Total PA Requests	Requests Denied		Denied Requests Appealed[1]		
			Number	Percent[2]	Total Percent[2]	Percent Upheld	Percent Overturned
IP	**MH/SUD**	1,471	149	10.1%	2.0%	100%	0%
	M/S	1,196	47	3.9%	2.1%	0%	100%
OP	**MH/SUD**	849	103	12.1%	6.8%	85.7%	14.3%
	M/S	19,856	4,106	20.7%	3.1%	59.5%	40.5%
Rx	**MH/SUD**	1,263	336	26.6%	0.9%	0%	100%
	M/S	4,863	2,735	56.2%	0.9%	70.8%	29.2%

[1] Due to the small number of appeals, caution should be used when interpreting these results. NA indicates a denominator of zero, or no requests were appealed.

[2] 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.

UHA exhibited a substantial difference in the percentage of PA requests denied for Rx coverage determinations (29.6 percentage points) and moderate differences among IP and OP PA denials (6.2 percentage points and 8.6 percentage points, respectively). However, only PA denials for IP services were higher among MH/SUD services compared to M/S services (10.1 percent versus 3.9 percent). It is recommended that UHA investigate the nature of its IP UM differences to determine the reason(s) and take steps to correct any potential errors in either its data, UM practices, or other operations.

Summary of Overall Strengths and Areas Requiring Improvement

Upon review of its Annual MHP Attestation and submitted claims and UM data, no findings were noted for UHA related to the parity of MH/SUD and M/S services.

Performance Strengths	**Strength:** No strengths were identified following review of the 2022 MHP Analysis findings.
Area(s) Requiring Improvement	**Area(s) requiring improvement:** No areas requiring improvement were identified based on the 2022 MHP Analysis findings.

Appendix P. Detailed MHP Results for Yamhill Community Care Organization

MHP Attestation Review

Table P-1 presents a summary of attestation review and highlights the number of operational changes identified by the CCO, the number of changes compliant with parity standards, and the subsequent compliance score.

Table P-1—MHP Attestation Review Results: YCCO

OR 2022 MHP Attestation Form Element	Total # of Change(s) Noted in 2021	Total # of Change(s) *Compliant* With Parity Standards	CCO Compliance Score
General Questions—Delegation & Medical Guidelines/Evidence	NA	NA	NA
Utilization Management (IP, OP, and Rx)	NA	NA	NA
Provider Admission Criteria	NA	NA	NA
Out-of-Network/Out-of-State Limits	NA	NA	NA
Enhanced Quality Services MH/SUD Information	NA	NA	NA
Overall Compliance Score	NA	NA	NA

In 2022, YCCO transitioned administration of its MH/SUD services to Yamhill Community Care (i.e., Providence), which also managed YCCO's medical services, terminating its subcontract with the Yamhill County MH program. Since this change was effective as of January 1, 2022, HSAG had previously reviewed this material change as part of the 2021 MHP Analysis, and it was subsequently approved by OHA. No other changes were implemented in 2022. As such, the CCO continued to demonstrate compliance with MHP requirements and standards.

Administrative Data Profile

Table P-2 presents a summary of the results from the analysis of paid claims by service and benefit type. Overall, YCCO showed a substantial difference (12.9 percentage points) in the percentage of paid claims between MH/SUD (92.1 percent) and M/S (79.2 percent) services, as well as individually for IP and OP claims (16.7 percentage points and 13.4 percentage points, respectively). However, the percentage of paid claims was lower among MH/SUD IP claims compared to M/S IP claims. The percentage of paid IN MH/SUD claims (99.7 percent) and M/S claims (93.6 percent) was also moderate.

Table P-2—Number and Percentage of Claims by Benefit Type for YCCO

Service Type	Benefit Type	Total Claims	Paid Claims[1]		In-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	1,131	771	68.2%	NA	NA
	M/S	17,834	15,140	84.9%	NA	NA
OP	MH/SUD	123,604	114,140	92.3%	NA	NA
	M/S	345,523	272,625	78.9%	NA	NA
Total	**MH/SUD**	**124,735**	**114,911**	**92.1%**	**114,566**	**99.7%**
	M/S	**363,357**	**287,765**	**79.2%**	**269,429**	**93.6%**

Note: NA indicates that in- and out-of-network counts were not collected separately for IP and OP claims.

[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.

Table P-3 presents a summary of the results from the analysis of PAs by service and benefit type. Due to the low number of PA denials that were appealed, results associated with the percentage of PA denials appealed, appeals upheld, and appeals overturned should be interpreted with caution, including any assessment of parity. Future studies may regularly incorporate a file review of MH/SUD and M/S appeals as a more effective measure of parity across services.

Table P-3—Prior Authorization Results by Benefit Type for YCCO

Service Type	Benefit Type	Total PA Requests	Requests Denied		Denied Requests Appealed[1]		
			Number	Percent[2]	Total Percent[2]	Percent Upheld	Percent Overturned
IP	**MH/SUD**	369	37	10.0%	21.6%	75.0%	25.0%
	M/S	1,994	81	4.1%	0%	NA	NA
OP	**MH/SUD**	2,399	126	5.3%	10.3%	76.9%	23.1%
	M/S	15,198	1,173	7.7%	4.0%	70.2%	29.8%
Rx	**MH/SUD**	467	128	27.4%	1.6%	0%	100%
	M/S	1,429	744	52.1%	2.6%	63.2%	36.8%

[1] Due to the small number of appeals, caution should be used when interpreting these results. NA indicates a denominator of zero, or no requests were appealed.

[2] 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.

YCCO exhibited a substantial difference in the percentage of PA requests denied for Rx coverage determinations (24.7 percentage points), a moderate difference among IP denials (5.7 percentage points), and a minimal difference for OP denials (2.4 percentage points). However, only PA denials were higher among MH/SUD IP requests compared to M/S IP requests (10.0 percent versus 4.1 percent). It is recommended that YCCO investigate the nature of its IP UM differences to determine the reason(s) and take steps to correct any potential errors in either its data, UM practices, or other operations.

Summary of Overall Strengths and Areas Requiring Improvement

Upon review of its Annual MHP Attestation and submitted claims and UM data, no findings were noted for YCCO related to the parity of MH/SUD and M/S services.

Performance Strengths	**Strength:** No strengths were identified following review of the 2022 MHP Analysis findings.
Area(s) Requiring Improvement	**Area(s) requiring improvement:** No areas requiring improvement were identified based on the 2022 MHP Analysis findings.

Appendix Q. Detailed MHP Results for Oregon Health Plan Fee-for-Service

MHP Attestation Review

Table Q-1 presents a summary of the attestation review and highlights the number of operational changes identified by OHP FFS, the number of changes compliant with parity standards, and the subsequent compliance score.

Table Q-1—MHP Attestation Review Results: OHP FFS

OR 2022 MHP Attestation Form Element	Total # of Change(s) Noted in 2021	Total # of Change(s) *Compliant* With Parity Standards	CCO Compliance Score
General Questions—Delegation & Medical Guidelines/Evidence	1	1	100%
Utilization Management (IP, OP, and Rx)	6	6	100%
Provider Admission Criteria	NA	NA	NA
Out-of-Network/Out-of-State Limits	NA	NA	NA
Enhanced Quality Services MH/SUD Information	NA	NA	NA
Overall Compliance Score	**7**	**7**	**100%**

Overall, OHP FFS demonstrated compliance with MHP requirements and standards when changes were identified in key operational areas. These changes included:

- Increased reimbursement rates for MH/SUD services.
- Updates to M/S QTL requirements related to speech, occupational, and physical therapy.
- Updates to PA criteria for treatment related to smoking cessation and appropriate use of MH medications.
- Updates to documentation requirements for UM for secure residential treatment facilities.

Administrative Data Profile

Table Q-2 presents a summary of the results from the analysis of paid claims by service and benefit type. Overall, the difference in the percentage of paid claims for OHP FFS was substantial (21.3percentage points), with a greater percentage of MH/SUD claims (69.4 percent) being paid compared to M/S claims (48.2 percent). However, the percentage of paid claims for IP showed a moderate difference (6.8 percentage points, respectively), where MH/SUD claims were paid less frequently than M/S claims. These results placed OHP FFS at, near, or below the lowest percentage of paid claims relative to the CCOs for all but OP MH/SUD. This difference may be explained by one or more factors, including PA processes, claims processes, the needs of its member population, providers'

familiarity with and ability to submit complete and accurate claims, or OHP FFS' data quality. It is recommended that OHP FFS investigate the nature of its paid claims rates to determine the reason(s) and take steps to correct any potential errors in either its data, claims payment practices, provider education, or other operations.

Table Q-2—Number and Percentage of Claims by Benefit Type for OHP FFS

Service Type	Benefit Type	Total Claims	Paid Claims[1]		In-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	4,275	1,702	39.8%	NA	NA
	M/S	65,040	30,307	46.6%	NA	NA
OP	MH/SUD	1,056,400	734,853	69.6%	NA	NA
	M/S	3,648,635	1,758,745	48.2%	NA	NA
Total	**MH/SUD**	**1,060,675**	**736,555**	**69.4%**	**NA**	**NA**
	M/S	**3,713,675**	**1,789,052**	**48.2%**	**NA**	**NA**

Note: NA indicates that in- and out-of-network counts were not collected separately for IP and OP claims.
[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.

Table Q-3 presents a summary of the results from the analysis of PAs by service and benefit type. Due to the low number of PA denials that were appealed, results associated with the percentage of PA denials appealed, appeals upheld, and appeals overturned should be interpreted with caution, including any assessment of parity. Future studies may regularly incorporate a file review of MH/SUD and M/S appeals as a more effective measure of parity across services.

Table Q-3—Prior Authorization Results by Benefit Type for OHP FFS

Service Type	Benefit Type	Total PA Requests	Requests Denied		Denied Requests Appealed[1]		
			Number	Percent[2]	Total Percent[2]	Percent Upheld	Percent Overturned
IP	**MH/SUD**	2,059	4	0.2%	NA	NA	NA
	M/S	112	21	18.8%	NA	NA	NA
OP	**MH/SUD**	3,780	48	1.3%	NA	NA	NA
	M/S	563	128	22.7%	NA	NA	NA
Rx	**MH/SUD**	9,154	2,188	23.9%	4.6%	9.9%	90.1%
	M/S	12,258	2,281	18.6%	3.7%	20.0%	80.0%

[1] Due to the small number of appeals, caution should be used when interpreting these results.
[2] 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.

OHP FFS exhibited substantial differences in the percentage of PA requests denied for IP and OP coverage determinations (18.6 percentage points and 21.4 percentage points, respectively) and a moderate difference among Rx denials (5.3 percentage points). However, only PA denials were higher among MH/SUD Rx requests compared to M/S Rx requests 23.9 percent versus 18.6 percent). It is recommended that OHP FFS investigate the nature of its Rx UM differences to determine the reason(s) and take steps to correct any potential errors in either its data, UM practices, or other operations.

OHP FFS was the only organization unable to submit provider data sufficient for determining the average number of contracted providers; number of providers terminated or not recredentialed in CY 2021; or the numbers of applications processed, approved, and denied, which may have limited its capacity to conduct internal monitoring for parity of MH/SUD and M/S provider enrollment practices. In reviewing the processes leading to OHP FFS' omission, HSAG confirmed that two factors affected its ability to provide the required data elements. First, provider enrollment at the state level does not involve an evaluation network needs; any and all providers may submit an application for enrollment. As long as qualifications are met, the provider is enrolled with the State Medicaid program. Second, key data elements required to support the 2022 MHP Evaluation were not directly available within its information systems (i.e., credentialing decision date, credentialing decision, and reason for denial of application).

Summary of Overall Strengths and Areas Requiring Improvement

Upon review of its Annual MHP Attestation and submitted claims and UM data, no findings were noted for OHP FFS related to the parity of MH/SUD and M/S services; however, one finding was noted related to the quality of provider enrollment data captured and reported as part of the 2022 MHP Analysis.

Performance Strengths	**Strength:** No strengths were identified following review of the 2022 MHP Analysis findings.
Area(s) Requiring Improvement	**Area(s) requiring improvement:** OHP FFS was unable to submit all the required provider enrollment data for the 2022 MHP Analysis. **[Quality and Access]** **Rationale:** MH/SUD and M/S provider enrollment practices and outcomes cannot be evaluated if relevant data are not 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. **Required action(s):** OHP FFS must update or modify its administrative systems to capture additional data elements (e.g., application receipt date, enrollment data, 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, it is recommended that OHP FFS work with OHA and its contractor to map available data fields to required MHP evaluation data elements. OHP FFS must implement these changes in order to support future MHP reporting requirements.

Appendix R. MHP Community Partner Feedback

Salient points from multiple MHP community partner feedback sessions are collected here and separated by community partner group and date. HSAG has removed identifying information and revised feedback for clarity and pertinence to MHP.

Consumers

- March 7, 2022
  - MH/SUD services described as generally lacking compared to M/S.
  - Telehealth expansion has been helpful for increasing access to MH/SUD services.
  - Reported critical "lag" time between MH/SUD provider appointment availability and prescription refill needs, leading to negative, preventable outcomes.
  - Communication between CCOs, providers, pharmacies, and members regarding MH/SUD care was characterized as poor and inconsistent.
  - *Services Requested but not Required to Cover:* Members do not understand the health-related services (HRS) benefits or how to request/access them.
- October 12, 2022 & October 14, 2022
  - Network adequacy is a critical part of MHP evaluation, and community partners need additional time for input.
  - Future work should include qualitative assessments as well.
  - MHP work should acknowledge and bring forward the human impact of inadequate behavioral health care.

CCOs

- April 26, 2022
  - Timely access standards for MH/SUD are stricter than for M/S and may contribute to a lack of MH/SUD providers willing to see Medicaid members.
  - *Services Requested but not Required to Cover:* Community Benefit and Flex HRS are different. Flex HRS services are not reported with a diagnosis code and are difficult to separate into MH/SUD and M/S.
- CCOs were provided with an opportunity for written feedback on individual results between October 27, 2022 and November 10, 2022. No feedback was received.

Providers

- June 10, 2022
  - MH/SUD provider recruitment pool is small. System-wide staffing crisis creates long waitlists, particularly for MH (e.g., counselors).
  - MH/SUD telehealth services are often reimbursed at unsustainably low rates by CCOs.
  - CCOs are inconsistent in reimbursement rates, both between CCOs and between MH and SUD services, reimbursing less for MH than for SUD services.
  - *Services Requested but not Required to Cover*: Injection-delivered pharmaceuticals (e.g., Sublocade and other injectable forms of buprenorphine) for treatment of narcotic dependence are an SUD "tool," but are not billable by MH/SUD—only M/S. This results in a high barrier for PA, high cost, and low reimbursement rates (even below cost).
- November 18, 2022
  - Future evaluations should consider increasing specificity in defining in- and out-of-network providers, including how to classify providers operating under single case agreements. CCOs are inconsistent in their documentation of network contract status.
  - OHA should consider incorporating 360 degree qualitative methods to support future audit activities to ensure input from patients and providers, in addition to CCOs and OHP FFS.
  - Medicaid members often present with higher acuity associated with exposure to adverse social determinants of health. As such, members health can be at risk due to administrative barriers (level of care approvals for residential versus intensive outpatient programs) and the availability and access to care.
  - Network adequacy measures (e.g., provider ratios, time and distance analyses) should pair member clinical conditions with specific provider types.

Appendix S. Statewide Denial Reasons

Table S-1 on the following page shows the statewide aggregate percentage of denial reasons for all service types and by benefit (i.e., MH/SUD and M/S) for IP, OP, and Rx 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 S-1—Statewide PA Denial Reasons by Service Type and Benefit

Prior Authorization Denial Reason	All Service Types			IP			OP			Rx		
	Total	MH/SUD	M/S	Total	MH/SUD	M/S	Total	MH/SUD	M/S	Total	MH/SUD	M/S
Not Medically Necessary	41.8%	47.3%	41.4%	80.9%	76.9%	81.7%	47.7%	35.6%	48.1%	33.5%	50.3%	32.0%
Not a Covered Benefit	31.9%	39.8%	31.4%	6.5%	10.0%	5.8%	31.5%	53.8%	30.7%	33.2%	35.8%	33.0%
Service is *Below the Line*	21.7%	4.7%	22.7%	2.6%	0.0%	3.1%	16.8%	2.1%	17.3%	28.0%	6.2%	30.0%
Administrative Denial	2.4%	3.7%	2.3%	6.6%	10.6%	5.8%	1.7%	2.6%	1.6%	3.0%	3.7%	3.0%
Partial Denial	0.8%	2.5%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.7%	3.7%	1.5%
Other	1.6%	2.0%	1.5%	3.5%	2.5%	3.6%	2.4%	5.8%	2.2%	0.6%	0.2%	0.6%