Oregon Health Authority

2023 Mental Health Parity Evaluation Summary Report

December 2023

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Introduction

Background

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

- Aggregate lifetime and annual dollar limits (AL/ADLs).
- Financial requirements (FRs—such as copays).
- Quantitative treatment limitations (QTLs—such as day and visit limits).
- Non-quantitative treatment limitations (NQTLs—such as prior authorization [PA] and provider network admission requirements).

Additional MHP regulations require that criteria for medical necessity determinations for MH/SUD benefits must be made available to beneficiaries and providers upon request, as well as the reason for denial of reimbursement or payment for MH/SUD benefits. States must also implement monitoring procedures to ensure continued compliance and to identify when changes in benefit design or operations could affect compliance and require an updated analysis. Finally, Oregon House Bill 3046 (HB 3046), enrolled in 2021 and effective in 2022, outlined additional MHP reporting requirements for Coordinated Care Organizations (CCOs) and OHP fee-for-service (FFS), culminating in the presentation of a comprehensive report to the Oregon Legislature annually.

To comply with federal and State requirements, the Oregon Health Authority (OHA) contracted with its external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG), to conduct an evaluation of parity for MH/SUD benefits as relative to M/S benefits provided under OHP managed care benefit packages in accordance with requirements in 42 CFR §438, Subpart K and Oregon HB 3046.

The 2023 analysis included a review of each CCO's and OHP FFS' treatment limitations used by the organization to manage MH/SUD and M/S benefits to ensure compliance with MHP requirements, a review of claims and utilization management (UM) data to identify key patterns and outcomes associated with the administration of covered benefits, a file review targeting service authorization denials and appeals to ensure accurate implementation of policies and procedures, and an evaluation of the adequacy of the provider network and timeliness of access to MH/SUD treatment and services. The

2023 MHP Analysis and report were designed to assess and document parity across MH/SUD and M/S benefits for participating CCOs and OHP FFS.

Table 1-1 describes the organizations evaluated in the 2023 MHP Analysis and the associated organization abbreviations.

Table 1-1—List of Organization Names and Abbreviations

Organization Name	CCO Short Name
Advanced Health	AH
AllCare CCO, Inc.	AllCare
Cascade Health Alliance, LLC	CHA
Columbia Pacific CCO, LLC	CPCCO
Eastern Oregon CCO, LLC	EOCCO
Health Share of Oregon	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-N
Trillium Community Health Plan, Inc.–South	TCHP-S
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:

- Conduct a review of the treatment limitations of OHA's 16 CCOs and OHP FFS on MH/SUD benefits to ensure they are comparable to and applied no more stringently than limitations applied to M/S benefits.
- Evaluate claims, UM data, and provider enrollment data to assess the impact of MH/SUD and M/S operations on claims and utilization decisions.
- Conduct a review of a sample of CCO and OHP FFS service authorization denials and appeals encompassing both MH/SUD and M/S denials to assess implementation of policies and procedures.

- Complete an evaluation of the adequacy of the provider network and timeliness of access to MH/SUD treatment and services.
- Identify each CCO's and OHP FFS' performance strengths, opportunities for improvement, and areas requiring corrective action.
- Gather information and perspective regarding findings from the documentation review, data analysis, and compliance determinations during meetings with community partners (CPs).
- Identify potential areas of interest from CPs to inform the scope of the 2024 MHP activity.
- Prepare a comprehensive report inclusive of all 2023 MHP activity findings and input from CPs for OHA to submit to the Oregon Legislative Assembly as required by HB 3046.

2. Process and Methodology

The 2023 MHP Evaluation assessed the extent to which coverage and access to services for the treatment of MH/SUD conditions were provided in parity with treatments provided for M/S conditions. The evaluation included a review of organizational policies and procedures governing the implementation of treatment limitations applied to MH/SUD and M/S services, as well as outcomes of these organizational systems. 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 2023 MHP activities are described below.

1. **Protocol Development and Dissemination:** HSAG developed the 2023 MHP Analysis Protocol, which presented details and guidance to OHA, the CCOs, and the OHP FFS on the process for conducting the 2023 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]
   - **2023 MHP Treatment Limitation Review Tool**—A standardized questionnaire used by the CCOs and OHP FFS to submit documentation demonstrating compliance with MHP treatment limitations; collects information on the policies, procedures, and/or practices that impact MH/SUD and M/S parity.
   - **2023 MHP Data Submission Template**—A Microsoft Excel-based template used by the CCOs and OHP FFS to report data on inpatient (IP), outpatient (OP), and pharmacy (Rx) claims and UM data; MH/SUD and M/S provider credentialing data; and member-level detail files. The template is also used to collect grievances, appeals, and additional service authorization denial data for OHP FFS.
2. **MHP Technical Assistance Webinar:** HSAG conducted a webinar with the CCOs and OHP FFS on March 17, 2023. The webinar provided an overview of MHP regulations; details of the 2023 MHP Analysis Protocol and tools; an overview of the MHP Analysis timeline; a review of required documentation and submission guidelines, analysis, and reporting processes; and an opportunity for questions and answers. HSAG and OHA produced a Questions & Answers document to provide clarification to the CCOs and OHP FFS on any questions received during and after the webinar.

[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: Nov 30, 2023.

3. **Documentation Submission:** The CCOs and OHP FFS were required to submit the *MHP Treatment Limitation Review Tool* and all applicable supporting documentation, as well as submit claims, UM, and credentialing data through the *MHP Data Submission Template*. All requested data was due for submission on or before **June 1, 2023**.
4. **Desk Review and Analysis:** HSAG conducted a desk review of each CCO's and OHP FFS' submitted documentation and data to evaluate parity between MH/SUD and M/S services and benefits. HSAG performed an analysis of the claims, UM, and credentialing data to assess the impact of MH/SUD and M/S operations on claims and utilization decisions. Reported rates were validated against member level detail (MLD) files and used to develop an administrative profile of each CCO and OHP FFS. HSAG completed a file review of MH/SUD and M/S service authorization denials and appeals to further understand UM decision details and in understanding parity. HSAG also performed an assessment of the CCOs' and OHP FFS' MH/SUD provider network to assess the adequacy, availability, and timeliness of access to MH/SUD services. The evaluation incorporated a multi-dimensional approach using a series of measures to support network reporting. When necessary, HSAG followed up with the CCOs, OHP FFS, or OHA to obtain missing documentation, or receive clarification on submissions.
5. **Report Production:** HSAG compiled the preliminary results from all information obtained for each CCO and OHP FFS. Per HB 3046, HSAG summarized the results of its review and presented the findings to OHA and its CPs to solicit input on the assessment of the CCOs' and OHP FFS' compliance with the requirement for parity between MH/SUD and M/S covered benefits, identifying areas in which MH parity was not achieved and corrective actions were required to ensure future parity. HSAG received feedback from OHA and its CPs and drafted a final MHP Evaluation report for submission to OHA and the Oregon Legislature, no later than December 31, 2023.
6. **Corrective Action Plan and Implementation:** Based on documentation of findings for a CCO or OHP FFS, OHA will work with the CCO and OHP FFS to address and resolve any findings identified during the 2023 MHP Evaluation.

Description of Data Obtained

To assess the CCOs' and OHP FFS' compliance with the federal, State, and contract requirements for parity between the MH/SUD and M/S covered benefits, HSAG obtained information from multiple documents and sources completed and submitted by each organization, including, but not limited to:

- A completed *MHP Treatment Limitation Review Tool*, including identification of all NQTLs used by the organizations to manage MH/SUD and M/S benefits for IP, OP, Rx, and emergency care (EC) services and supplemental documentation.
- A completed *MHP Data Submission Template*, including:
  - Membership counts.
  - Summary results for aggregated counts of claims, UM decisions, and provider enrollment and credentialing.
  - Detailed, member-level utilization data records.

- Clinical/administrative records for a selected sample of service authorization denials and member appeals.
- Documentation of the CCOs' and OHP FFS' methodologies for assessing the appointment availability.
- CCO and OHP FFS grievance data.
- MH/SUD provider capacity and member enrollment data.

HSAG obtained additional information for the MHP Evaluation through interactions, discussions, and interviews with each CCO's and OHP FFS' key staff members, as necessary. Furthermore, OHA convened meetings with three groups of CPs (i.e., consumers, CCOs, and providers) to solicit community input on the MHP 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 in the 2023 MHP Evaluation.

MHP Treatment Limitation Review Tool Analysis

For its review of the *MHP Treatment Limitation Review Tool*, HSAG assessed each CCO's and OHP FFS' responses across two evaluation domains:

- The comparability of the processes, strategies, evidentiary standards, and other factors (in writing and in operation) used in applying treatment limitations to MH/SUD benefits and M/S benefits.
- The stringency with which the processes, strategies, evidentiary standards, and other factors (in writing and operation) were applied to MH/SUD benefits and M/S benefits.

HSAG used the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant*, as defined in Table 2-1, to indicate the degree to which each CCO's and OHP FFS' performance was compliant with parity requirements based on whether the treatment limitations on MH/SUD benefits identified by the organization were comparable to, and applied no more stringently than, the limitations applied to M/S benefits. A designation of *Not Applicable* (*NA*) was used when a specific limitation classification on the review tool 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 Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*.[2-2] HSAG reviewed all submitted documentation to further clarify identified limitations, as well as information available from prior MHP analyses, as appropriate.

[2-2] Ibid.

Table 2-1—Rating Definitions for MHP Compliance Determinations

Rating	Definition
Compliant	Indicates that the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency*.
Partially Compliant	Indicates that the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was: • *Comparable* but applied with different *stringency, or* • Not *comparable* but applied with equivalent *stringency*. OR • Documentation was incomplete (i.e., one or more evaluation elements were not addressed), but organizational structure was identified.
Not Compliant	Indicates that the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was not *comparable* and applied with different *stringency*. If documentation and evidence was insufficient to demonstrate an adequately defined program, a rating of *Not Compliant* was also applied.

From the ratings assigned to each individual limitation identified, HSAG aggregated compliance ratings across all limitations by limitation subcategory. An overall or aggregate subcategory rating of *Compliant* was assigned if all individual treatment limitations applicable to a CCO were compliant, while an overall or aggregate subcategory rating of *Not Compliant* was assigned if not all individual treatment limitations were compliant. An overall or aggregate subcategory rating of *Partially Compliant* was based on any combination of compliant, partially compliant, or not compliant ratings. Elements not applicable to the organization were scored *NA* and were not included in the aggregate rating.

Administrative Data Profile

To further understand the impact of CCO and OHP FFS policies and procedures on the management of MH/SUD and M/S benefits, HSAG analyzed CCO and OHP FFS data collected between January 1, 2022, and December 31, 2022, across three key domains. The data included aggregate counts for claims/encounters and UM decisions for MH/SUD and M/S services as well as MH/SUD provider enrollment data and identification of members representing the MH, SUD, and M/S claims. HSAG reviewed all submitted data for consistency and conducted a comparative analysis to identify trends between MH/SUD and M/S services, between CCOs and OHP FFS, and statewide. Data collected to support the Administrative Data Profiles included services covered through four OHP benefit packages (i.e., CCOA, CCOB, CCOE, and CCOB).[2-3]

[2-3] OHP benefit levels include CCOA (physical, behavioral, and oral health benefits); CCOB (i.e., physical and behavioral health benefits); CCOE (i.e., behavioral health benefits only); and CCOG (i.e., behavioral and oral health benefits).

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

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

Deviation Rating	Definition
None	Difference between MH/SUD and M/S profile metric is **less than** 5 percentage points.
Moderate	Difference between MH/SUD and M/S profile metric is: • **greater than or equal** to 5 percentage points, and • **less than** 10 percentage points.
Substantial	Difference between MH/SUD and M/S profile metric is **greater than or equal to** 10 percentage points.

Adequacy of MH/SUD Provider Networks

The 2023 MHP Evaluation assessed the adequacy of the CCOs' and OHP FFS' MH/SUD provider networks by evaluating several interrelated measures of members' access to MH and SUD services.

Provider Network Capacity

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

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

Time and Distance

HSAG assessed the geographic distribution of MH and SUD providers relative to member populations as represented by the percentage of members having access to an MH and SUD provider within the OHA-defined time and distance standards. These standards included the average travel time (in minutes) and driving distance (in miles) to the nearest provider for each provider type. To refine the time and distance measures, CCO and OHP FFS members were limited to those reported in the *2023 MHP Data*

Submission Template based on the MH/SUD claims identified in each organization's summary claim counts. Table 2-3 outlines OHA's time and distance standards.

Table 2-3—Time and Distance Standards

Geographic Classification	Definition	Time Standard	Distance Standard	Percentage of Overall Member Access Standard
Urban	A geographic area that is less than 10 map miles from a population center of 30,000 people or more.	30 Minutes	30 Miles	95%
Rural	A geographic area that is 10 or more map miles from a population center of 30,000 people or less.	60 Minutes	60 Miles	95%

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

Appointment Availability

HSAG reviewed the CCOs' responses to the 2023 DSN Provider Narrative Review Tool and OHP FFS' submission of the OHP FFS Appointment Availability Questionnaire to understand how each organization monitored the availability of appointments to MH/SUD and M/S services and providers. HSAG qualitatively assessed the scope and consistency of each CCO's and OHP FFS' methodology and approach to monitoring appointment availability across MH/SUD and M/S services.[2-4]

Access-Related Grievances

HSAG reviewed and assessed the percentage of access-related MH and SUD grievances to identify potential areas of concern with the availability of MH and SUD providers within each CCO's and OHP FFS' network. Although descriptive, the review of access-related grievances was used to observe patterns that may be associated with the adequacy of MH/SUD and M/S provider networks. Additionally, to assess parity, HSAG evaluated the extent to which the grievance metrics differed between MH/SUD and M/S services. HSAG used deviation ratings of *None*, *Moderate*, and *Substantial*, as defined in Table 2-4, to indicate the degree to which the CCO's and OHP FFS' reported grievance metrics differed across MH/SUD and M/S services.

[2-4] In 2023, appointment availability data and results were insufficient to assess or report quantitative results, or to compare CCO and OHP FFS performance to federal and State requirements.

Table 2-4—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 CP groups to solicit feedback from the community and provide input on both the assessment of parity as well as the direction of future MHP analyses. The CP groups were composed of OHP members, CCOs, and providers and were initially convened between April and May of 2023. These discussion-oriented meetings served three key objectives:

1. Inform CPs of the 2023 MHP Analysis and scope of review.
2. Solicit input on MHP areas of concern.
3. Receive feedback on current and future study objectives, future evaluation topics, and potential methods.

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

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

- Evaluation results from the 2023 MHP Analysis, including a summary of findings from the Treatment Limitation Analysis, Administrative Data Profile, and evaluation of the adequacy of the provider network and timeliness of access to MH/SUD treatment and services.
- Conclusions drawn from the CCO and OHP FFS findings.
- Recommendations for methodology changes in future MHP evaluations.
- The results of OHA's 2024/2025 topic selection survey.

Table 2-5 contains a list of CP groups and meeting dates in 2023. OHA coordinated meetings in fall 2023 to review preliminary findings and discuss special evaluation topics for inclusion in the 2024 MHP Evaluation. The CCO partners received preliminary copies of their MHP findings in November 2023, and were provided an opportunity to review the results and submit written feedback.

Table 2-5—MHP Community Partner Groups and Meeting Dates

Community Partner Group	Initial Meeting	Closing Meeting(s)
Consumers	04/12/2023	11/08/2023
CCOs	05/23/2023	12/05/2023
Providers	04/11/2023	11/15/2023

3. Results

This section contains the results from the 2023 MHP Evaluation and includes the qualitative and quantitative findings associated with the *MHP Treatment Limitation Review Tool*, Administrative Data Profile, and the assessment of the adequacy of the provider network and timeliness of access to MH/SUD treatment and services. Together, these analyses evaluated the extent to which there was parity in the administration of MH/SUD benefits and M/S benefits by the CCOs and OHP FFS.

Treatment Limitation Reviews

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

- Financial Requirements (FR)—*payments by members for services received that are in addition to payments made by the CCO (e.g., copayments and deductibles).*
- Aggregate Lifetime or Annual Dollar Limits (AL/ADLs)—*dollar limits on the total amount of a specified benefit over a lifetime or on an annual basis.*
- Quantitative Treatment Limitations (QTLs)—*limits*[3-1] *on the scope or duration of a benefit that are expressed numerically (e.g., days or visit limits).*
- Non-Quantitative Treatment Limitations (NQTLs)—*limits on the scope or duration of benefits, such as PA or network admission standards. NQTLs were separated into three main categories—i.e., Medical Management, Provider Network, and Pharmacy Management*.

Responses to the *MHP Treatment Limitation Review Tool*, along with supplemental documentation (e.g., policies, procedures, processes, and workflows), were used to assess the extent to which treatment limitations were implemented and whether documentation demonstrated compliance with how MH parity requirements for MH/SUD and M/S services and benefits. To assess compliance, CCO and OHP FFS documentation was reviewed to determine:

- The rationale for implementing the treatment limitation.
- The process and strategy for applying the treatment limitation.
- The evidentiary standards used to define the treatment limitation and assess medical necessity.
- The frequency and stringency with which the treatment limitation was applied.

[3-1] Soft limits, or benefit limits that allow an individual to exceed numerical limits for MH/SUD or M/S benefits on the basis of medical necessity, are considered NQTLs.

Information collected was then used to determine whether processes were standardized, implemented, and applied with comparable frequency and rigor across MH/SUD and M/S benefits. Detailed results and findings for individual CCOs and OHP FFS are available in Appendix A through Appendix Q.

Financial Requirements

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

Aggregate Lifetime or Annual Dollar Limits

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

Quantitative Treatment Limitations

Although most CCOs reported that their organizations did not apply QTLs in the administration of MH/SUD and M/S benefits across IP, OP, Rx, or EC services, seven CCOs and OHP FFS reported using QTLs in the management of MH/SUD or M/S benefits. Specifically:

- EOCCO, IHN, PCS-CG, PCS-CO, PCS-Lane, and PCS-MP noted implementation of quantity limits on the days supply for MH/SUD and M/S prescriptions.
- UHA and OHP FFS noted implementation of limits on the number of hours and/or visits associated with select MH/SUD services (e.g., withdrawal management, residential treatment, and testing) and M/S services (e.g., acupuncture, home health services, and occupational/physical therapy).

However, upon review, the QTLs were identified as soft limits and incorrectly categorized since the seven CCOs and OHP FFS allowed members to receive additional services based on an evaluation of medical necessity through PA or concurrent review (CR). As such, none of the CCOs or OHP FFS reported the use of QTLs in the administration of MH/SUD or M/S benefits across IP, OP, Rx, or EC services.

Non-Quantitative Treatment Limitations

Since the regulatory structure of Medicaid and the OHP makes the implementation of FRs, AL/ADLs, and QTLs unlikely, NQTLs represent a key mechanism used by the CCOs and OHP FFS to manage and ensure members' health care is necessary and appropriate. To facilitate the comprehensive review of NQTLs implemented by the CCOs and OHP FFS, the *MHP Treatment Limitation Review Tool* included pre-populated listings of possible NQTLs across three domains—Medical Management, Provider Network, and Pharmacy Management. Table 3-1 lists the types of NQTLs pre-populated in the tool to assist the CCOs and OHP FFS in identifying NQTLs used by each organization.

Table 3-1—Prepopulated NQTLs

Medical Management	Provider Network	Pharmacy Management
• Medical necessity criteria • Practice guidelines selection/criteria • Prior authorization • Concurrent review • Retrospective review • Outlier management • Experimental/investigational determinations • Fail-first requirements • Failure to complete exclusions • Medical appropriateness reviews • Requirements for lower cost therapies to be tried first	• Provider enrollment, admission, and credentialing requirements • Reimbursement rates • Geographic restrictions • Specialty requirements or exclusions • Facility type requirements • Network tiers • Out-of-network/out-of-state access requirements or exclusions	• Methods for determining usual, customary, and reasonable charges • Formulary design for prescription drugs • Prescription drug benefit tiers (e.g., generic versus brand name, high cost versus low cost).

All CCOs and OHP FFS implemented at least one NQTL across the three domains (Medical Management, Provider Network, and Pharmacy Management) in support of MH/SUD and M/S benefits. Of the treatment limitations, the most prevalent were UM processes (i.e., prior authorization [PA], concurrent review [CR], and retrospective review [RR]); medical necessity criteria; provider credentialing requirements; and drug utilization review mechanisms (e.g., formulary design).

For each NQTL reported, the CCOs and OHP FFS were required to provide appropriate documentation (e.g., descriptions, policies, procedures, processes, and flowcharts) that addressed the following questions:

1. Why was the NQTL assigned? What evidence supports the rationale for using the NQTL?
2. What procedures/processes/requirements are used to apply the NQTL by benefit and service type (e.g., time frames, evidentiary standards/documentation requirements, reviewer qualifications, monitoring/oversight of processes)?
3. How frequently/strictly is the NQTL applied (e.g., frequency of application, penalties associated with NQTL)?
4. What evidence supports the rationale for how frequently/strictly the NQTL is applied?

In general, most of the CCOs demonstrated compliance with parity requirements when sufficient information and supporting documentation were provided for the implemented NQTL. The majority of *Partially Compliant* and *Not Compliant* findings resulted from insufficient information or documented evidence of parity related to the selection of NQTLs and the consistency and stringency with which they were applied to MH/SUD and M/S benefits across service types. For example, CCOs and OHP FFS sometimes limited responses to listing references to regulatory requirements and coverage guidelines when defining the NQTLs used to manage members' health care services—i.e., Oregon Administrative

Rules (OARs) and the Health Evidence Review Commission (HERC) Prioritized List of Health Services. Without supporting documentation (e.g., internal policies, procedures, processes, standard operating procedures, and workflows) to demonstrate how the treatment limitations were implemented and applied to MH/SUD and M/S benefits, the CCOs and OHP FFS were unable to fully demonstrate that NQTLs were comparable and not applied more stringently for MH/SUD benefits compared to M/S benefits. In the absence of complete responses to and supporting documentation for treatment limitation questions, the evaluation of parity between MH/SUD and M/S benefits was limited and inconclusive, resulting in parity compliance ratings less than *Compliant*.

Table 3-2 highlights the overall ratings of compliance with parity requirements for the CCOs and OHP FFS for NQTLs, by domain and overall.

Table 3-2—Overall Compliance With Parity Requirements by CCO/OHP FFS and NQTL Domain

CCO Name	Medical Management	Provider Network	Pharmacy Management	Overall Compliance Rating
AH	Partially Compliant	–	Partially Compliant	**Partially Compliant**
AllCare	Partially Compliant	–	Partially Compliant	**Partially Compliant**
CHA	Compliant	Compliant	Compliant	**Compliant**
CPCCO	Compliant	Compliant	Compliant	**Compliant**
EOCCO	Partially Compliant	Compliant	Partially Compliant	**Partially Compliant**
Health Share	Partially Compliant	Partially Compliant	Partially Compliant	**Partially Compliant**
IHN	Compliant	Compliant	Compliant	**Compliant**
JCC	Compliant	Compliant	Compliant	**Compliant**
PCS-CG	Compliant	Compliant	Partially Compliant	**Partially Compliant**
PCS-CO	Compliant	Compliant	Partially Compliant	**Partially Compliant**
PCS-Lane	Compliant	Compliant	Partially Compliant	**Partially Compliant**
PCS-MP	Compliant	Compliant	Partially Compliant	**Partially Compliant**
TCHP-N	Compliant	–	Compliant	**Compliant**
TCHP-S	Compliant	–	Compliant	**Compliant**
UHA	Compliant	Compliant	Partially Compliant	**Partially Compliant**
YCCO	Compliant	–	Compliant	**Compliant**
OHP FFS	Not Compliant	Not Compliant	Not Compliant	**Not Compliant**

– indicates the CCO/OHP FFS reported it did not apply the category of NQTL treatment limitation to any service classification for MH/SUD or M/S benefits.

Medical Management

Most of the CCOs' policies included standardized processes that applied to both MH/SUD and M/S benefits, including UM and PA policies and service authorization handbooks. For Medical Management

limits applied to IP, OP, and Rx services, each CCO's UM processes were established to confirm benefit coverage and ensure members received medically necessary and appropriate treatment in the least restrictive environment while maintaining the safety of the individual, compliance with federal and State requirements, and monitoring for the overutilization of services. Evidentiary standards used to apply UM decisions to MH/SUD and M/S included the OARs, the HERC Prioritized List of Health Services and guidelines, CMS' National Coverage Determination (NCD) or Local Coverage Determination (LCD) criteria guidelines, Milliman Care Guidelines, and other clinical guidelines developed by professional medical associations. All instances of Medical Management NQTLs identified by the CCOs for EC were further described as limits placed on non-emergency care. A review of documentation confirmed that any PA or CR of MH/SUD and M/S services occurred after the stabilization of an emergency or crisis.

Overall, documentation demonstrated that the CCOs have established standardized processes to support the implementation of MH/SUD and M/S benefits through Medical Management. A review of the treatment limitations included in CCOs' Medical Management programs did not identify any explicit parity concerns related to their application to MH/SUD and M/S benefits; however, three of the CCOs (i.e., AllCare, EOCCO, and Health Share) received *Partially Compliant* parity ratings due to insufficient documentation regarding the processes, strategies, evidentiary standards, and other factors needed to demonstrate that these CCOs' treatment limitations were comparable and were not applied more stringently for MH/SUD benefits compared to M/S benefits. Two of the CCOs (AH and EOCCO) used concurrent review to manage OP MH/SUD services but did not report the use of concurrent review to support the delivery of OP M/S benefits. Neither of these CCOs included documentation to explain the differences in their processes resulting in a *Partially Compliant* parity rating. However, documentation from other compliance monitoring review activities indicated that the delivery of services was likely managed through PA processes. For example, a CCO may require a new PA for OP M/S services, rather than rely on concurrent review, when the terms of the initial PA end (e.g., initial number of visits or days approved). Due to Health Share's complete delegation of managed care functions related to benefit delivery to its subcontractors, evidence of parity for this CCO was dependent on the quality of its subcontractors' policies, procedures, and processes. As such, Health Share's *Partially Compliant* parity rating was due to lack of sufficient documentation submitted to support an assessment for all NQTLs excluding medical necessity, PA, and RR.

OHP FFS' documentation and tool responses were limited to listing references to regulatory requirements and coverage guidelines when defining the NQTLs used to manage members' health care services—i.e., OARs and the HERC Prioritized List of Health Services. OHP FFS also provided a link to its *Prior Authorization Handbook*; however, the handbook was a provider-facing document that included instructions for providers to submit PA requests. Without supporting documentation (e.g., internal policies, procedures, processes, standard operating procedures, and workflows) to demonstrate how the treatment limitations were implemented and applied to MH/SUD and M/S benefits, OHP FFS was unable to demonstrate that NQTLs were comparable and not applied more stringently for MH/SUD benefits compared to M/S benefits. The lack of standardized processes and procedures resulted in a *Not Compliant* parity rating for OHP FFS.

Provider Network

Among CCOs reporting the implementation of Provider Network NQTLs, most limited implementation of NQTLs to credentialing and recredentialing of providers as other network limitations were managed through the CCOs' PA programs. In general, the CCOs' policies and procedures highlighted standardized processes to manage individual and organizational credentialing and recredentialing of providers within their networks that were comparable and no more stringently applied to MH/SUD providers than for M/S providers.

Overall, 11 CCOs identified provider enrollment and credentialing as an NQTL, with documentation demonstrating that each organization had standardized processes to support the processes for credentialing new providers and recredentialing existing providers. Moreover, the CCOs' policies and procedures were aligned with State and federal regulations and applied consistently for MH/SUD and M/S providers. Although not all CCOs identified provider enrollment, credentialing, and recredentialing activities as an NQTL, documentation from other compliance monitoring activities supports the implementation of these NQTLs by all CCOs as required by federal and State regulations. While compliance to regulatory standards varied by CCO, no evidence of parity issues has been identified historically. In addition to credentialing procedures, Health Share identified the use of out-of-network/out-of-state access requirements as an NQTL. However, the CCO's responses and supporting documentation were insufficient to demonstrate how each subcontractor, or the CCO as a whole, was applying these restrictions to MH/SUD and M/S services. Omitted information included the rationale for using the NQTL; its application to MH/SUD and M/S providers; descriptions of the requirements, including the processes for determining how and what provider specialty restrictions are applied; and evidence to support development of the NQTL. As a result, Health Share received a parity rating of *Partially Compliant*.

Similar to the CCOs, OHP FFS identified provider enrollment, credentialing, and recredentialing as a Provider Network NQTL, along with reimbursement rates, geographic restrictions, and specialty requirements. However, geographic restrictions and specialty requirements were limited to M/S providers and were not relevant to the parity evaluation. For provider enrollment/credentialing and reimbursement rates, OHP FFS documentation and tool responses were limited to listing references to regulatory requirements (i.e., OARs), fee schedules, and a link to the OHP Provider Enrollment website. Without supporting documentation (e.g., internal policies, procedures, processes, standard operating procedures, and workflows) to demonstrate how these treatment limitations were implemented and applied to MH/SUD and M/S providers, OHP FFS was unable to demonstrate whether these NQTLs were in parity. The lack of standardized processes and procedures resulted in a *Not Compliant* parity rating for OHP FFS.

Pharmacy Management

Overall, the CCOs and OHP FFS reported the implementation of a variety of Pharmacy Management NQTLs. Among the most prevalent treatment limitations were prescription drug formularies, PA requirements, development of reasonable charges, step therapy restrictions, age restrictions, and quantity limits. For Pharmacy Management limits, the CCO's processes were established to confirm benefit

coverage and ensure members received medically necessary and appropriate medication management in compliance with clinical guidelines while maintaining the safety of the individual and monitoring the overutilization of prescription use.

Overall, documentation demonstrated that the CCOs have established standardized processes to support the management of pharmacy services for members receiving MH/SUD and M/S benefits. A review of the treatment limitations included in the CCOs' Pharmacy Management programs did not identify any explicit parity concerns related to their application to members with MH/SUD and M/S benefits. However, while there were no parity concerns for the CCOs' PA processes for prescription drugs, several CCOs received *Partially Compliant* parity ratings due to insufficient information regarding processes, strategies, evidentiary standards, and other factors used in developing prescription drug formularies, determining reasonable charges, step therapy and age restrictions, and/or quantity limits.

Similar to the CCOs, OHP FFS implemented several Pharmacy Management NQTLs, including PA for prescriptions; determining usual, customary, and reasonable charges; formulary design; and benefit tiers. However, OHP FFS' documentation and tool responses were limited to listing references to regulatory requirements and providing a link to the OHP website when defining the NQTLs used to manage members' MH/SUD and M/S pharmacy benefits. Without supporting documentation (e.g., internal policies, procedures, processes, standard operating procedures, and workflows) to demonstrate how the treatment limitations were implemented and applied to MH/SUD and M/S pharmacy benefits, OHP FFS was unable to demonstrate that the NQTLs were comparable and not applied more stringently for MH/SUD benefits compared to M/S benefits. The lack of standardized processes and procedures resulted in a *Not Compliant* parity rating.

Availability of Information

In addition to understanding the various financial and treatment limitations that affect the administration of MH/SUD and M/S benefits, the Medicaid/CHIP [Children's Health Insurance Program] parity rule also includes a requirement regarding the availability of information related to MH/SUD benefits. Specifically, CCOs and OHP FFS must make the criteria for medical necessity determinations for MH/SUD benefits available to members, potential members, and affected providers, upon request. Table 3-3 shows the parity ratings for CCOs and OHP related to compliance with availability of information requirements.

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

CCO Name	Compliance Rating
AH	Partially Compliant
AllCare	Partially Compliant
CHA	Compliant
CPCCO	Compliant
EOCCO	Compliant

CCO Name	Compliance Rating
Health Share	Compliant
IHN	Compliant
JCC	Compliant
PCS-CG	Compliant
PCS-CO	Compliant
PCS-Lane	Compliant
PCS-MP	Compliant
TCHP-N	Compliant
TCHP-S	Compliant
UHA	Compliant
YCCO	Compliant
OHP FFS	Partially Compliant

Overall, the CCOs and OHP FFS demonstrated that medical necessity criteria information was made available to members, potential members, and network providers through a variety of formats, including member handbooks, provider manuals, CCO websites, and via notices to members when a service or reimbursement for an MH/SUD service was denied. Two CCOs (i.e., AH and AllCare) and OHP FFS received *Partially Compliant* parity ratings due to insufficient documentation demonstrating how medical necessity criteria were disseminated to all required individuals or evidence that these criteria were shared. Additionally, the review identified that several organizations included links to the HERC Prioritized List of Health Services without interpretive guidelines or instructions, which could represent a barrier to members' understanding of these resources. While these findings did not signify a parity concern since the same efforts were applied to MH/SUD and M/S benefits, the CCOs and OHP FFS should take steps to ensure that available information is readily accessible to members.

Administrative Data Profiles

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

- Claims, including IP and OP services[3-2]
- UM, including IP, OP, and Rx coverage determinations
- Provider enrollment

[3-2] Claims data included dental claims but excluded non-emergency medical transportation (NEMT) and Rx 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.[3-3] As such, the larger the number in the figure, the greater the difference between the MH/SUD and M/S performance metrics. Detailed results and findings for individual CCOs and OHP FFS are available in Appendix A through Appendix Q.

Claims

To conduct the claims analysis, the CCOs and OHP FFS submitted claims counts that encompassed all covered services (except NEMT and Rx[3-4]) by claim type (i.e., IP and OP) and provider network status (i.e., in-network [IN] and out-of-network [OON]) at the header and detail claim level. Since claims are paid at the detail (service) line level, aggregate header counts were categorized as paid, partially paid, and denied. Claims were defined as *partially paid* if at least one detail claim line was denied; claims that included all paid detail lines or all denied detail lines should be classified as paid claims and denied claims, respectively. The total number of IP and OP claims was evaluated at the header level and reported as the total number paid (i.e., paid and partially paid claims) and denied overall, and by network status. The aggregate counts from the CCOs and OHP FFS were then used to generate the percentage of claims paid by benefit type; the difference between the percentage of paid claims for MH/SUD versus M/S services was then evaluated as the core metric for evaluating parity. The absolute difference was used to classify the deviation in the rates of claims paid between MH/SUD and M/S services to determine if the difference was negligible (less than 5 percentage points), moderate (greater than or equal to 5 percentage points, but less than 10 percentage points), or substantial (greater than or equal to 10 percentage points).

Although data were not available to determine the types of services that were paid versus denied, moderate and substantial differences in rates identify areas where operational policies and procedures (i.e., claims submission requirements, authorization determinations, claims processing, provider billing, etc.) highlight instances where MH/SUD and M/S outcomes were different and warrant further review, especially when the differences were outliers compared to other CCOs and the CCO aggregate. In addition to assessing the absolute difference in the percentage of paid claims, the analysis indicated whether the difference reflected greater rates of payment for MH/SUD services over M/S services.

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 there was considerable variation in payment rates across individual CCOs and OHP FFS. However, when CCO and OHP FFS differences were moderate or substantial for paid IP and OP claims, the deviation was generally due to a higher

[3-3] `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.

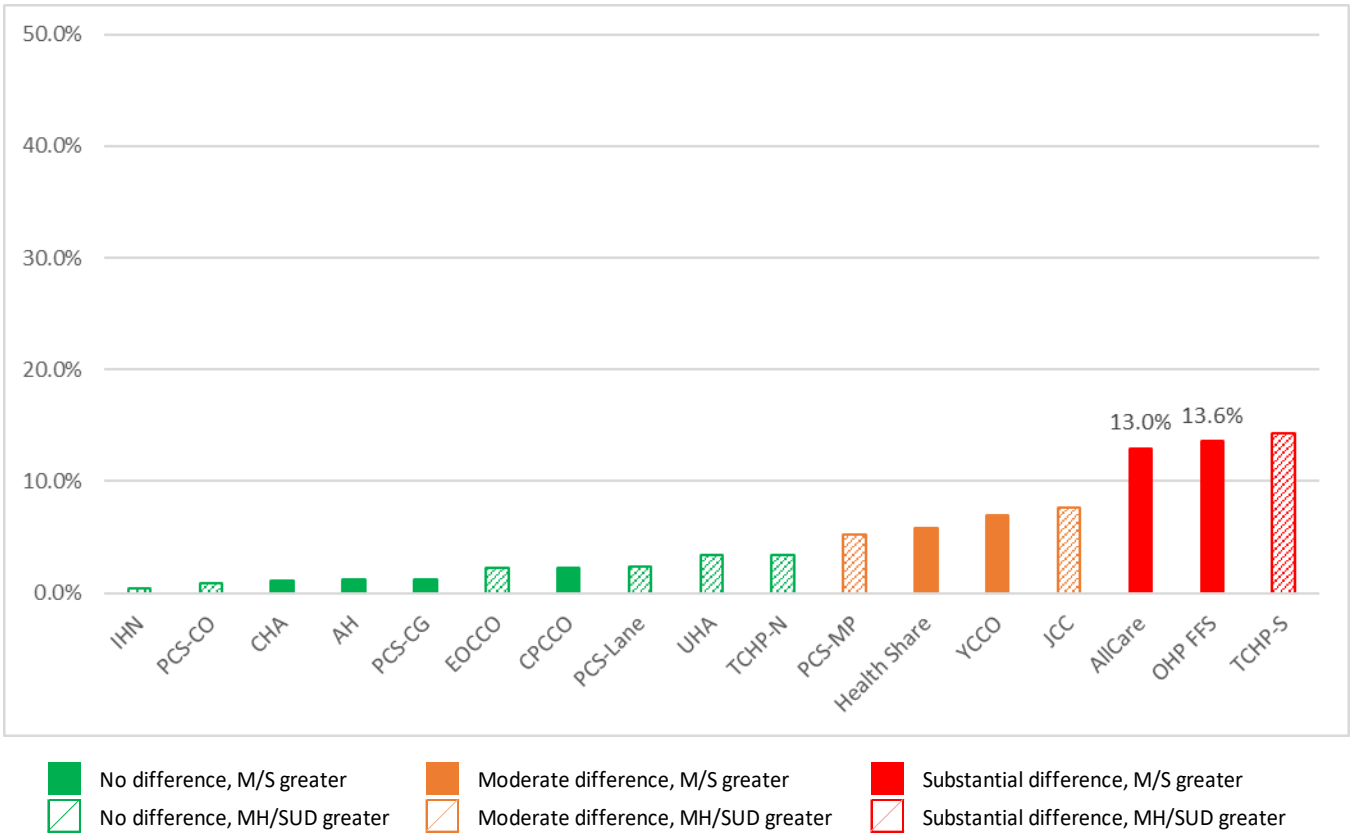
[3-4] NEMT and Rx claims were excluded from the analysis due to a general diagnosis code used for NEMT and the absence of a diagnosis code on incoming Rx claims. As a result, the CCOs and OHP FFS were unable to distinguish and classify individual claims as MH/SUD or M/S.

percentage of paid MH/SUD claims versus paid M/S claims. When the payment of claims was stratified by IN and OON claims, in at least half of the CCOs exhibiting moderate to substantial differences in the percentages of OON paid IP and OP claims, the deviation was due to a higher percentage of paid M/S claims versus paid MH/SUD claims. The following figures display the results of 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 paid compared to M/S claims.

Inpatient Claims

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

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



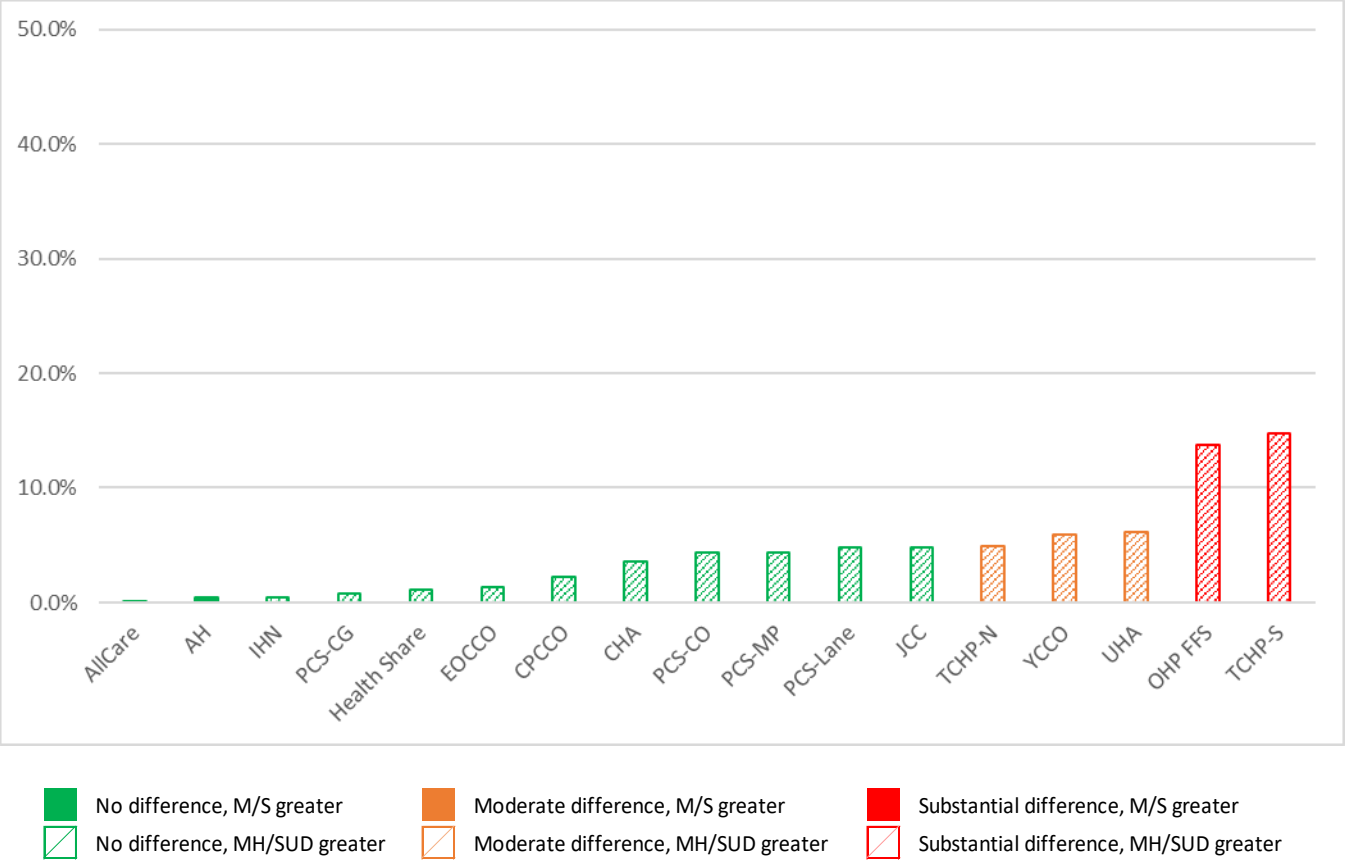
Overall, the difference in the statewide CCO percentage of IP paid claims for MH/SUD services (83.4 percent) and M/S services (83.8 percent) was negligible (0.4 percentage points), with individual CCO differences ranging from 0.4 percentage points (IHN) to 14.3 percentage points (TCHP-S). Three CCOs and OHP FFS exhibited substantial differences in the percentage of paid IP claims; however, only one

CCO and OHP FFS exhibited substantial differences wherein IP MH/SUD claims had a substantially lower paid rate than IP M/S claims (AllCare [13.0 percentage points] and OHP FFS [13.6 percentage points]). Four CCOs (i.e., PCS-MP, Health Share, YCCO, and JCC) exhibited a moderate difference in the percentage of IP paid claims, although only Health Share and YCCO showed higher percentages of paid claims for IP M/S claims. The remaining 10 CCOs had less than a 5-percentage-point difference in IP paid claims rates.

Outpatient Claims

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

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

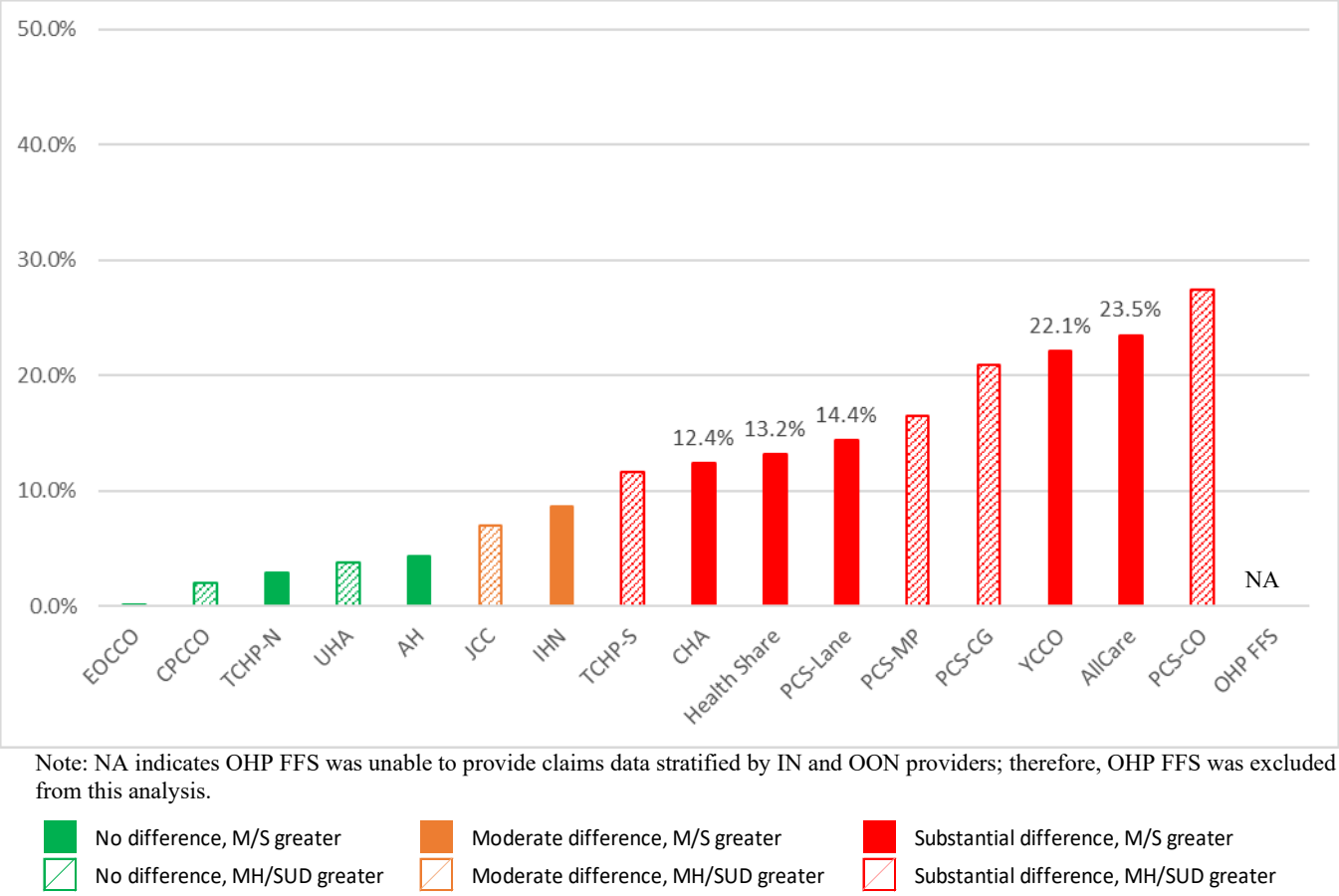


Similar to IP claims, the difference in the statewide CCO percentage of OP paid claims for MH/SUD services (91.9 percent) and M/S services (88.7 percent) was negligible at 3.2 percentage points, with individual CCO differences ranging from 0.1 percentage points (AllCare) to 14.8 percentage points (TCHP-S). TCHP-S was the only CCO to exhibit a substantial difference in the percentage of paid OP claims, as did OHP FFS (13.7 percentage points). Among the remaining CCOs, only three exhibited a moderate difference in the percentage of OP paid claims (TCHP-N, YCCO, and UHA); however, the percentage of OP paid claims was higher for MH/SUD services in all cases. The remaining 12 CCOs had less than a 5-percentage-point difference in OP paid claims rates.

Out-of-Network Paid Claims

Figure 3-3 shows the absolute difference in the percentage of paid IP MH/SUD and M/S claims for OON providers for all CCOs.[3-5]

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



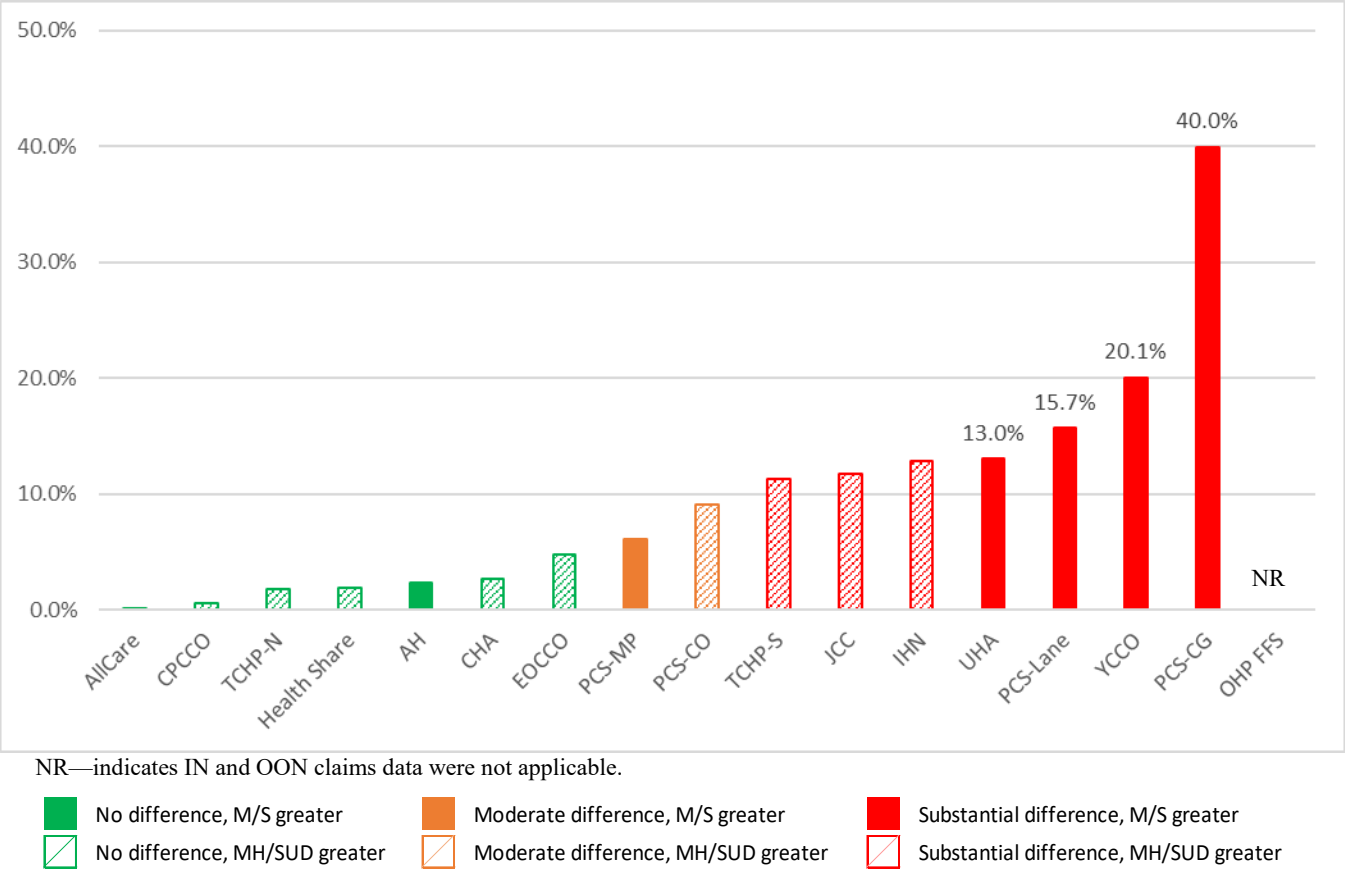
Note: NA indicates OHP FFS was unable to provide claims data stratified by IN and OON providers; therefore, OHP FFS was excluded from this analysis.

While the difference in the statewide CCO percentage of OON IP paid claims for MH/SUD services (67.3 percent) and M/S services (71.1 percent) was negligible at 3.8 percentage points, variation across the CCOs and OHP FFS was considerably greater with differences ranging from 0.0 percentage points (EOCCO) to 27.4 percentage points (PCS-CO). Of the 16 CCOs, 11 exhibited moderate or substantial differences in the percentage of OON IP paid claims for MH/SUD and M/S services. More importantly, five of the CCOs (CHA, Health Share, PCS-Lane, YCCO, and AllCare) showed substantial differences wherein the percentage of paid claims was substantially lower for OON MH/SUD IP claims.

[3-5] Due to the structure of its program, OHP FFS does not distinguish between IN and OON providers; any provider enrolled with Oregon Medicaid is classified as IN. As such, OHP FFS is listed as "NA" for this measure.

Figure 3-4 shows the absolute difference in the percentage of paid OP MH/SUD and M/S claims for OON providers for all CCOs.[3-6]

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



NR—indicates IN and OON claims data were not applicable.

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

Similar to OON IP paid claims, the difference in the statewide CCO percentage of OON OP paid claims for MH/SUD (76.7 percent) and M/S (72.2 percent) services was also negligible at 4.5 percentage points. However, individual CCO performance showed considerable differences with results ranging from 0.1 percentage points (AllCare) to 40.0 percentage points (PCS-CG). Of the 16 CCOs, nine exhibited moderate or substantial differences in the percentage of OON OP paid claims between MH/SUD and M/S services. More importantly, four of the CCOs (UHA, PCS-Lane, YCCO, and PCS-CG) showed substantial differences in which the percentage of paid claims was substantially lower for OON MH/SUD IP claims.

[3-6] Due to the structure of its program, OHP FFS does not distinguish between IN and OON providers; any provider enrolled with Oregon Medicaid is classified as IN. As such, OHP FFS is listed as "NA" for this measure.

Utilization Management

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

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

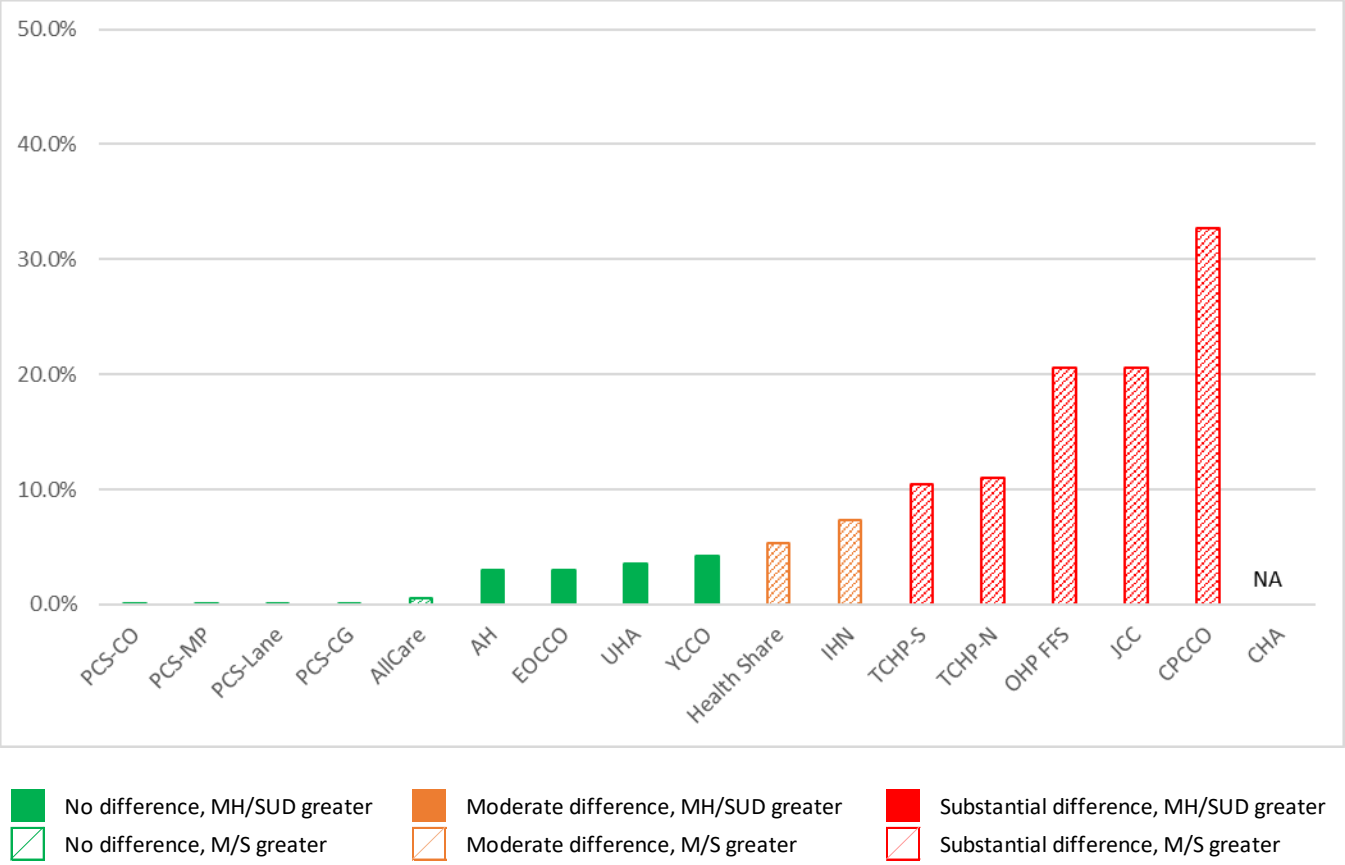
Overall, the difference in the percentage of denials for MH/SUD and M/S PA requests varied across all service types (i.e., IP, OP, and Rx), as illustrated by the CCO aggregate denial rates. While the percentage point differences in the CCO aggregate IP and Rx denial rates were negligible (2.9 percentage points and 3.2 percentage points, respectively), the percentage point difference in the CCO aggregate denial rate for OP MH/SUD services (0.9 percent) and OP M/S services (13.2 percent) was substantial at 12.3 percentage points. However, the differences in OP 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.

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 2022 and was, therefore, excluded from this comparative analysis.

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

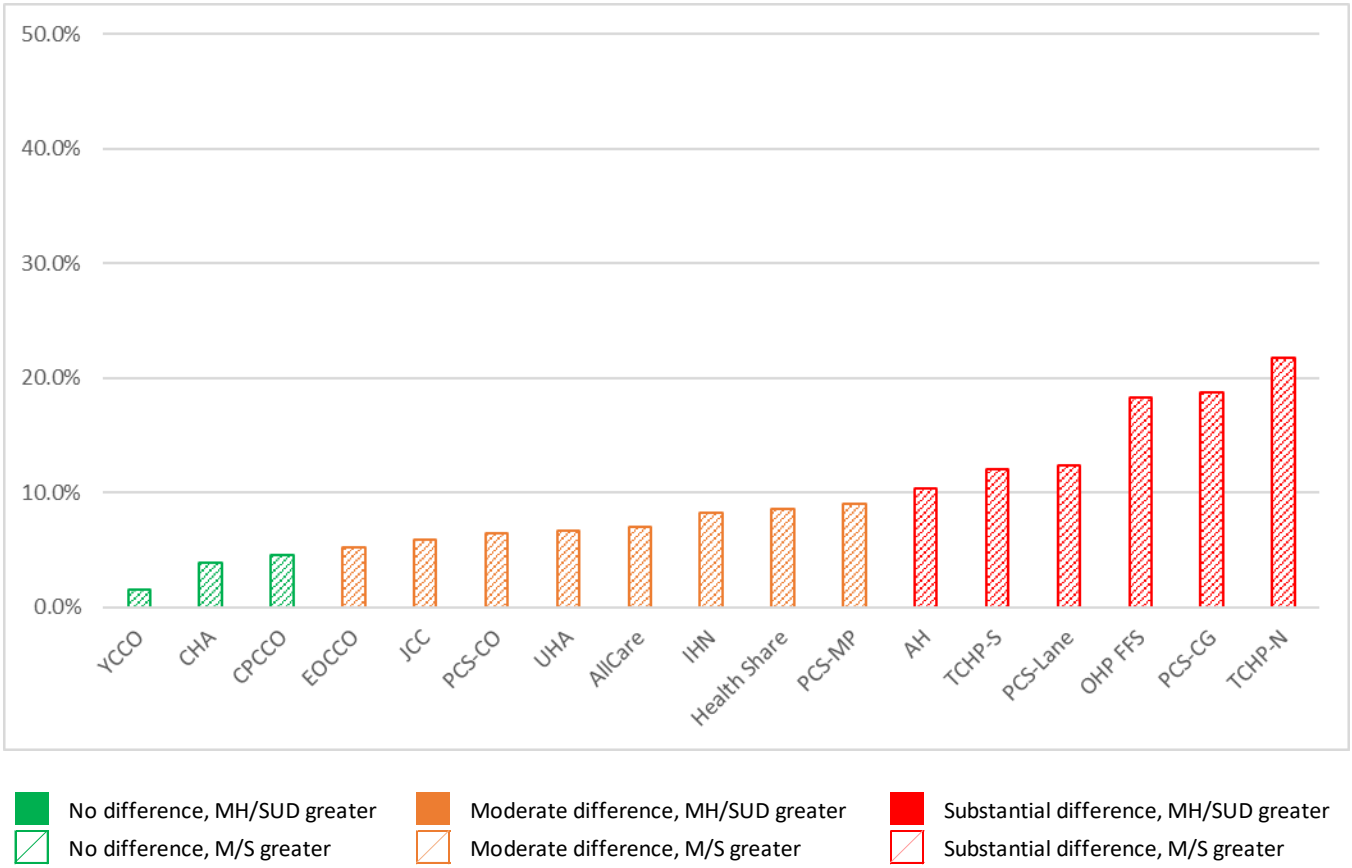


Overall, the difference in the statewide CCO percentage of denied IP PA requests for MH/SUD services (1.5 percent) and M/S services (4.4 percent) was negligible at 2.9 percentage points, with individual CCO differences ranging from 0.0 percentage points (PCS-CO) to 32.7 percentage points (CPCCO). Six CCOs and OHP FFS exhibited moderate or substantial differences in the percentage of denied IP PA requests; however, the rate of denial was lower for MH/SUD IP PA requests compared to M/S. 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

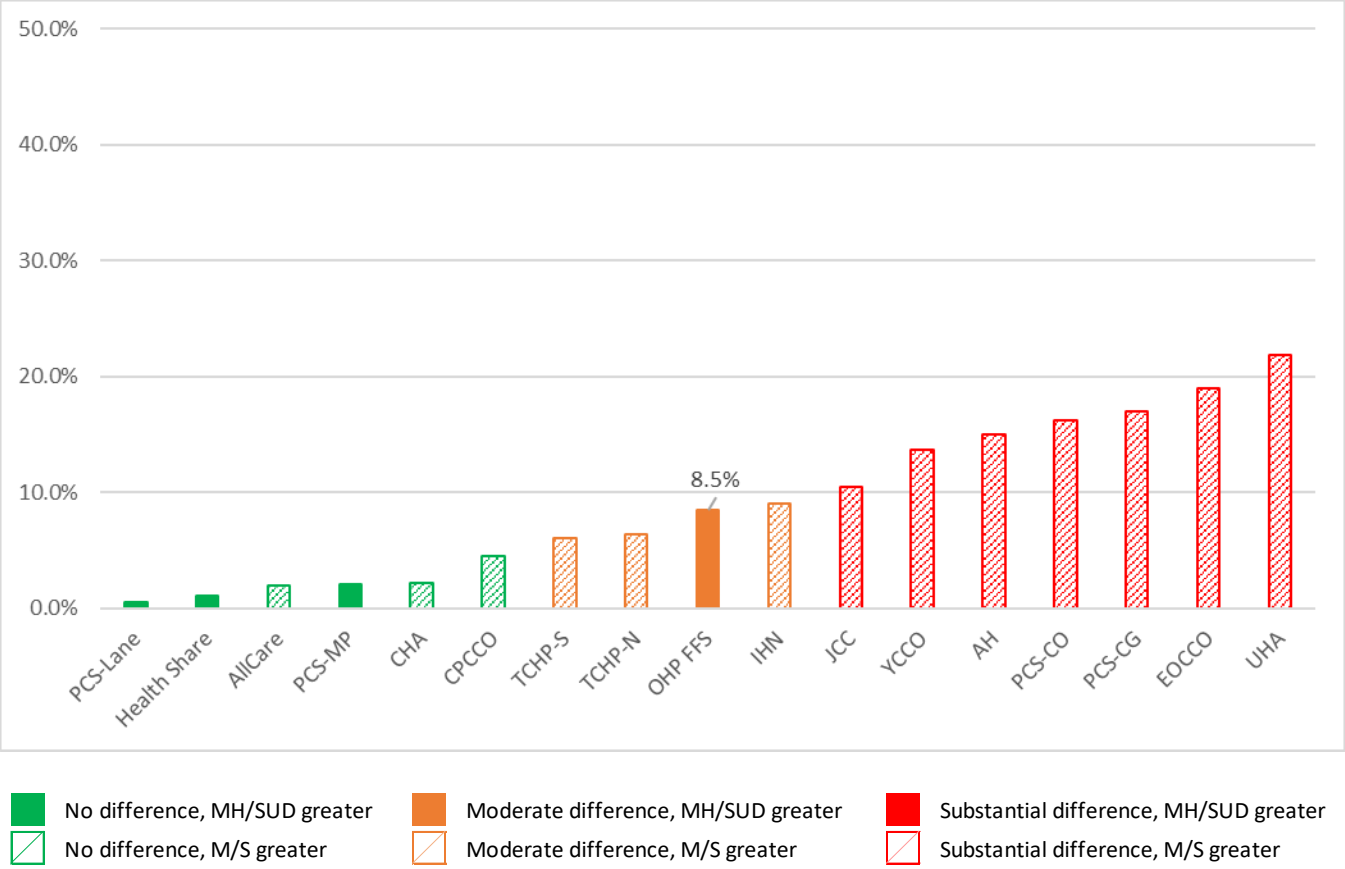


Overall, the difference in the statewide CCO percentage of denied OP PA requests for MH/SUD services (0.9 percent) and M/S services (13.2 percent) was substantial at 12.3 percentage points, with individual differences ranging from 1.5 percentage points (YCCO) to 21.8 percentage points (TCHP-N). Five CCOs (AH [10.3 percentage points], TCHP-S [12.0 percentage points], PCS-Lane [12.3 percentage points], PCS-CG [18.7 percentage points], and TCHP-N [21.8 percentage points]) and OHP FFS showed substantial differences in the percentage of denied OP PA requests; however, in all cases, the rate of denial was lower for OP MH/SUD PA requests than OP M/S PA requests. Only three CCOs (YCCO, CHA, and CPCCO) 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.

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 services (44.2 percent) and M/S services (47.4 percent) was negligible at 3.2 percentage points, with individual CCO differences ranging from 0.5 percentage points (PCS-Lane) to 21.8 percentage points (UHA). Ten CCOs exhibited moderate or substantial differences in the percentage of denied Rx PA requests; however, the rate of denial was lower for MH/SUD Rx PA requests compared to M/S. OHP FFS showed a moderate difference of 8.5 percentage points wherein MH/SUD Rx PA requests (27.0 percent) were denied at a higher rate than M/S Rx PA requests (18.5 percent). The remaining six CCOs had less than a 5-percentage-point difference in Rx PA denial rates.

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, member eligibility)
- Below the Line (BTL)—service requested was below the line on the OHP Prioritized List[3-7]
- Does Not Meet Criteria—requested service does not meet clinical treatment guidelines for medical necessity or appropriateness
- Not a Covered Benefit—variety of noncoverage denials (e.g., noncovered services, benefit exclusions)
- Treatment Limitations—UM controls implemented by health plans to manage member health care (i.e., provider network, visit limits, drug utilization procedures)
- Unknown—documentation insufficient to categorize

Table 3-4 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 3-4—Statewide PA Denial Reasons by Service Type and Benefit

Denial Reason	Total	Inpatient		Outpatient		Pharmacy	
		MH/SUD	M/S	MH/SUD	M/S	MH/SUD	M/S
Does Not Meet Criteria	41.5%	81.6%	48.8%	41.6%	45.5%	62.9%	32.6%
Not a Covered Benefit	26.6%	0.7%	14.1%	10.1%	35.7%	6.4%	18.9%
Treatment Limitation	12.5%	6.9%	22.8%	12.4%	3.0%	22.6%	22.9%
Service is *Below the Line*	9.6%	0.0%	0.9%	1.2%	5.0%	2.4%	17.4%
Administrative Denial	4.7%	8.2%	9.7%	11.3%	2.8%	4.4%	6.9%
Out-of-Network Provider	3.2%	0.3%	1.4%	19.8%	5.4%	0.1%	0.4%
Unknown	1.9%	2.3%	2.3%	3.6%	2.7%	1.2%	0.9%

Overall, across all CCOs and regardless of benefit, approximately two in five PA requests were denied for services determined to not be medically necessary (41.5 percent), followed by PA requests denied because the service was not a covered benefit (26.6 percent). Together, these two categories accounted

[3-7] Oregon Health Authority. Prioritized List of Health Services. Available at: https://www.oregon.gov/oha/hsd/ohp/pages/prioritized-list.aspx. Accessed on: Dec 1, 2023.

for the majority of all PA denials (68.1 percent) as well as individually across IP (65.4 percent), OP (80.6 percent), and Rx (53.7 percent) services.[3-8] The next most frequent denial reason for a PA request were due to UM controls implemented by the CCOs and OHP FFS (Treatment Limitation = 12.5 percent) and related to services being below the line (9.6 percent). Overall, less than 10 percent of the denial reasons were related to administrative denials (4.7 percent), OON providers (3.2 percent), or unknown reasons (1.9 percent). Although denial reasons were generally consistent across CCOs and OHP FFS, several differences were identified when examining denials by service type and benefit, including:

- While denials for IP PA requests failing to meet criteria was the most prevalent reason for both MH/SUD and M/S services, the rate of denials among MH/SUD-related services was substantially higher (i.e., 81.6 percent versus 48.8 percent, or 32.8 percentage points).
- OP PA requests for MH/SUD and M/S services were denied most frequently for requests not meeting criteria (41.6 percent and 45.5 percent, respectively). However, while OP PA denials related to services not being a covered benefit were the next most frequent denial reasons for M/S (35.7 percent), it only accounted for 10.1 percent of MH/SUD OP PA denials. Among MH/SUD OP PA denials, the next most frequent denial reasons were related to *Treatment Limitation* (12.4 percent), *Administrative Denials* (11.3 percent), and *Out-of-Network Providers* (19.8 percent); accounting for 43.4 percent of all denials.

Record Review—Denials and Appeals

To further assess the quality and timeliness of UM determinations, HSAG requested, reviewed, and obtained clinical and administrative records from the CCOs and OHP FFS for service authorizations resulting in a Notice of Adverse Benefit Determination (NOABD) and subsequent member appeals for CCOs.[3-9] The file review included:

- Assessing compliance with federal and State regulations governing the processing of member NOABDs for service authorization denials and Notices of Appeal Resolution (NOARs), including timeliness and accessibility.
- Assessing the timeliness of service authorization denials and member appeal decisions.

In alignment with prior findings, the file reviews continued to demonstrate generalized issues with the CCOs' and OHP FFS' compliance with federal and State regulatory requirements surrounding the processing of NOABDs and NOARs. However, these issues were related to general implementation of the CCOs' and OHP FFS' procedures and did not reveal substantial differences in the application to MH/SUD and M/S services. Overall, the file reviews showed the CCOs and OHP FFS had consistent issues meeting readability and accessibility standards (i.e., materials are to be written at a sixth-grade

[3-8] The total service category rates (i.e., MH/SUD and M/S combined) are not presented in Table 3-4 but can be found in Appendix S.

[3-9] OHP FFS did not have an appeal process; members or their authorized representatives may request a contested case hearing if they disagree with an adverse benefit decision.

reading level) for both denial and appeal written notices, while CCOs and OHP FFS were generally compliant with denial and appeal time frames.

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 2022. All counts were stratified by benefit type to facilitate comparisons. These data points were collected to offer information on parity of provider credentialing practices between MH/SUD and M/S. The aggregate counts from the CCOs and OHP FFS were then used to generate the percentage of providers terminated and approved[3-10] by benefit type; the difference between the percentage of providers terminated and approved MH/SUD and M/S providers was then evaluated as the core metric for evaluating parity. The absolute difference was used to classify the deviation in termination and approval rates between MH/SUD and M/S providers to determine if the difference was negligible (less than 5 percentage points), moderate (greater than or equal to 5 percentage points, but less than 10 percentage points), or substantial (greater than or equal to 10 percentage points). In addition to assessing the absolute difference in the percentage of terminated and approved providers, the analysis indicated whether the difference identified greater rates of termination/approval for MH/SUD providers versus M/S providers.

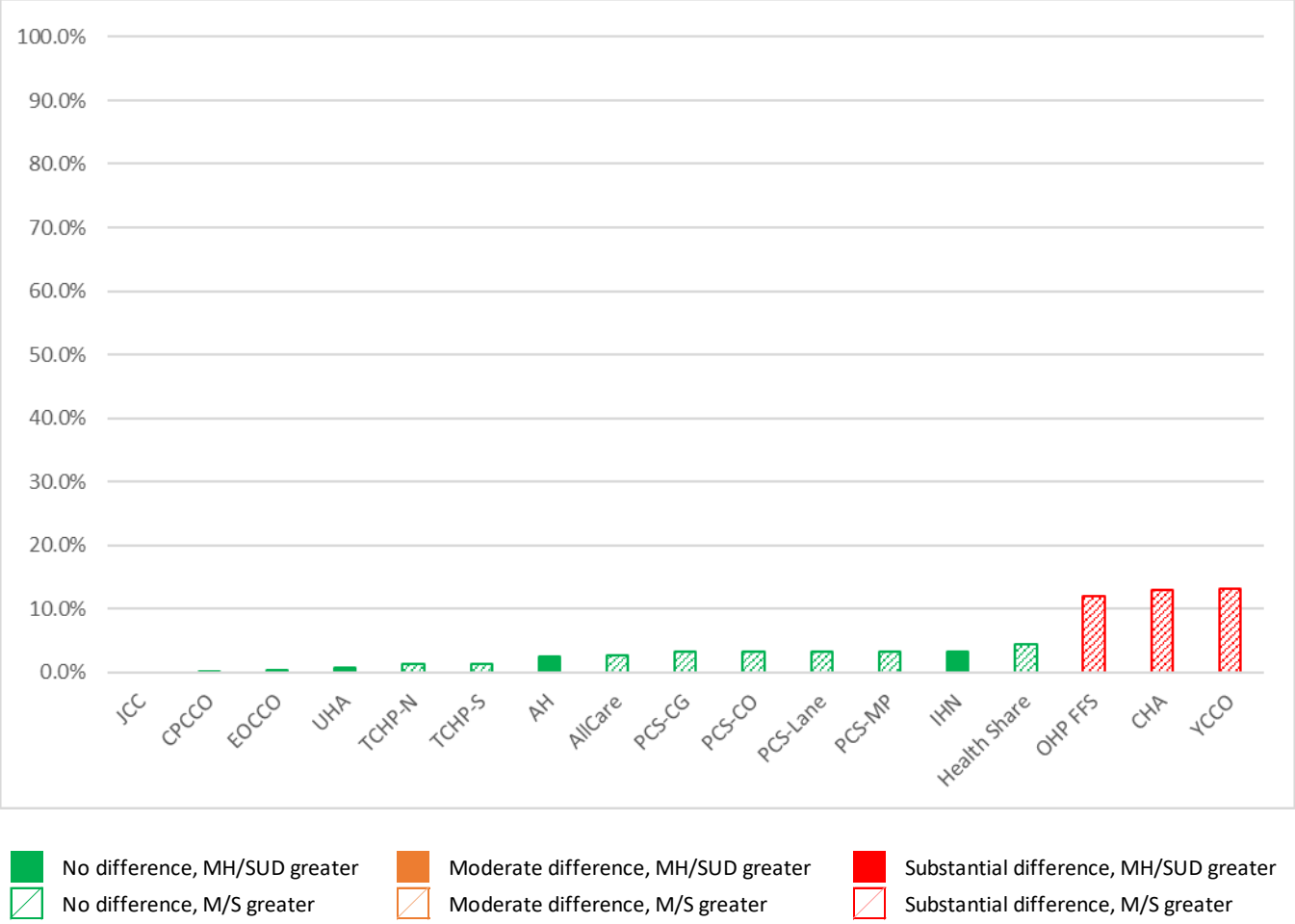
The following figures display the results of the comparisons in the percentage of terminated and approved applications for MH/SUD and M/S providers for all CCOs and OHP FFS, where available.

Provider Terminations

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

[3-10] Due to limitations associated with the structure and availability of provider data within OHP FFS' information systems, OHP FFS is unable to accurately track MH/SUD and M/S providers and cannot distinguish new enrollment or reenrollment applications for providers based on specialty type (i.e., MH/SUD versus M/S). Further, MH/SUD and M/S counts are estimated since exact delineation of provider type is not currently possible within these data systems. As such, while OHP FFS is included in the termination analysis, results are not available on approval rates and OHP FFS is excluded from those results.

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



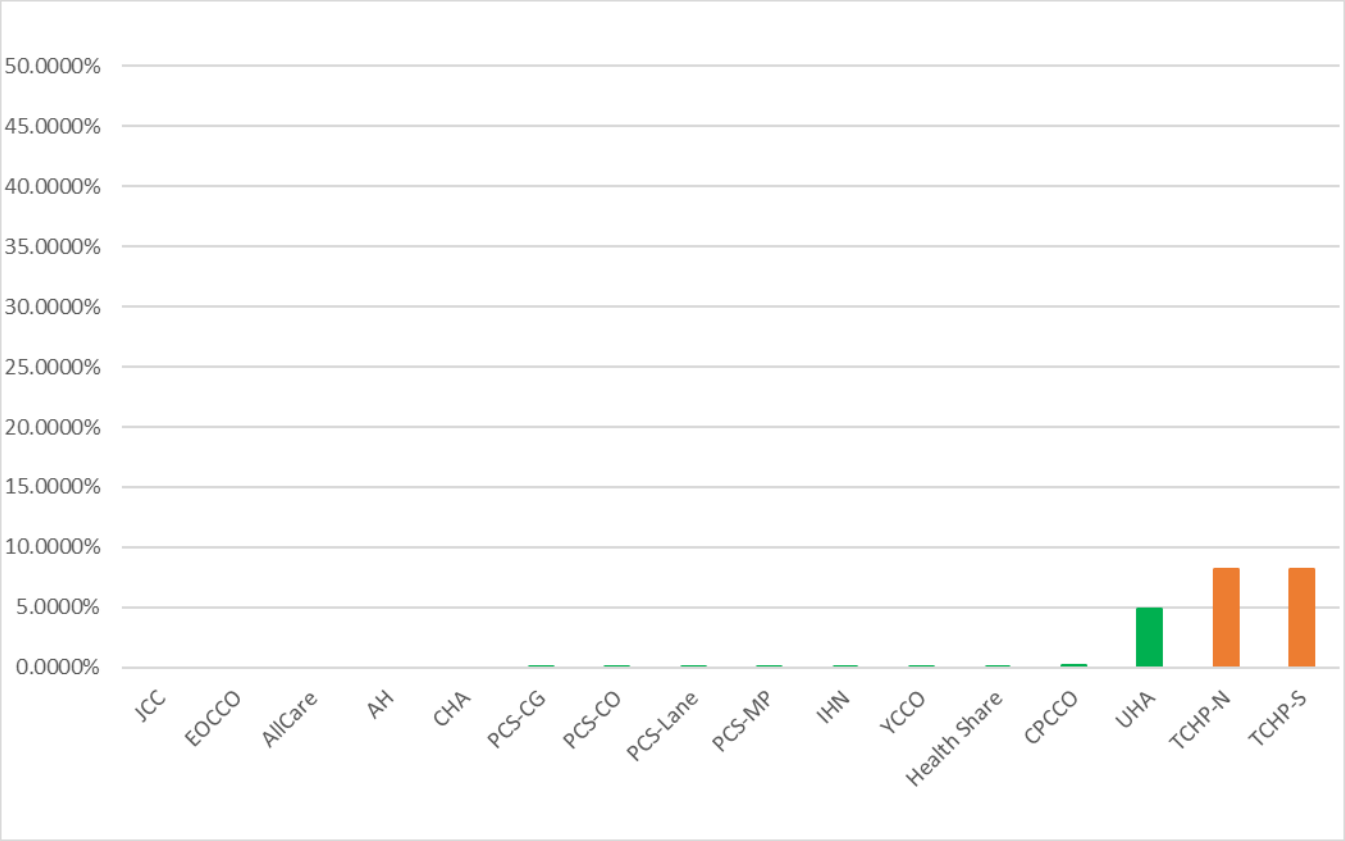
Overall, the absolute difference in the statewide CCO percentage of terminated providers for MH/SUD (9.5 percent) and M/S (11.5 percent) was negligible (< 5 percentage points), with individual CCO differences ranging from 0.0 percentage points (JCC) to 13.1 percentage points (YCCO). Excluding two CCOs (CHA and YCCO) and OHP FFS, the remaining CCOs exhibited little to no difference in the percentage of MH/SUD and M/S providers terminated or not recredentialed in CY 2022. YCCO (13.1 percentage points), CHA (13.0 percentage points), and OHP FFS (12.0 percentage points) exhibited substantial differences in the percentage of terminated providers; however, in all cases the percentage of terminated MH/SUD providers was lower than percentage of terminated M/S providers.

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



Note: OHP FFS was unable to distinguish the number of MH/SUD and M/S applications or providers up for recredentialing and is excluded from this analysis.

Overall, the difference in the statewide CCO percentage of provider applications approved for MH/SUD providers (97.6 percent) and M/S providers (97.7 percent) was negligible at 0.1 percentage points, with individual CCO differences ranging from 0.0 percentage points (JCC, EOCCO, AllCare, AH, and CHA) to 8.2 percentage points (TCHP-N and TCHP-S). Only two CCOs exhibited a moderate difference in the percentage of MH/SUD and M/S provider applications approved in CY 2022 (i.e., TCHP-N and TCHP-S, each at 8.2 percent) wherein MH/SUD approval rates were lower than M/S approval rates

Adequacy of MH/SUD Provider Networks

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

Provider Network Capacity

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

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

Provider Counts

Table 3-5 shows the total number of providers in network (i.e., Total) and total number and percentage of MH providers contracted with each CCO (i.e., MH (#) and MH (%), respectively). The table also indicates, for each CCO, whether the change from Quarter 2 (Q2) 2022 to Q1 2023 resulted in a substantial increase (i.e., ↑, or 10 percent) or decrease (i.e., ↓, or 10 percent) in the total number of MH providers. The data represent a calendar difference of approximately nine months to one year. Although a comparative review of the distribution of providers showed substantial changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years. Provider data used to generate Q2 2022 network capacity counts and provider-to-member ratios used different data elements to classify providers than were used in Q1 2023, in accordance with OHA reporting requirements.

Table 3-5—Number and Percentage of MH Practitioners by Quarter

	Q2 2022			Q1 2023			Difference	
CCO	Total	MH (#)	MH (%)	Total	MH (#)	MH (%)	#	% Change
AH	682	159	23.3%	807	202	25.0%	43	27.0% ↑
AllCare	1,097	118	10.8%	2,326	526	22.6%	408	345.8% ↑
CHA	712	148	20.8%	657	141	21.5%	-7	-4.7%

CCO	Q2 2022			Q1 2023			Difference	
	Total	MH (#)	MH (%)	Total	MH (#)	MH (%)	#	% Change
CPCCO	16,003	2,255	14.1%	11,981	2,409	20.1%	154	6.8%
EOCCO	15,194	1,373	9.0%	9,353	1,358	14.5%	-15	-1.1%
Health Share	16,791	1,902	11.3%	14,372	2,503	17.4%	601	31.6% ↑
IHN	5,811	1,271	21.9%	6,878	1,608	23.4%	337	26.5% ↑
JCC	15,894	2,258	14.2%	12,235	2,528	20.7%	270	12.0% ↑
PCS-CG	11,488	3,607	31.4%	13,203	4,250	32.2%	643	17.8% ↑
PCS-CO	11,852	3,608	30.4%	13,520	4,251	31.4%	643	17.8% ↑
PCS-Lane	12,155	3,610	29.7%	13,823	4,250	30.7%	640	17.7% ↑
PCS-MP	12,132	3,612	29.8%	13,751	4,253	30.9%	641	17.7% ↑
TCHP-N	12,014	1,971	16.4%	7,783	1,993	25.6%	22	1.1%
TCHP-S	7,773	1,598	20.6%	6,768	1,814	26.8%	216	13.5% ↑
UHA	1,206	147	12.2%	901	177	19.6%	30	20.4% ↑
YCCO	7,728	1,868	24.2%	8,635	2,382	27.6%	514	27.5% ↑
OHP FFS	—	—	—	—	6,933	NA	NA	NA

— indicates data were not available.

NA—indicates calculation included one or more missing data elements.

Note: OHP FFS provider data were not available for Q2 2022. Counts for Q1 2023 were based on provider counts captured for time and distance analysis and may represent inflated numbers due to the counting of multiple provider locations.

Between 2022 and 2023, CCOs showed substantial increases in MH provider counts across the board with few decreases. Several factors likely contributed to these increases, including the CCOs' efforts to increase enrollment and contracting with MH providers in response to members' needs as well as improvements to the quality of provider data and changes in study protocols (e.g., provider categorization). However, caution should be used when interpreting the results as some CCOs report provider network capacity data at an enterprise level which may increase the overall number of providers regardless of location and/or availability to Medicaid members. This situation is often identified with CCOs managing multiple service areas or having extensive delegated services (e.g., PCS, TCHP, and Health Share). Additionally, PCS reported a somewhat higher percentage of its provider workforce as MH providers in comparison to other CCOs (i.e., approximately 30 percent for PCS compared to approximately 20 percent to 25 percent overall), which may also indicate a data issue.

Table 3-6 shows the total number of providers in network (i.e., Total), total number and percentage of SUD providers contracted with each CCO (i.e., SUD (#) and SUD (%), respectively). The table also indicates, for each CCO, whether the change from Q2 2022 to Q1 2023 resulted in a substantial increase (i.e., ↑, or 10 percent) or decrease (i.e., ↓, or 10 percent) in the total number of SUD providers. The data

represent a calendar difference of approximately nine months to one year. Although a comparative review of the distribution of providers showed substantial changes in some cases, caution should be used when interpreting network stability due to differences in reporting across calendar years. Provider data used to generate Q2 2022 network capacity counts and provider-to-member ratios used different data elements to classify providers than were used in Q1 2023, in accordance with OHA reporting requirements.

Table 3-6—Number and Percentage of SUD Practitioners by Quarter

	Q2 2022			Q1 2023			Difference	
CCO	Total	SUD (#)	SUD (%)	Total	SUD (#)	SUD (%)	#	% Change
AH	682	33	4.8%	807	56	6.9%	23	69.7% ↑
AllCare	1,097	38	3.5%	2,326	144	6.2%	106	278.9% ↑
CHA	712	66	9.3%	657	69	10.5%	3	4.5%
CPCCO	16,003	486	3.0%	11,981	528	4.4%	42	8.6%
EOCCO	15,194	337	2.2%	9,353	292	3.1%	-45	-13.4% ↓
Health Share	16,791	522	3.1%	14,372	582	4.0%	60	11.5% ↑
IHN	5,811	334	5.7%	6,878	412	6.0%	78	23.4% ↑
JCC	15,894	486	3.1%	12,235	534	4.4%	48	9.9%
PCS-CG	11,488	505	4.4%	13,203	551	4.2%	46	9.1%
PCS-CO	11,852	505	4.3%	13,520	551	4.1%	46	9.1%
PCS-Lane	12,155	505	4.2%	13,823	551	4.0%	46	9.1%
PCS-MP	12,132	505	4.2%	13,751	551	4.0%	46	9.1%
TCHP-N	12,014	293	2.4%	7,783	293	3.8%	0	0.0%
TCHP-S	7,773	357	4.6%	6,768	415	6.1%	58	16.2% ↑
UHA	1,206	82	6.8%	901	100	11.1%	18	22.0% ↑
YCCO	7,728	304	3.9%	8,635	417	4.8%	113	37.2% ↑
OHP FFS	—	—	—	—	1,013	NA	NA	NA

— indicates data were not available.

NA—indicates calculation included one or more missing data elements.

Note: OHP FFS provider data were not available for Q2 2022. Counts for Q1 2023 were based on provider counts captured for time and distance analysis and may represent inflated numbers due to the counting of multiple provider locations.

Between 2022 and 2023, demand for SUD services greatly increased in Oregon. Most CCOs responded with some level of increase in SUD provider networks, with seven CCOs (i.e., AH, AllCare, Health Share, IHN, TCHP-S, UHA, and YCCO) showing substantial increases in the number of contracted SUD providers. The reported increase in providers was likely due to CCOs' efforts to increase the

number of SUD providers as well as general improvement in the completeness and quality of CCOs' provider data. One CCO, EOCCO, exhibited a substantial decrease (13.4 percent, or 45 providers). Further analysis of this CCO's data showed that the decrease was driven by losses of SUD providers serving pediatric members. However, this finding likely reflects a data quality issue as EOCCO reported nearly all its providers as exclusively serving either adult or pediatric populations, with few providers documented as serving both adults and children. Additionally, several CCOs reported comparatively small numbers of providers in 2022 and/or 2023 (i.e., AH, AllCare, CHA, and UHA) which may also impact reported changes in rates. As such, caution should be used when interpreting these results.

Provider-to-Member Ratios

Table 3-7 shows the unique counts of MH and SUD providers, the number of members identified as having an MH or SUD diagnosis,[3-11] and the ratio of providers to members within each CCO's network. The provider-to-member ratio was calculated by dividing the number of members with an MH or SUD diagnosis enrolled with a CCO by the number of MH or SUD providers in the CCO's network. This metric serves as a way to standardize estimations of a CCO's or OHP FFS' provider network as it adjusts for membership size. Since OHA did not have specific provider-to-member ratio standards for any provider type, the results below are presented for information only.

Table 3-7—Provider-to-Member Ratios by CCO and Provider Type

	MH			SUD		
CCO	Providers (N)	Members (N)	Ratio	Providers (N)	Members (N)	Ratio
AH	202	8,416	1:42	56	4,634	1:83
AllCare	526	9,814	1:19	144	3,350	1:24
CHA	141	2,869	1:21	69	2,519	1:37
CPCCO	2,409	6,837	1:3	528	1,940	1:4
EOCCO	1,358	11,438	1:9	292	3,639	1:13
Health Share	2,503	85,559	1:35	582	20,323	1:35
IHN	1,608	19,147	1:12	412	14,632	1:36
JCC	2,528	12,866	1:6	534	3,230	1:7
PCS-CG	4,250	3,221	1:1	551	595	1:2
PCS-CO	4,251	18,512	1:5	551	4,137	1:8
PCS-Lane	4,250	22,986	1:6	551	5,106	1:10
PCS-MP	4,253	26,498	1:7	551	6,095	1:12
TCHP-N	1,993	4,072	1:3	293	1,205	1:5

[3-11] The member population used to determine provider-to-member ratios was restricted to members with at least one inpatient or outpatient claim with an MH or SUD diagnosis during calendar year (CY) 2022 to better reflect the population in need of MH and SUD providers.

CCO	MH			SUD		
	Providers (N)	Members (N)	Ratio	Providers (N)	Members (N)	Ratio
TCHP-S	1,814	6,998	1:4	415	2,331	1:6
UHA	177	5,707	1:33	100	1,562	1:16
YCCO	2,382	8,996	1:4	417	3,947	1:10
OHP FFS	6,933	127,890	1:19	1,013	19,226	1:19

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

Time and Distance

As part of its evaluation, HSAG assessed the geographic distribution of MH and SUD providers relative to members with an MH or SUD diagnosis[3-12] to assess the percentage of members with access to an MH and SUD provider within the OHA-defined time and distance standards. These standards included the average travel time (in minutes) and driving distance (in miles) to the nearest provider for each type of provider. Additionally, the analysis included the travel time and distance to the subsequent second and third nearest provider to further assess the overall availability of MH and SUD providers.

Table 3-8 presents the average time and distance to the nearest three MH providers, by CCO and geographic setting (i.e., urban or rural). If the average driving time or distance exceeded the time and distance requirements set forth by OHA, the result is shaded in red. AH, CHA, PCS-CG, and UHA do not have urban settings within their service regions and are listed as not applicable (NA) and shaded gray for those categories.

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

CCO	Urban						Rural					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
AH	NA	NA	NA	NA	NA	NA	3.2	4.0	4.6	2.9	3.7	4.3
AllCare	2.6	2.9	3	2.4	2.6	2.7	7.1	8.0	8.2	6.6	7.3	7.5

[3-12] The member population used to determine time and distance was restricted to members with at least one inpatient or outpatient claim with an MH or SUD diagnosis during CY 2022 to better reflect the population in need of MH and SUD providers.

CCO	Urban						Rural					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
CHA	NA	NA	NA	NA	NA	NA	4.7	5.2	5.4	4.3	4.8	5.0
CPCCO	6.2	6.2	12.6	5.7	5.7	11.6	4.0	4.3	5.4	3.7	3.9	5.0
EOCCO	1.5	1.5	1.5	1.5	1.5	1.5	5.8	7.0	7.4	5.3	6.4	6.8
Health Share	1.3	1.5	1.6	0.8	0.9	1	5.1	5.1	8.3	4.7	4.7	7.7
IHN	0.8	1	1.1	0.8	0.9	1.1	2.3	3.2	3.8	2.2	2.9	3.5
JCC	1.1	1.2	1.4	1	1.1	1.2	4.6	5.1	5.2	4.3	4.7	4.8
PCS-CG	NA	NA	NA	NA	NA	NA	3.4	3.9	4.2	3.1	3.6	3.9
PCS-CO	1.2	1.3	1.5	1.1	1.2	1.4	3.7	4.1	4.3	3.4	3.8	4.0
PCS-Lane	1	1.3	1.4	0.8	1	1.2	3.3	3.8	3.9	3.1	3.5	3.6
PCS-MP	1	1.5	1.7	0.9	1.3	1.5	3.0	3.5	3.8	2.7	3.2	3.5
TCHP-N	1.4	1.6	1.8	0.8	1	1.1	6.2	8.0	8.0	5.7	7.4	7.4
TCHP-S	1.5	1.7	1.8	1.3	1.4	1.5	3.5	4.0	4.1	3.3	3.7	3.8
UHA	NA	NA	NA	NA	NA	NA	3.1	3.9	4.0	2.9	3.7	3.7
YCCO	1.9	2.2	2.9	1.7	2	2.6	4.2	4.6	4.7	3.9	4.3	4.4
OHP FFS	1.2	1.5	1.8	1.0	1.2	1.4	4.3	5.4	6.9	4.0	4.9	6.4

Overall, the average drive times and distances to the nearest three MH providers for all CCOs and OHP FFS were within time and distance requirements set by OHA (i.e., 30 minutes/30 miles for urban areas and 60 minutes/60 miles for rural areas.)

Table 3-9 presents the average time and distance to the nearest three MH providers, by CCO and geographic setting (i.e., urban or rural). If the average driving time or distance exceeded the time and distance requirements set forth by OHA, the result is shaded in red. Again, AH, CHA, PCS-CG, and UHA do not have urban settings within their service regions and are listed as not applicable (NA) and shaded gray for those categories.

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

CCO	Urban						Rural					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
AH	NA	NA	NA	NA	NA	NA	7.6	11.8	12.1	7.0	10.9	11.1
AllCare	3.2	3.3	3.4	3	3.1	3.1	10.6	10.7	10.7	9.6	9.7	9.7

CCO	Urban						Rural					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
CHA	NA	NA	NA	NA	NA	NA	5.4	5.5	5.8	5.0	5.1	5.4
CPCCO	15.8	16.3	16.3	14.5	15	15	6.0	6.1	11.8	5.5	5.6	10.8
EOCCO	1.7	1.8	33.3	1.6	1.7	30.6	6.4	6.7	7.0	5.9	6.2	6.5
Health Share	2.2	2.9	3.2	1.4	1.8	2	12.9	18.6	18.9	11.9	16.6	16.8
IHN	1.8	2	2.1	1.7	1.8	1.9	12.8	13.1	13.2	11.7	12.1	12.1
JCC	2.5	2.9	2.9	2.1	2.6	2.6	12.1	17.6	17.6	10.3	15.0	15.0
PCS-CG	NA	NA	NA	NA	NA	NA	11.8	11.8	11.8	10.8	10.8	10.8
PCS-CO	2.2	2.6	2.8	2.1	2.5	2.6	6.5	6.8	7.1	6.0	6.3	6.6
PCS-Lane	2.7	2.9	3.4	2.3	2.4	2.9	10.2	30.4	32.0	9.4	27.6	29.0
PCS-MP	2.1	3.4	4.1	1.7	2.9	3.4	4.6	6.7	7.6	4.2	6.2	6.9
TCHP-N	3	3.4	3.6	1.9	2.2	2.3	19.1	19.2	19.3	17.0	17.2	17.2
TCHP-S	3	3.2	3.3	2.5	2.7	2.7	14.2	23.6	23.6	13.0	21.6	21.6
UHA	NA	NA	NA	NA	NA	NA	4.0	5.7	8.4	3.7	5.3	7.7
YCCO	3.2	3.6	3.6	2.8	3.2	3.2	5.4	13.1	13.4	5.0	12.0	12.1
OHP FFS	2.6	3.3	3.5	2.0	2.6	2.7	8.4	11.3	13.6	7.7	10.4	12.4

Overall, OHP FFS and all CCOs except EOCCO exhibited average drive times and distances to the nearest three SUD providers that were within time and distance requirements set by OHA (i.e., 30 minutes/30 miles for urban areas and 60 minutes/60 miles for rural areas). The average time and distance for EOCCO members to the third nearest SUD provider was 33.3 minutes and 30.6 miles, respectively, in urban areas. Although just over the OHA-defined standard, this average time and distance represented a substantial increase from the average reported time and distance to the nearest two providers (i.e., less than two minutes/two miles).

Table 3-10 presents the percentages of CCO members[3-13] with access to MH and SUD services, by CCO and geographic setting. AH, CHA, PCS-CG, and UHA do not have urban settings within their service regions and are listed as not applicable (NA) and shaded gray for those categories. Results showing less than 95 percent of members meeting the state-defined time and distance access standards are shaded red.

[3-13] The member population used to determine time and distance was restricted to members with at least one inpatient or outpatient claim with an MH or SUD diagnosis during CY 2022 to better reflect the population in need of MH and SUD providers.

Table 3-10—Time and Distance Results by CCO and Geography

CCO	MH		SUD	
	Urban	Rural	Urban	Rural
AH	NA	100.0%	NA	100.0%
AllCare	100.0%	100.0%	100.0%	100.0%
CHA	NA	100.0%	NA	100.0%
CPCCO	100.0%	100.0%	92.6%	100.0%
EOCCO	100.0%	99.6%	100.0%	99.0%
Health Share	100.0%	100.0%	100.0%	100.0%
IHN	100.0%	100.0%	100.0%	100.0%
JCC	100.0%	100.0%	100.0%	100.0%
PCS-CG	NA	100.0%	NA	100.0%
PCS-CO	100.0%	100.0%	100.0%	100.0%
PCS-Lane	100.0%	100.0%	100.0%	100.0%
PCS-MP	100.0%	100.0%	100.0%	100.0%
TCHP-N	100.0%	100.0%	100.0%	100.0%
TCHP-S	100.0%	100.0%	100.0%	100.0%
UHA	NA	100.0%	NA	100.0%
YCCO	100.0%	100.0%	100.0%	100.0%
OHP FFS	100.0%	>99.9%	>99.9%	99.8%

All CCOs and OHP FFS met the urban and rural time and distance access standards for MH and SUD providers with the exception of CPCCO, which did not meet the urban access standard for SUD providers. However, the CCO was nearly compliant with the access standard, with 92.6 percent of its members (or 16 members) within 30 minutes or 30 miles of the nearest SUD provider. When considering the CCO's full membership (i.e., those with and without an MH or SUD diagnosis in 2022), results were similar at 92.3 percent compliance, with 371 members affected. Additionally, the CCO's sole urban setting, within its otherwise rural service region, is a small, remote community that had been classified under OHA's methodology as urban due to the community's proximity to a sufficiently populous town located just across the Washington border. CPCCO's results for rural time and distance access indicate 100 percent access for both restricted and unrestricted member populations.

Appointment Availability

Even with adequate capacity and the appropriate distribution of services, assessing the timeliness of access to relevant services is critical to ensuring adequate access to care. *Appointment Availability* addresses how quickly OHP members are able to make an appointment and get in to see a provider. Although not directly captured in this evaluation, the CCOs' responses to the 2023 DSN Provider

Narrative Review Tool were reviewed to understand how each organization monitored the availability of appointments to MH/SUD and M/S services and providers. Information on OHP FFS' processes for monitoring appointment availability was obtained from its completion of an Appointment Availability Questionnaire designed for the 2023 MHP Evaluation. HSAG assessed the scope and consistency of each CCO's and OHP FFS' methodology and approach to monitoring appointment availability across MH/SUD and M/S services. Table 3-11 presents a summary of each CCO's and OHP FFS' appointment availability monitoring.

Table 3-11—Monitoring of Appointment Availability by CCO

CCO	Is the Plan Generally Monitoring Appointment Availability?	Is the Plan Specifically Monitoring Appointment Availability of MH/SUD?	Description of Monitoring Method
AH	Yes	Yes	Provider clinics surveyed electronically each quarter. Annual verbal survey of 500 members. Assessed appointment wait time average, cancellations, reschedules, and third next available appointment (TNAA). Included surveys of MH/SUD providers. The CCO conducted member grievance monitoring.
AllCare	No	No	None determined.
CHA	Yes	Yes	Monthly secret shopper calls to randomly selected providers. Provider type rotated monthly between PCP, primary care dentist (PCD), and behavioral health. However, aggregate results were not provided. The CCO conducted member grievance monitoring.
CPCCO	Undetermined	Undetermined	CCO provided a description of methodology including behavioral health-specific provider surveys and site visits. However, evidence was insufficient to determine implemented monitoring of M/S or MH/SUD providers for appointment availability. The CCO conducted member grievance monitoring.
EOCCO	Yes	Yes	Provider surveys and quarterly data submissions for appointment availability compliance. However, for all service categories except dental, evidence suggested that quarterly grievance monitoring remained the primary appointment availability monitoring method, which suggested an insufficient monitoring process.
Health Share	Yes	Yes	Convened a workgroup across health plans and behavioral health providers to review aggregate information on third next available appointments, provider surveys, site visits, and grievance monitoring. However, subcontractors' monitoring methods varied greatly, making overall comparison opaque across plans and for Health Share overall. Additionally,

CCO	Is the Plan Generally Monitoring Appointment Availability?	Is the Plan Specifically Monitoring Appointment Availability of MH/SUD?	Description of Monitoring Method
			behavioral health monitoring focused on outpatient appointments only. The CCO conducted member grievance monitoring.
IHN	Yes	Yes	Annual provider surveys, including behavioral health. The CCO conducted member grievance monitoring.
JCC	Undetermined	Undetermined	CCO provided a description of methodology including behavioral health-specific provider surveys and site visits. However, evidence was insufficient to determine implemented monitoring of M/S or MH/SUD providers for appointment availability. The CCO conducted member grievance monitoring.
PCS-CO	Yes	Yes	Third party conducted random sample of 4,000 members per month by CCO region selected by eligible claim type including MH/SUD. Third party conducted monthly provider surveys, ensuring MH/SUD providers were included in representative sample. Internal threshold of 90 percent provider compliance with State timeliness standards. Results reviewed by multiple committees; evidence of follow-up with noncompliant providers submitted. The CCO conducted member grievance monitoring.
PCS-CG	Yes	Yes	See PCS-CO.
PCS-Lane	Yes	Yes	See PCS-CO.
PCS-MP	Yes	Yes	See PCS-CO.
TCHP-N	Yes	Yes	Third party vendor conducted annual provider appointment availability survey, including prescribing and non-prescribing MH/SUD providers. The CCO conducted member grievance monitoring.
TCHP-S	Yes	Yes	See TCHP-N.
UHA	Yes	Yes	Conducted quarterly provider surveys and monthly secret shopper calls, including for behavioral health providers and subcontractors. The CCO conducted member grievance monitoring.
YCCO	Yes	Yes	Conducted quarterly provider surveys. However, survey results show very low response rates. The CCO was working to correct this. The CCO conducted member grievance monitoring.
OHP FFS	No	No	OHP FFS did not monitor appointment availability.

Overall, nearly all CCOs reported assessing appointment availability as part of their ongoing monitoring of network adequacy using provider surveys. These provider surveys were generally stratified by provider type and included assessments of appointment availability to MH/SUD providers. In most cases, appointment availability monitoring through provider surveys was conducted annually or quarterly. However, most CCOs either did not describe or provide sufficient evidence for monitoring beyond provider attestation surveys. Only two CCOs conducted secret shopper surveys of their provider offices while five CCOs proactively surveyed members for their experience with appointment availability. OHP FFS reported that it does not currently have any mechanisms in place to monitor appointment availability for MH/SUD or M/S providers and relied solely on grievance data[3-14] and issues raised through OHA's Ombuds Program.

Access-Related Grievances

The 2023 MHP Evaluation also reviewed the percentage of access-related MH and SUD grievances to identify potential areas of concern with the availability of MH and SUD providers within each CCO's and OHP FFS' network. Table 3-12 shows the percentage of access-related grievances compared to the overall number of grievances for MH and SUD services. At the time of this review, OHP FFS did not capture grievance data consistently across divisions such that information was reliably categorized, or easily extracted and monitored. As such, OHP FFS is not included in this analysis.

Table 3-12—Percentage of Access-Related MH/SUD Grievances

CCO	Total Grievances	MH/SUD		MH/SUD Access-Related Grievances	
		Number	Percent	Number	Percent
AH	361	15	4.2%	4	26.7%
AllCare	184	70	38.0%	4	5.7%
CHA	107	1	0.9%	0	0.0%
CPCCO	309	8	2.6%	2	25.0%
EOCCO	809	43	5.3%	10	23.3%
Health Share	7,414	149	2.0%	31	20.8%
IHN	743	9	1.2%	4	44.4%
JCC	332	4	1.2%	1	25.0%
PCS-CG	118	1	0.8%	0	0.0%
PCS-CO	730	7	1.0%	0	0.0%
PCS-Lane	2,044	9	0.4%	1	11.1%
PCS-MP	1,675	21	1.3%	3	14.3%

[3-14] As noted in the "Access-Related Grievances" section, OHP FFS did not maintain a centralized repository of grievances, nor did it track and categorize the types of grievances received. As such, OHP FFS was unable to effectively monitor or extract grievances for reporting and monitoring.

CCO	Total Grievances	MH/SUD		MH/SUD Access-Related Grievances	
		Number	Percent	Number	Percent
TCHP-N	356	8	2.2%	0	0.0%
TCHP-S	716	17	2.4%	1	5.9%
UHA	695	10	1.4%	2	20.0%
YCCO	322	11	3.4%	2	18.2%

Overall, only 2.2 percent of all CCO grievances in 2022 were associated with MH/SUD services and benefits. The percentage of MH/SUD-related grievances across individual CCOs ranged from 0.4 percent (PCS-Lane) to 38.0 percent (AllCare), with an average CCO rate of 3.1 percent. Results showed a consistent distribution of MH/SUD-related grievances except for AllCare, with most CCOs exhibiting less than 6 percent of all grievances related to MH/SUD services. Although this finding represents an outlier, and less than 10 percent of AllCare's MH/SUD grievances were related to access, nearly 90 percent of AllCare's MH/SUD grievances were related to interactions with MH/SUD providers, highlighting potential issues with access, timeliness, and quality of care. While the percentage of access-related grievances associated with MH/SUD services was low for CCOs, with a CCO aggregate rate of 17.0 percent, the range of access-related MH/SUD grievances across individual CCOs was substantially wider. For seven CCOs, the percentage of MH/SUD access-related grievances was 20.0 percent or greater, with one CCO (IHN) showing 44.4 percent of its MH/SUD grievances being related to access. Although these results suggest that access-related grievances represent a focus of many MH/SUD grievances, the results should be interpreted with caution due to the overall low total numbers of MH/SUD grievances.

4. Discussion

Conclusions

The overall findings from the 2023 MHP Evaluation are presented below.

Treatment Limitation Review

Overall, neither the CCOs nor OHP FFS reported that their organizations applied FRs or AL/ADLs in the administration of MH/SUD and M/S benefits for IP, OP, Rx, or EC services. Additionally, while some CCOs and OHP FFS reported using QTLs in the management of MH/SUD and M/S benefits, the QTLs were identified as soft limits and incorrectly categorized by the CCOs and OHP FFS. This finding suggests confusion among CCO and OHP FFS staff regarding the nature of benefit limitations and how they apply to understanding parity across MH/SUD and M/S benefits. These findings align with prior MHP evaluations and the regulatory structure of the Oregon Medicaid program.

Of the four treatment limitations, the CCOs and OHP FFS used a variety of NQTLs (i.e., Medical Management, Provider Network, and Pharmacy Management) to manage and ensure members' health care services received were necessary and appropriate. Among the most prevalent were UM processes (i.e., prior authorization [PA], concurrent review [CR], and retrospective review [RR], medical necessity criteria, provider credentialing requirements, and drug utilization review mechanisms (i.e., formulary design). Overall, the CCOs demonstrated a high level of compliance with parity requirements for individual NQTLs when sufficient information and supporting documentation were provided for the implemented NQTL. Seven CCOs demonstrated full compliance across all NQTL domains while nine CCOs received an overall parity rating of *Partially Compliant* due to one or more domains being *Partially Compliant*—most frequently NQTLs associated with Pharmacy Management. However, the majority of the *Partially Compliant* and *Not Compliant* findings resulted from insufficient information or clear evidence of parity associated with selection of the NQTL and the consistency and stringency with which it was applied to MH/SUD and M/S benefits across service types (i.e., IP, OP, and Rx). Only two CCOs were *Partially Compliant* across all reported domains, due to the lack of information regarding delegated subcontractors' policies and procedures, or challenges addressing MHP requirements. However, while some CCOs received overall ratings of *Partially Compliant*, evidence does not suggest any parity concerns in the implementation of treatment limitations or MH/SUD and M/S benefits.

OHP FFS was the only organization to receive a *Not Compliant* rating for all NQTLs across all domains. This was largely due to lack of supporting documentation (e.g., internal policies, procedures, processes, standard operating procedures, and workflows) to demonstrate how the treatment limitations were implemented and applied to MH/SUD and M/S benefits, OHP FFS was unable to demonstrate that NQTLs were comparable and not applied more stringently for MH/SUD benefits compared to M/S benefits. In general, OHP FFS frequently limited its responses to listing references to regulatory requirements (i.e., OARs), coverage guidelines (i.e., the HERC Prioritized List of Health Services),

provider-facing manuals (e.g., *Prior Authorization Handbook),* and links to OHP webpages. While OHP FFS did provide some process flows, these documents represented step-by-step processing and failed to address the rationale for using the NQTL; its application to MH/SUD and M/S providers; descriptions of the requirements, including the processes for determining how and what provider specialty restrictions are applied; and evidence to support development of the NQTL. Overall, the lack of defined operational policies and procedures supporting the implementation and management of NQTLs resulted in inconclusive findings related to the parity for OHP FFS, although outcomes reported in the Administrative Data Profile did not suggest major concerns with 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 continued to show minimal differences in the administration of MH/SUD and M/S benefits across the CCOs and OHP FFS, although considerable variation in CCO performance remains within each of the measures. 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. Identified differences in claims, UM, and provider enrollment outcome patterns suggest additional review by the CCOs and OHP FFS is needed.

Claims

Overall, the difference in the percentage of paid MH/SUD and M/S claims for the CCO aggregate across all claims (i.e., IP, OP, IN, and OON) was negligible, although individual CCOs and OHP FFS exhibited considerable variation in payment rates across all stratifications. When individual CCO and OHP FFS differences were moderate or substantial for paid IP and OP claims, the deviation was generally due to a higher percentage of paid MH/SUD claims versus paid M/S claims. However, when restricting the analysis to OON paid IP and OP claims, at least half of the CCOs exhibited moderate or substantial differences in the percentages of OON paid IP and OP claims wherein the deviation was due to a lower percentage of paid MH/SUD claims compared to paid M/S claims. Although differences in the percentage of paid OON claims may be legitimate, they may also indicate procedural or network differences that highlight potential barriers to members' access to MH/SUD services. The CCOs should review OON claim denials to understand factors affecting the lower percentage of paid MH/SUD IP and OP claims compared to M/S IP and OP claims, and assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside the CCO's network (e.g., appointment availability).

Utilization Management

Overall, differences in the percentage of denials for MH/SUD and M/S PA requests continued to vary across all service types (i.e., IP, OP, and Rx). While the percentage point differences in the CCO

aggregate denial rates were negligible between IP and Rx MH/SUD and M/S services, the percentage point difference in the CCO aggregate OP denial rate was substantial (greater than 10 percentage points). However, when CCO and OHP FFS absolute differences in the percentage of PA denials were *moderate* or *substantial*, MH/SUD PA requests were typically denied less frequently than M/S PA requests. A review of denial reasons across benefit type and services revealed that most denials were related to services not meeting clinical criteria or for non-covered services. However, while patterns of denial reasons were relatively stable, OP PA denials demonstrated variations in between MH/SUD and M/S services with a greater percentage of MH/SUD OP PA denials related to UM controls and treatment limitations, administrative denials, and OON providers suggesting an area requiring greater review to ensure parity across MH/SUD and M/S services.

While all required UM data (i.e., PA, appeals, and hearings) are reported in the CCO appendices, the review of UM data at the aggregate level was limited to PA denials due to the small number of appeals and hearings reported by individual CCOs. In total, appeals were submitted for fewer than 10 percent of all IP, OP, and Rx denials, with less than 5 percent of all appeals being associated with MH/SUD services. Of note, while the percentage of overturned OP MH/SUD appeals was comparable to the percentage of overturned OP M/S appeals, the difference in the rate of overturned IP and Rx appeals substantially higher for MH/SUD appeals than M/S appeals (i.e., 15.4 percent and 10.6 percent, respectively). While the results indicate potential barriers to MH/SUD services may exist, caution should be used when generalizing these results due to the small number of appeals. However, the pattern does suggest that greater review by OHA better understand why the discrepancy exists.

In addition to administrative data sources, a review of NOABDs and NOARs was conducted to evaluate whether UM processes were implemented in alignment with policies and procedures. In general, the file reviews revealed issues with the CCOs' and OHP FFS' compliance with federal and State regulatory requirements surrounding the processing of NOABDs and NOARs; however, these issues did not reveal substantial differences in the application of UM processes to the delivery of MH/SUD and M/S services.

Provider Enrollment

Overall, the difference in the statewide CCO percentage of terminated providers for MH/SUD and M/S providers was negligible, with 14 CCOs exhibiting little to no difference in the percentage of MH/SUD and M/S providers terminated or not recredentialed in CY 2022, While the remaining CCOs and OHP FFS showed substantial differences in the percentage of terminated providers, those differences were related to higher termination rates among 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 two CCOs exhibiting little to no difference in the percentage of MH/SUD and M/S provider applications approved in CY 2022.

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Between 2022 and 2023, CCOs exhibited substantial increases in the number of contracted MH and SUD provider counts across all CCOs, with only a few demonstrating decreases in the count of MH and SUD providers. Several factors likely contributed to these increases, including the CCOs' efforts to increase enrollment and contracting with MH providers in response to members' needs as well as improvements to the quality of provider data and changes in study protocols (e.g., provider categorization). Additionally, provider-to-member ratios were low, indicating the CCOs and OHP FFS had a large number of providers contracted to perform MH and SUD services relative to members with an MH or SUD diagnosis.

Time and Distance

The 2023 MHP Evaluation assessed the geographic distribution of MH and SUD providers relative to members with an MH or SUD diagnosis. In general, the results demonstrated that the average drive time and distance to the nearest three MH and SUD providers were within time and distance requirements set by OHA for both urban and rural geographic settings (i.e., 30 minutes/30 miles for urban areas and 60 minutes/60 miles for rural areas). Moreover, with one exception, the CCOs and OHP FFS were in compliance with OHA time and distance standards, demonstrating that 95 percent of members with an MH or SUD diagnosis had access to MH and SUD services. However, while these results suggest that MH and SUD providers were distributed in proportion to members' locations, the findings should be interpreted with caution, as the specific types of MH and SUD providers within time and distance parameters may or may not be relevant to specific member needs. Additionally, time and distance metrics represent only one of several network monitoring metrics used to assess provider network adequacy.

Appointment Availability

Overall, nearly all CCOs reported assessing appointment availability as part of their ongoing monitoring of network adequacy using provider surveys. In some cases, CCOs conducted secret shopper surveys of providers or surveyed members about their experience with appointment availability. However, the CCOs described a variety of approaches to collecting and using these data, with widely varying degrees of relevance, rigor, and utility. As a result, data are not comparable across plans and, in some cases, are of limited value to support network adequacy monitoring for CCOs. Importantly, these provider surveys frequently stratified results by provider type and included assessments of appointment availability to MH/SUD providers. To evaluate the availability and accessibility of appointments to MH/SUD providers, OHA will need to develop both data collection and measurement protocols, as well as appointment availability standards. OHP FFS reported that it did not have any mechanisms in place to monitor appointment availability for MH/SUD or M/S providers.

Access-Related Grievances

Overall, only 2.2 percent of all CCO grievances were associated with MH/SUD benefits or service, with an average CCO rate of 3.1 percent. The results showed a consistent distribution of MH/SUD-related grievances, with most CCOs having less than 6 percent of all grievances related to MH/SUD services (excluding AllCare at 38.0 percent). Further, while the percentage of access-related grievances associated with MH/SUD services was low for CCOs, with an aggregate rate of 17.0 percent, the range of access-related MH/SUD grievances across individual CCOs was substantially wider. It is important to note that grievances are a limited monitoring tool for CCOs, given that members must have both the means and the inclination to file a grievance. These results reinforce OHA's guidance that grievance monitoring, while required and valuable, likely captures only a fraction of members' overall experiences and should not be used as the total or primary mechanism for monitoring network adequacy and decision making. Further, due to the nature of MH/SUD clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan than those with a M/S diagnosis, contributing to the low rate of grievances and thereby underestimating these results.

MHP Community Partner Input

OHA conducted meetings with three different CP 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 CPs (see Appendix R. MHP Community Partner Feedback) was used not only to help make final parity decisions but will be used to guide the development of future MHP analytic activities. Following its initial meetings, OHA developed a survey of potential topics of targeted evaluations that could be incorporated into the 2024 and 2025 MHP evaluations. The list of topics was derived from CP feedback as well as from both their feasibility and relevance to MH parity. An online survey was released on October 24, 2023, to all CPs and OHA staff, and closed on November 2, 2023. Results of the survey were reviewed with each of OHA's CPs in fall 2023 and will be used to guide the MHP Evaluation protocol for 2024. The top two topics selected by CPs were as follows:

- Evaluation of differences in the implementation of covered benefits between CCOs and OHP FFS for select MH and SUD services, including the assessment of billing requirements.
- Identification and calculation of performance measures to assess the prevalence and timeliness of follow-up services between settings of care—hospital, emergency department, etc.

Finally, CPs continued to emphasize the need to include not only quantitative assessment of parity but also qualitative assessments that center on the "individuals behind the numbers" as well as looking beyond compliance with regulatory standards and understanding the impact on members and their experience.

Parity Determination

Based on the findings outlined in the 2023 MHP Evaluation, and in collaboration with the CP groups, the administration of MH/SUD and M/S benefits was largely found to be in parity for the CCOs. Although the evaluation identified several opportunities for improvement, results did not identify systemic issues that negatively impacted parity between MH/SUD and M/S services. Rather, findings frequently highlighted general regulatory compliance issues affecting both MH/SUD and M/S benefits uniformly. Individual CCO and OHP FFS results, as well as strengths, weaknesses, and recommendations, are provided for each organization in the appendices and should be reviewed by each respective organization to support and ensure continued compliance with parity standards.

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:

- Based on the findings in this report, HSAG recommends that, in addition to completing planned attestations in 2024 and 2025, CCOs and OHP FFS receiving a treatment limitation rating of *Partially Met* or *Not Met* for medical management, provider network, or pharmacy management controls should be required to resubmit responses and documentation to demonstrate compliance with parity requirements until all outstanding items are resolved. Additionally, due to the complexity of Oregon's Medicaid program with respect to the structure and administration of covered benefits, OHA should consider modifying its approach to conducting future reviews of CCOs' and OHP FFS' policies and procedures supporting the administration of MH/SUD and M/S benefits. The CCOs' and OHP FFS' reliance on the HERC Prioritized List of Health Services and guidelines and OARs, as well as the absence of comprehensive policies, procedures, processes, and workflows, the assessment of parity between the administration of MH/SUD and M/S benefits was often limited. To allow sufficient time to review and conduct key informant interviews with relevant CCO and OHP FFS staff, the review of NQTLs (i.e., Medical Management, Provider Network, and Pharmacy Management) should be conducted as part of a three-year cycle, beginning in 2026 following the current 3-year parity cycle, wherein each NQTL domain is reviewed separately. In addition to allowing a greater dive into the nuanced implementation of these processes, the State would also be able to provide additional technical assistance regarding the documentation necessary to demonstrate compliance allowing for a comprehensive analysis.
- While the 2023 MHP Evaluation incorporated file review to augment findings from the administrative data profile, the review was limited to an assessment of the timing and compliance of denial and appeal decision notices. Based on the results of the treatment limitation and administrative profile reviews, OHA should consider conducting an independent, focused review of denials and appeal decisions to fully understand how the CCOs' and OHP FFS' NQTLs impact MH parity. This review should occur independently of the MHP analysis to ensure that a sufficient sample of MH/SUD and M/S case files can be reviewed in aggregate and at the CCO level. This review should also include an independent clinical review to determine whether denial and appeal decisions align with OHA's expectations for the evaluation of medical necessity and

appropriateness. Additionally, based on the distribution of OP PA denial reasons, OHA should further assess MH/SUD denials related to plan-implemented treatment limitations and OON providers to ensure ongoing parity.

- Based on the special investigation topics selected in collaboration with the CPs, OHA should begin working to develop study protocols and evaluation metrics for inclusion in the 2024 and 2025 MHP Evaluation. To ensure the selection of appropriate MH and SUD services (e.g., peer support services, MH residential services, crisis respite, and withdrawal management), OHA should include key members from the CPs and OHA subject matter experts in the development process.
- As mentioned in CP feedback, OHA should evaluate whether timelines for receiving MHP evaluation data from the CCOs and OHP FFS, and legislative reporting can be adjusted to allow more time for CPs to provide meaningful feedback.
- While the MHP Evaluation has been established to confirm parity in the implementation and delivery of MH/SUD and M/S benefits, OHA CPs continue to identify the need for targeted evaluations of MH and SUD outcomes. As such, OHA should consider conducting additional targeted evaluations of members' and providers' experience to assess the quality, timeliness, and access to MH and SUD health care services outside of the annual parity evaluation.

Appendix A. MHP Results for Advanced Health (AH)

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the CCO to manage the administration of MH/SUD and M/S covered benefits, and assess whether documentation demonstrated compliance with MHP requirements in how they were applied to MH/SUD and M/S services and benefits. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency.* A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria. In contrast, a *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both. In general, *Partially Compliant* findings resulted from insufficient information or clear evidence of parity associated with selection of the NQTLs and the consistency and stringency with which the treatment limitations were applied to MH/SUD and M/S benefits across service types (i.e., inpatient [IP], outpatient [OP], pharmacy [Rx] or emergency care [EC]). Table A-1 presents a summary of HSAG's assessment of the CCO's compliance based on the analysis of treatment limitations applied, including the CCO's parity rating by treatment limitation type.

Table A-1—Overall Treatment Limitation Review Results by Treatment Limitation Type

OR 2023 MHP Treatment Limitation Review Element	CCO Compliance Rating
Financial Requirements (FRs)	*NA*
Aggregate Lifetime and Annual Dollar Limits (AL/ADLs)	*NA*
Quantitative Treatment Limitations (QTLs)	*NA*
Non-Quantitative Treatment Limitations (NQTLs)	*Partially Compliant*
Availability of Information	*Partially Compliant*
Overall Compliance Rating	***Partially Compliant***

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the compliance rating is not applicable.

Overall, the CCO demonstrated partial compliance with MHP requirements and standards related to treatment limitations used by the organizations to manage MH/SUD and M/S benefits. However, these results did not identify any systemic issues that negatively affected parity between the administration of MH/SUD and M/S services. Rather, AH's findings highlighted general regulatory compliance issues related to documentation and demonstration of implementation that affected both MH/SUD and M/S benefits uniformly. Key findings for each treatment limitation element included:

Financial Requirements

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

Aggregate Lifetime and Annual Dollar Limits

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

Quantitative Treatment Limitations

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

Non-Quantitative Treatment Limitations

Table A-2 presents a summary of the NQTLs implemented by the CCO, including compliance with parity requirements.

Table A-2—Parity Results by Specific Treatment Limitation Type and Benefit and Service Type

NQTL	Applicable Benefit and Service Type								Parity Rating
	MH/SUD				M/S				
	IP	OP	Rx	EC	IP	OP	Rx	EC	
Medical Management	X	X			X	X			*Partially Compliant*
Provider Network									*NA*
Pharmacy Management			X			X			*Partially Compliant*
Other: Not applicable									*NA*

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the parity rating is not applicable.

Medical Management

- Most of AH's policies included standardized processes that applied to both MH/SUD and M/S benefits, including a Utilization Management and Service Authorization Handbook.
- The CCO's utilization management (UM) processes were designed to ensure coverage, medical necessity, appropriate treatment in the least restrictive environment that maintains the safety of the individual, compliance with federal and State requirements, and prevention of unnecessary overutilization. AH reported that the evidence used to apply UM to MH/SUD and M/S included OARs, the HERC Prioritized List of Health Services and guidelines, CMS' NCD or LCD criteria

guidelines, Agency for Healthcare Research and Quality (AHRQ), Milliman Care Guidelines, ACR [American College of Radiology] Appropriateness Criteria, Hayes review, and Up-to-Date. The processes, strategies, and evidentiary standards used in applying Medical Management NQTLs to MH/SUD benefits in the two classifications (i.e., IP and OP) were comparable to the evidentiary standards used in administering NQTLs to M/S benefits in the same classifications. The CCO used nationally recognized, evidence-based medical necessity criteria for MH/SUD and M/S benefits in the two classifications to administer its processes with equivalent stringency.

- AH indicated the NQTL of concurrent review (CR) is applied to MH/SUD benefits for the IP and OP service classification and to M/S benefits for the IP service classification. The strategies used to determine assignment of the CR NQTL were consistent between MH/SUD and M/S benefits, and the evidentiary standards used in administering the NQTL to MH/SUD benefits in the IP service classification were comparable to the evidentiary standards used in administering NQTLs to M/S benefits in the IP service classification. However, the NQTL of CR is applied to the OP service classification for MH/SUD benefits but is not applied to the OP service classification for M/S benefits. The CCO did not demonstrate that the processes and requirements used to apply the NQTL by benefit and service classification to MH/SUD benefits are applied with no more stringency than M/S benefits in the same classification, resulting in a *Partially Compliant* finding.
- Retrospective review (RR) was also identified by the CCO as an NQTL applied to MH/SUD benefits for the IP and OP service classification and to M/S benefits for the IP service classification. The strategies used to determine assignment of the RR NQTL were consistent between MH/SUD and M/S benefits, and the evidentiary standards used in administering the NQTL to MH/SUD benefits in the IP service classification were comparable to the evidentiary standards used in administering NQTL to M/S benefits in the IP service classification. However, the NQTL of RR was applied to the OP service classification for MH/SUD benefits but not applied to the OP service classification for M/S benefits. The CCO did not demonstrate that the processes and requirements used to apply the NQTL by benefit and service classification to MH/SUD benefits are applied with no more stringency than M/S benefits in the same classification, resulting in a *Partially Compliant* finding.

Provider Network

- AH reported the CCO does not apply NQTLs related to the provider network, including admission standards, reimbursement rates, restrictions based on geographic location/specialty requirements/facility types, network tiers, or OON providers for IP, OP, Rx, or EC for MH/SUD or M/S benefits.

Pharmacy Management

- AH identified the use of a formulary for prescription drugs with the intent to provide medications that are effective for above-the-line conditions and those that are cost effective. The CCO also provided its non-formulary drug use criteria. However, the CCO did not include processes, strategies, evidentiary standards, and other factors used in formulary design for prescription drugs, resulting in a *Partially Compliant* finding.

Other NQTLs

- No additional NQTLs were identified by the CCO.

Availability of Information

AH identified the criteria used for medical necessity determinations applied to MH/SUD benefits, including OARs, HERC Prioritized List of Health Services and guideline notes, and Milliman Care Guidelines. The CCO listed the Notice of Adverse Benefit Determination as a means to inform members of the ability to request copies of the medical necessity criteria and the Grievance System Policy and Procedure Manual as its mechanism to notify providers. However, the CCO did not include mechanisms to disseminate information to potential members (e.g., CCO's website and member handbook), resulting in a *Partially Compliant* finding.

Administrative Data Profile

Claims

Table A-3 presents a summary of the results from the analysis of paid claims by service and benefit type. In general, AH showed negligible difference (less than 1 percentage point) in the percentage of paid claims between MH/SUD (86.6 percent) and M/S (87.1 percent) services. Similarly, a minimal difference (2.6 percentage points) was also noted between the percentage of OON MH/SUD paid claims (63.5 percent) and M/S claims (66.1 percent), as well as for OON IP and OP claims individually (4.3 percentage points and 2.4 percentage points, respectively). The percentages of the total paid claims and OON paid claims were lower for MH/SUD services compared to M/S services.

Table A-3—Number and Percentage of Claims by Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims[1]		Out-of-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	7,813	6,019	77.0%	2,373	65.3%
	M/S	20,242	15,843	78.3%	6,708	69.6%
OP	MH/SUD	131,938	114,991	87.2%	15,516	63.2%
	M/S	331,887	290,783	87.6%	40,528	65.6%
Total	**MH/SUD**	**139,751**	**121,010**	**86.6%**	**17,889**	**63.5%**
	M/S	**352,129**	**306,626**	**87.1%**	**47,236**	**66.1%**

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.

Utilization Management

Table A-4 presents a summary of the results from the analysis of PAs by service and benefit type. No substantial differences in the percentage of denied M/S and MH/SUD PAs were found that would have suggested an MH parity concern. Due to the low number of PA denials that were appealed (excluding

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

Table A-4—Prior Authorization Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals[1]		Hearings[1]	
		Total	Denied Number	Percent[2]	Total Percent[2]	Overturned Percent	Total Percent	Overturned Percent
IP	MH/SUD	23	1	4.3%	0.0%	NA	0.0%	NA
	M/S	1,561	21	1.3%	100%	100%	0.0%	NA
OP	MH/SUD	994	106	10.7%	4.0%	25.0%	0.5%	0.0%
	M/S	15,007	3,150	21.0%	96.0%	21.9%	4.0%	0.0%
Rx	MH/SUD	1,139	374	32.8%	14.0%	28.6%	0.0%	NA
	M/S	5,053	2,417	47.8%	86.0%	30.2%	2.0%	0.0%

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

[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.

Provider Enrollment

Table A-5 presents a summary of the results from the analysis of provider enrollment and terminations. AH showed no difference (0.0 percentage points) between the percentage of MH/SUD and M/S provider applications approved in CY 2022. Although the CCO exhibited a higher percentage of MH/SUD provider terminations (12.8 percent) compared to M/S providers (10.3 percent), the difference was minimal at 2.5 percentage points.

Table A-5—CY 2022 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	189	100%	37	12.8%
M/S	207	100%	40	10.3%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table A-6 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Q2 2022 to Q1 2023 resulted in a substantial increase (i.e., ↑, or 10 percent) or decrease (i.e., ↓, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately nine months to one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

AH showed substantial increases in both MH and SUD providers between Q2 2022 and Q1 2023. At the same time, the CCO's overall network increased by approximately 125 providers. While the increase in provider counts was due to improved data quality, other factors likely contributed to the increase in MH and SUD provider numbers, including efforts described by the CCO to increase enrollment of MH/SUD providers in response to network gaps, changes to study methodology, and taxonomic transitions.

Table A-6—Number and Percentage of MH/SUD Practitioners by Quarter and Provider Type

Provider Type	Q2 2022			Q1 2023			Difference	
	All Providers (N)	Provider (N)	Providers (%)	All Providers (N)	Provider (N)	Providers (%)	Provider (N)	Percent Change
MH	682	159	23.3%	807	202	25.0%	43	27.0% ↑
SUD	682	33	4.8%	807	56	6.9%	23	69.7% ↑

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

Provider-to-Member Ratios

Table A-7 presents the provider-to-member ratios for MH and SUD providers in Q1 2023.

Table A-7—Provider-to-Member Ratios by Benefit and Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	202	8,416	1:42
SUD	56	4,634	1:83

Time and Distance

Table A-8 presents the average time and distance to the nearest three MH and SUD providers by setting urbanicity (i.e., urban or rural). The state-established time and distance standards are 30 minutes/30 miles in urban settings and 60 minutes/60 miles in rural settings for at least 95.0 percent of members. The CCO met the rural time and distance access requirements for average time and distance to the nearest three MH and SUD providers. The CCO had no urban settings within its service area as defined by state-established urbanicity parameters.

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

Provider Type	Urban						Rural					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	NA	NA	NA	NA	NA	NA	3.2	4.0	4.6	2.9	3.7	4.3
SUD	NA	NA	NA	NA	NA	NA	7.6	11.8	12.1	7.0	10.9	11.1

Table A-9 presents the percentages of CCO members with access to MH and SUD services by urbanicity. The CCO demonstrated 100 percent access to MH and SUD providers in rural settings. The CCO had no urban settings within its service region as defined by state-established urbanicity parameters.

Table A-9—Time and Distance Results by Geography

MH		SUD	
Urban	Rural	Urban	Rural
NA	100%	NA	100%

Appointment Availability

AH monitored appointment availability for both M/S and MH/SUD providers. Monitoring activities described and demonstrated by the CCO as part of its *DSN Provider Narrative Template* included:

- Quarterly provider surveys subdivided by provider type.
- Annual survey of 500 members.
- Grievance monitoring.

Access-Related Grievances

Table A-10 presents the percentage of access-related grievances compared to the overall number of grievances for MH and SUD services. The CCO showed a low percentage of grievances (4.2 percent)

that were associated with MH/SUD services and benefits. Of those grievances, more than 25.0 percent were related to access issues. Although these results suggest access as a potential focus for MH/SUD grievances, the results should be interpreted with caution due to the low overall total number of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.[A-1]

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

Total Grievances	MH/SUD		MH/SUD Access-Related Grievances	
	Number	Percent	Number	Percent
361	15	4.2%	4	26.7%

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2023 MHP Evaluation, MH/SUD and M/S benefits administration was found to be in parity for AH. While the evaluation identified several opportunities for improvement, results did not identify any systemic issues that negatively affected parity between MH/SUD and M/S services. Rather, findings frequently highlighted general regulatory compliance issues affecting both MH/SUD and M/S benefits uniformly. Individual CCO results were used to identify the following strengths, weaknesses, and recommendations with respect to the quality, timeliness, and accessibility of health care services.

Strength/ Weakness	Description	Domain(s)*
–	**Weakness:** AH was partially compliant with the Medical Management NQTL requirement. **Why the weakness exists:** The CCO did not demonstrate that the processes and requirements used to apply concurrent and retrospective review NQTLs by benefit and service classification to MH/SUD benefits are applied with no more stringency than M/S benefits in the same classification. **Recommendations:** The CCO should review its implementation of concurrent and retrospective review NQTLs for OP MH/SUD services to ensure that the additional limitation based on the benefit does not impede the member's ability to access OP care more so than M/S.	🔑

[A-1] It is important to note that grievances are an inherently limited monitoring tool for CCOs, given that members must have both the means and the inclination to file a grievance. These results reinforce OHA's guidance that grievance monitoring, while required and valuable, likely captures only a fraction of members' overall experiences and should not be used as the only mechanism for monitoring network adequacy and decision making.

Strength/ Weakness	Description	Domain(s)*
–	**Weakness:** AH was partially compliant with the Pharmacy Management–Formulary Design NQTL requirement. **Why the weakness exists:** The CCO did not provide its rationale for the assignment of the NQTL (i.e., prescription drug formulary); procedures used for the development formulary (e.g., individuals involved in formulary development, professional guidelines used, and how often the formulary is reviewed and updated/by whom); or how frequently or strictly the NQTL is applied (e.g., ability of the provider to request an exception). **Recommendations:** The CCO should identify processes, strategies, evidentiary standards, and other factors used in formulary design and application for prescription drugs.	🔑

= Quality, = Timeliness, 🔑 = Access

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

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the CCO to manage the administration of MH/SUD and M/S covered benefits, and assess whether documentation demonstrated compliance with MHP requirements in how they were applied to MH/SUD and M/S services and benefits. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency.* A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria. In contrast, a *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both. In general, *Partially Compliant* findings resulted from insufficient information or clear evidence of parity associated with selection of the NQTLs and the consistency and stringency with which the treatment limitations were applied to MH/SUD and M/S benefits across service types (i.e., inpatient [IP], outpatient [OP], pharmacy [Rx] or emergency care [EC]). Table B-1 presents a summary of HSAG's assessment of the CCO's compliance based on the analysis of treatment limitations applied, including the CCO's parity rating by treatment limitation type.

Table B-1—Overall Treatment Limitation Review Results by Treatment Limitation Type

OR 2023 MHP Treatment Limitation Review Element	CCO Compliance Rating
Financial Requirements (FRs)	*NA*
Aggregate Lifetime and Annual Dollar Limits (AL/ADLs)	*NA*
Quantitative Treatment Limitations (QTLs)	*NA*
Non-Quantitative Treatment Limitations (NQTLs)	*Partially Compliant*
Availability of Information	*Partially Compliant*
Overall Compliance Rating	***Partially Compliant***

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the compliance rating is not applicable.

Overall, AllCare's responses in the *2023 MHP Treatment Limitation Review Tool* and supplemental documentation appeared to be limited to changes implemented since the CY 2022 review rather than comprehensive responses addressing all treatment limitations applied by the CCO to manage MH/SUD and M/S benefits as directed by the OR 2023 MHP Protocol. In the absence of sufficient information and complete responses, the evaluation of parity between processes, evidentiary standards, and other factors used in the application of treatment limitations in the administration of MH/SUD and M/S benefits was limited and inconclusive. The CCO received a less than *Compliant* rating for any treatment limitation review element that did not demonstrate parity between MH/SUD and M/S or that did not contain sufficient information to make a determination. However, these results did not identify any

systemic issues leading to parity issues that negatively affected parity between the administration of MH/SUD and M/S services. Rather, AllCare's findings highlighted general regulatory compliance issues related to documentation and demonstration of implementation that affected both MH/SUD and M/S benefits uniformly. Key findings for each treatment limitation review element included:

Financial Requirements

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

Aggregate Lifetime and Annual Dollar Limits

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

Quantitative Treatment Limitations

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

Non-Quantitative Treatment Limitations

Table B-2 presents a summary of the NQTLs implemented by the CCO, including compliance with parity requirements.

Table B-2—Parity Results by Specific Treatment Limitation Type and Benefit and Service Type

NQTL	Applicable Benefit and Service Type								Parity Rating
	MH/SUD				M/S				
	IP	OP	Rx	EC	IP	OP	Rx	EC	
Medical Management						X	X		*Partially Compliant*
Provider Network									*NA*
Pharmacy Management			X				X		*Partially Compliant*
Other: Not applicable									*NA*

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the parity rating is not applicable.

Medical Management

- AllCare's responses in the *MHP Treatment Limitation Review Tool* were limited to Medical Management NQTL changes implemented during CY 2022, resulting in *Partially Compliant* findings, and HSAG's review was limited to the information available.
- The CCO indicated medical necessity criteria were not applicable for either MH/SUD or M/S benefits; however, the Availability of Information, Section 6, of the *MHP Treatment Limitation Review Tool* listed medical necessity criteria used for MH/SUD benefits.
- The PA NQTL was identified for only M/S benefits; however, the CCO asserted that PA requirements were listed on the AllCare CCO Prior Authorization Grid, which included authorization requirements for MH/SUD services.
- For PA limits applied to IP and OP health benefits, HSAG was able to obtain policies and procedures submitted for the CY 2023 Compliance Monitoring Review (CMR) activity. Based on the documentation submitted for the CMR activity, AllCare used utilization management (UM) processes to manage MH/SUD and M/S benefits. AllCare's Decision Making Process for Service Request policy indicated the CCO had systematic guidelines in place to map the Benefit Management and Pharmacy Services decision-making process for UM clinical and non-clinical staff and its subcontracted entities reviewing behavioral, physical, and oral health service requests. The policy also identified evidence used to apply UM to MH/SUD and M/S, including OARs, the HERC Prioritized List of Health Services and guidelines, Milliman Care Guidelines, and CMS' NCD and LCD criteria guidelines. However, in the absence of both identification by the CCO of the service classifications to which the PA NQTLs apply and a submission of all relevant policies and procedures that may impact the parity evaluation, HSAG was unable to determine whether the CCO was fully compliant with its application of the PA NQTL.

Provider Network

- AllCare reported the CCO does not apply NQTLs related to the provider network, including admission standards, reimbursement rates, restrictions based on geographic location/specialty requirements/facility types, network tiers, or OON providers for IP, OP, Rx, or EC for MH/SUD or M/S benefits.

Pharmacy Management

- AllCare identified methods for determining usual/customary/and reasonable charges, use of a formulary, and tier placement; however, the CCO's description addressed the use of the Pharmacy and Therapeutics/Drug Utilization Review Committee to review new drugs rather than the methods used to determine charges imposed by the CCO, factors used in formulary design, or use of tiers as an NQTL. The response also did not include processes, strategies, evidentiary standards, and other factors used in ensuring usual, customary, and reasonable charges are not applied more stringently for MH/SUD benefits compared to M/S benefits. The CCO also included the use of PA and quantity limit NQTLs; however, their response was limited to changes specific to M/S medications rather than a comprehensive response addressing PA and quantity limit NQTLs for both MH/SUD and M/S benefits, resulting in a *Partially Compliant* finding.

Other NQTLs

- No additional NQTLs were identified by the CCO.

Availability of Information

AllCare listed the criteria used for medical necessity determinations applied to MH/SUD benefits; however, the CCO did not describe its mechanism for dissemination to members or providers, resulting in a *Partially Compliant* finding. For pharmacy, the CCO indicated that no new policies were implemented during the CY 2022 review period; however, the review tool directed the CCO to identify both the criteria used for medical necessity determinations applied to MH/SUD benefits and the mechanism for disseminating information about each service classification.

Administrative Data Profile

Claims

Table B-3 presents a summary of the results from the analysis of paid claims by service and benefit type. In general, AllCare showed a negligible difference (less than 1 percentage point) in the percentage of paid claims between MH/SUD (97.3 percent) and M/S (97.2 percent) services. Similarly, a negligible difference (1.1 percentage points) was also noted between the total percentage of OON MH/SUD (91.5 percent) and M/S (92.6 percent) paid claims. However, substantial differences (12.9 percentage points and 23.5 percentage points, respectively) were noted between the percentages of IP MH/SUD paid claims (83.5 percent) and IP M/S paid claims (96.4 percent) as well as OON IP MH/SUD paid claims (70.9 percent) and IP M/S paid claims (94.4 percent).

Table B-3—Number and Percentage of Claims by Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims[1]		Out-of-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	2,053	1,714	83.5%	519	70.9%
	M/S	44,159	42,588	96.4%	9,052	94.4%
OP	MH/SUD	248,006	241,484	97.4%	21,216	92.2%
	M/S	669,379	650,778	97.2%	62,834	92.3%
Total	**MH/SUD**	**250,059**	**243,198**	**97.3%**	**21,735**	**91.5%**
	M/S	**713,538**	**693,366**	**97.2%**	**71,886**	**92.6%**

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.

Utilization Management

Table B-4 presents a summary of the results from the analysis of PAs by service and benefit type. Across all service types, a greater percentage of M/S PAs were denied compared to MH/SUD PAs. The CCO reported there were no PA denials appealed for IP, OP or Rx MH/SUD services. Due to the low number of PA denials that were appealed (excluding Rx), results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity.

Table B-4—Prior Authorization Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals[1]		Hearings[1]	
		Total	Denied		Total Percent[2]	Overturned Percent	Total Percent	Overturned Percent
			Number	Percent[2]				
IP	MH/SUD	253	0	0.0%	0.0%	NA	0.0%	NA
	M/S	4,384	26	0.6%	100%	0.0%	0.0%	NA
OP	MH/SUD	186	9	4.8%	0.0%	NA	0.0%	NA
	M/S	5,599	661	11.8%	100%	36.7%	8.3%	20.0%
Rx	MH/SUD	398	183	46.0%	0.0%	NA	0.0%	NA
	M/S	6,158	2,956	48.0%	100%	13.3%	3.3%	0.0%

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

[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.

Provider Enrollment

Table B-5 presents a summary of the results from the analysis of provider enrollment and terminations. AllCare showed no difference (0.0 percentage points) between the percentage of MH/SUD and M/S provider applications approved in CY 2022. The CCO exhibited a minimal difference (2.6 percentage points) in the percentage of MH/SUD terminated providers (8.6 percent) compared to MH/SUD providers (11.2 percent).

Table B-5—CY 2022 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	186	100%	102	8.6%
M/S	231	100%	264	11.2%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table B-6 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Q2 2022 to Q1 2023 resulted in a substantial increase (i.e., ↑, or 10 percent) or decrease (i.e., ↓, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately nine months to one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

AllCare showed substantial increases in both MH and SUD providers between Q2 2022 and Q1 2023. Several factors likely contributed to these increases, including CCO efforts to increase enrollment of MH/SUD providers in response to network gaps, changes to study methodology, taxonomic transitions, and especially improved quality of provider data.

Table B-6—Number and Percentage of MH/SUD Practitioners by Quarter and Provider Type

Provider Type	Q2 2022			Q1 2023			Difference	
	All Providers (N)	Provider (N)	Providers (%)	All Providers (N)	Provider (N)	Providers (%)	Provider (N)	Percent Change
MH	1,097	118	10.8%	2,326	526	22.6%	408	345.8% ↑
SUD	1,097	38	3.5%	2,326	144	6.2%	106	278.9% ↑

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

Provider-to-Member Ratios

Table B-7presents the provider-to-member ratios for MH and SUD providers in Q1 2023.

Table B-7—Provider-to-Member Ratios by Benefit and Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	526	9,814	1:19
SUD	144	3,350	1:24

Time and Distance

Table B-8 presents the average time and distance to the nearest three MH and SUD providers by setting urbanicity (i.e., urban or rural). The state-established time and distance standards are 30 minutes/30

miles in urban settings and 60 minutes/60 miles in rural settings for at least 95.0 percent of members. The CCO met the rural time and distance access requirements for average time and distance to the nearest three MH and SUD providers.

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

Provider Type	Urban						Rural					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	2.6	2.9	3	2.4	2.6	2.7	7.1	8.0	8.2	6.6	7.3	7.5
SUD	3.2	3.3	3.4	3	3.1	3.1	10.6	10.7	10.7	9.6	9.7	9.7

Table B-9 presents the percentages of CCO members with access to MH and SUD services by urbanicity. The CCO demonstrated 100 percent access to MH and SUD providers in urban and rural settings.

Table B-9—Time and Distance Results by Geography

MH		SUD	
Urban	Rural	Urban	Rural
100%	100%	100%	100%

Appointment Availability

Based on the lack of relevant information submitted by the CCO, it could not be determined if AllCare monitors appointment availability for either M/S or MH/SUD providers. This resulted in a finding of noncompliance in the 2023 DSN Evaluation.

Access-Related Grievances

Table B-10 presents the percentage of access-related grievances compared to the overall number of grievances for MH and SUD services. The CCO showed a relatively high percentage of grievances (38.0 percent) that were associated with MH/SUD services and benefits. Of those grievances, only 5.7 percent related to access issues. These results suggest that MH/SUD providers or services are a potential focus for overall grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD

diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.[B-1]

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

Total Grievances	MH/SUD		MH/SUD Access-Related Grievances	
	Number	Percent	Number	Percent
184	70	38.0%	4	5.7%

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2023 MHP Evaluation, MH/SUD and M/S benefits administration was found to be in parity for AllCare. While the evaluation identified several opportunities for improvement, results did not identify any systemic issues that negatively affected parity between MH/SUD and M/S services. Rather, findings frequently highlighted general regulatory compliance issues affecting both MH/SUD and M/S benefits uniformly. Individual CCO results were used to identify the following strengths, weaknesses, and recommendations with respect to the quality, timeliness, and accessibility of health care services.

Strength/ Weakness	Description	Domain(s)
–	**Weakness:** AllCare's responses in the *2023 MHP Treatment Limitation Review Tool* and supplemental documentation were insufficient to demonstrate compliance with parity requirements. **Why the weakness exists:** The CCO's responses and supplemental documentation were limited to changes to treatment limitations implemented during CY 2022 rather than comprehensive responses addressing all treatment limitations applied by the CCO to manage MH/SUD and M/S benefits as directed by the 2023 MHP Protocol. **Recommendations:** The CCO should ensure that submitted descriptions and supplemental documentation are inclusive of all treatment limitations used by the CCO to manage MH/SUD benefits and to demonstrate parity with the treatment limitations applied to M/S benefits. Responses should address the writing prompt questions in the tool related to the CCO's rationale for the NQTL; the procedures/processes/requirements used to apply the NQTL; the frequency and strictness of the NQTL; and the evidentiary standards to support the rationale for how frequently and strictly the NQTL is	

[B-1] It is important to note that grievances are an inherently limited monitoring tool for CCOs, given that members must have both the means and the inclination to file a grievance. These results reinforce OHA's guidance that grievance monitoring, while required and valuable, likely captures only a fraction of members' overall experiences and should not be used as the only mechanism for monitoring network adequacy and decision making.

Strength/ Weakness	Description	Domain(s)
	applied. In addition, the CCO should ensure that individuals completing the *MHP Treatment Limitation Review Tool* attend the MHP technical assistance webinar and that they request additional assistance, as needed, to ensure their understanding of the requirements.	
−	**Weakness:** AllCare was partially compliant with the Pharmacy Management–Methods for Determining Reasonable Charges, Formulary Design, and Tier Placement NQTL requirements. **Why the weakness exists:** The CCO did not provide its rationale for the assignment of the NQTL; the procedures used for the development of reasonable charges, formulary design, and/or tier placement (e.g., individuals involved in development, professional guidelines used, how often the NQTLs are reviewed and updated/by whom); or how frequently or strictly the NQTL is applied (e.g., ability of the provider to request an exception). **Recommendations:** The CCO should identify processes, strategies, evidentiary standards, and other factors used in formulary design and application for pharmacy management NQTLs.	🔑
−	**Weakness:** AllCare showed a substantial difference in the percentage of paid, OON MH/SUD IP claims compared to M/S IP claims. Although the difference in the percentage of paid claims may be legitimate, they may also highlight procedural or network differences indicating potential barriers for members accessing MH/SUD services. **Why the weakness exists:** OON IP MH/SUD claims were paid less frequently than M/S claims. **Recommendations:** AllCare should review OON claim denials to understand factors affecting the lower percentage of paid MH/SUD IP claims compared to M/S IP claims. The CCO should assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside of the CCO's network (e.g., appointment availability).	⏱️🔑

= Quality, ⏱️ = Timeliness, 🔑 = Access

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

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the CCO to manage the administration of MH/SUD and M/S covered benefits, and assess whether documentation demonstrated compliance with MHP requirements in how they were applied to MH/SUD and M/S services and benefits. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency.* A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria. In contrast, a *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both. In general, *Partially Compliant* findings resulted from insufficient information or clear evidence of parity associated with selection of the NQTLs and the consistency and stringency with which the treatment limitations were applied to MH/SUD and M/S benefits across service types (i.e., inpatient [IP], outpatient [OP], pharmacy [Rx] or emergency care [EC]). Table C-1 presents a summary of HSAG's assessment of the CCO's compliance based on the analysis of treatment limitations applied, including the CCO's parity rating by treatment limitation type.

Table C-1—Overall Treatment Limitation Review Results by Treatment Limitation Type

OR 2023 MHP Treatment Limitation Review Element	CCO Compliance Rating
Financial Requirements (FRs)	*NA*
Aggregate Lifetime and Annual Dollar Limits (AL/ADLs)	*NA*
Quantitative Treatment Limitations (QTLs)	*NA*
Non-Quantitative Treatment Limitations (NQTLs)	*Compliant*
Availability of Information	*Compliant*
Overall Compliance Rating	***Compliant***

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the compliance rating is not applicable.

Overall, the CCO demonstrated compliance with MHP requirements and standards related to treatment limitations used by the organizations to manage MH/SUD and M/S benefits. For most of the NQTLs that apply to medical management (e.g., medical necessity criteria, practice guidelines selection criteria, retrospective review, experimental/investigational determinations, fail-first requirements, medical appropriateness reviews, and requirements for lower cost therapies to be tried first) and pharmacy management (e.g., methods for determining usual, customary, and reasonable charges; formulary design for prescription drugs; and prescription drug benefit tiers), the CCO directed the reviewer to the PA descriptions within each medical and pharmacy management subsections. Key findings for each treatment limitation element included:

Financial Requirements

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

Aggregate Lifetime and Annual Dollar Limits

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

Quantitative Treatment Limitations

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

Non-Quantitative Treatment Limitations

Table C-2 presents a summary of the NQTLs implemented by the CCO, including compliance with parity requirements.

Table C-2—Parity Results by Specific Treatment Limitation Types and Benefit and Service Type

NQTL	Applicable Benefit and Service Type								Parity Rating
	MH/SUD				M/S				
	IP	OP	Rx	EC	IP	OP	Rx	EC	
Medical Management	X	X			X	X			*Compliant*
Provider Network	X	X	X	X	X	X	X	X	*Compliant*
Pharmacy Management			X				X		*Compliant*
Other: Not applicable									*NA*

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the parity rating is not applicable.

Medical Management

- Most of CHA's policies included standardized processes that applied to both MH/SUD and M/S benefits.
- CHA identified PA requirements for EC; however, the CCO further explained the PA NQTL was applied to non-emergency inpatient services only.
- The CCO's utilization management (UM) processes were designed to ensure coverage, medical necessity, appropriate treatment in the least restrictive environment that maintains the safety of the individual, compliance with federal and State requirements, and the prevention of unnecessary

overutilization. CHA reported that the evidence used to apply UM to MH/SUD and M/S included OARs, the HERC Prioritized List of Health Services and guidelines, Milliman Care Guidelines, as well as the guidelines of the National Comprehensive Cancer Network (NCCN), GOLD Initiative for Obstructive Lung Disease (GOLD), American Diabetes Association (ADA), the American Society of Addiction Medicine (ASAM), Substance Abuse and Mental Health Services Administration (SAMHSA), and Bright Futures. The processes, strategies, and evidentiary standards used in applying medical management NQTLs to MH/SUD benefits in the two classifications (i.e., IP and OP) were comparable to the evidentiary standards used in administering NQTLs to M/S benefits in the same classifications. The CCO used nationally recognized, evidence-based medical necessity health criteria for MH/SUD and M/S benefits in the two classifications to administer its processes with equivalent stringency.

Provider Network

- CHA reported the CCO does not apply NQTLs related the provider network, including admission standards, reimbursement rates, restrictions based on geographic location/specialty requirements/facility types, network tiers, or OON providers for IP, OP, Rx, or EC for MH/SUD or M/S benefits.

Pharmacy Management

- CHA identified having methods for determining usual/customary/and reasonable charges, use of a formulary, and tier placement, which were addressed within the CCO's description of PA processes for pharmacy benefits. The CCO reported Rx authorization determinations were based upon Federal Drug Administration labeling, the Prioritized List of Health Services, national guidelines including ADA, NCCN, and COPD Gold guidelines, CHA guidelines, and the availability of less costly alternatives. The strategies used to determine assignment of NQTL of Rx PA were consistent between MH/SUD and M/S benefits. The evidentiary standards used in administering the NQTL to MH/SUD benefits in the Rx service classification were comparable to the evidentiary standards used in administering the NQTL to M/S benefits in the Rx service classification. The CCO used nationally recognized medical necessity health criteria for MH/SUD and M/S benefits in the Rx service classification to administer its processes with equivalent stringency.

Other NQTLs

- No additional NQTLs were identified by the CCO.

Availability of Information

CHA reported disseminating medical necessity criteria and supplemental information to members, potential members, and providers through the member handbook and the CCO's website. The member handbook informed the members that OHP's covered benefits and treatments are based on a list of conditions and services named the Prioritized List of Health Services which is ranked by the HERC. The member handbook also included information about covered services for both MH/SUD and M/S benefits that require a PA. It also directs the members to call Customer Care for information about covered benefits, and directs the members to CHA's list of medical benefits for more information about

services requiring PA. The CCO's Notice of Adverse Benefit Determination informed members of their ability to request free copies of the criteria and standards used in making coverage determinations.

Administrative Data Profile

Claims

Table C-3 presents a summary of the results from the analysis of paid claims by service and benefit type. In general, CHA showed a minimal difference (3.5 percentage points) in the percentage of paid claims between MH/SUD (93.7 percent) and M/S (90.2 percent) services. A negligible difference (1.3 percentage points) was noted between the total OON MH/SUD paid claims (88.6 percent) and OON M/S paid claims (87.3 percent). However, a substantial difference (12.3 percentage points) was noted for the percentage of paid claims for OON MH/SUD IP claims (74.4 percent) compared to out-of-network M/S IP claims (86.7 percent).

Table C-3—Number and Percentage of Claims by Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims[1]		Out-of-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	5,235	4,820	92.1%	574	74.4%
	M/S	2,768	2,578	93.1%	530	86.7%
OP	MH/SUD	111,284	104,350	93.8%	7,386	90.0%
	M/S	325,679	293,827	90.2%	47,297	87.3%
Total	**MH/SUD**	**116,519**	**109,170**	**93.7%**	**7,960**	**88.6%**
	M/S	**328,447**	**296,405**	**90.2%**	**47,827**	**87.3%**

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.

Utilization Management

Table C-4 presents a summary of the results from the analysis of PAs by service and benefit type. Across all service types, a greater percentage of M/S PAs were denied compared to MH/SUD PAs. The CCO reported there were no PA requests for IP MH/SUD benefits. Due to the low number of PA denials that were appealed (excluding Rx), results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity.

Table C-4—Prior Authorization Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals[1]		Hearings[1]	
		Total	Denied		Total Percent[2]	Overturned Percent	Total Percent	Overturned Percent
			Number	Percent[2]				
IP	MH/SUD	0	0	NA	NA	NA	NA	NA
	M/S	25	1	4.0%	NA	NA	NA	NA
OP	MH/SUD	164	21	12.8%	0.0%	NA	0.0%	NA
	M/S	14,127	2,358	16.7%	100%	32.1%	8.6%	0.0%
Rx	MH/SUD	66	9	13.6%	0.0%	NA	0.0%	NA
	M/S	15,854	2,512	15.8%	100%	100%	0.0%	NA

[1] NA indicates a denominator of zero; results could not be calculated.

[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.

Provider Enrollment

Table C-5 presents a summary of the results from the analysis of provider enrollment and terminations. CHA showed no difference (0.0 percentage points) between the percentage of MH/SUD and M/S provider applications approved in CY 2022. The CCO exhibited a substantial difference (13 percentage points) in provider terminations, with M/S providers terminated at higher rates (24.3 percent) than MH/SUD providers (11.3 percent).

Table C-5—CY 2022 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	18	100%	3	11.3%
M/S	81	100%	29	24.3%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table C-6 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Q2 2022 to Q1 2023 resulted in a substantial

increase (i.e., ↑, or 10 percent) or decrease (i.e., ↓, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately nine months to one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

CHA showed a generally stable network in both MH and SUD providers between Q2 2022 and Q1 2023, with minor changes. Several factors likely contributed to this stability, including CCO efforts to increase enrollment of MH/SUD providers in response to network gaps, changes to study methodology, taxonomic transitions, and improved quality of provider data.

Table C-6—Number and Percentage of MH/SUD Practitioners by Quarter and Provider Type

Provider Type	Q2 2022			Q1 2023			Difference	
	All Providers (N)	Provider (N)	Providers (%)	All Providers (N)	Provider (N)	Providers (%)	Provider (N)	Percent Change
MH	712	148	20.8%	657	141	21.5%	-7	-4.7%
SUD	712	66	9.3%	657	69	10.5%	3	4.5%

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

Provider-to-Member Ratios

Table C-7 presents the provider-to-member ratios for MH and SUD providers in Q1 2023.

Table C-7—Provider-to-Member Ratios by Benefit and Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	141	2,869	1:21
SUD	69	2,519	1:37

Time and Distance

Table C-8 presents the average time and distance to the nearest three MH and SUD providers by setting urbanicity (i.e., urban or rural). The state-established time and distance standards are 30 minutes/30 miles in urban settings and 60 minutes/60 miles in rural settings for at least 95.0 percent of members. The CCO met the rural time and distance access requirements for average time and distance to the nearest three MH and SUD providers. The CCO had no urban settings within its service area as defined by state-established urbanicity parameters.

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

Provider Type	Urban						Rural					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	NA	NA	NA	NA	NA	NA	4.7	5.2	5.4	4.3	4.8	5.0
SUD	NA	NA	NA	NA	NA	NA	5.4	5.5	5.8	5.0	5.1	5.4

Table C-9 presents the percentages of CCO members with access to MH and SUD services by urbanicity. The CCO demonstrated 100 percent access to MH and SUD providers in rural settings. The CCO had no urban settings within its service region as defined by state-established urbanicity parameters.

Table C-9—Time and Distance Results by Geography

MH		SUD	
Urban	Rural	Urban	Rural
NA	100%	NA	100%

Appointment Availability

CHA monitored appointment availability for both M/S and MH/SUD providers. Monitoring activities described and demonstrated by the CCO as part of its *DSN Provider Narrative Template* included:

- Monthly secret shopper calls to provider cohorts subdivided by provider type.
- Grievance monitoring.

Access-Related Grievances

Table C-10 presents the percentage of access-related grievances compared to the overall number of grievances for MH and SUD services. The CCO showed a low percentage of grievances (0.9 percent) that were associated with MH/SUD services and benefits. The one grievance associated with MH/SUD was unrelated to access. These low results should be interpreted with caution due to the overall low total numbers of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.[C-1]

[C-1] It is important to note that grievances are an inherently limited monitoring tool for CCOs, given that members must have both the means and the inclination to file a grievance. These results reinforce OHA's guidance that grievance monitoring,

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

Total Grievances	MH/SUD		MH/SUD Access-Related Grievances	
	Number	Percent	Number	Percent
107	1	0.9%	0	0.0%

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2023 MHP Evaluation, MH/SUD and M/S benefits administration was found to be in parity for CHA. Individual CCO results were used to identify the following strengths, weaknesses, and recommendations with respect to the quality, timeliness, and accessibility of health care services.

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

= Quality, ⏱️ = Timeliness, 🔑 = Access

while required and valuable, likely captures only a fraction of members' overall experiences and should not be used as the only mechanism for monitoring network adequacy and decision making.

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

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the CCO to manage the administration of MH/SUD and M/S covered benefits, and assess whether documentation demonstrated compliance with MHP requirements in how they were applied to MH/SUD and M/S services and benefits. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency.* A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria. In contrast, a *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both. In general, *Partially Compliant* findings resulted from insufficient information or clear evidence of parity associated with selection of the NQTLs and the consistency and stringency with which the treatment limitations were applied to MH/SUD and M/S benefits across service types (i.e., inpatient [IP], outpatient [OP], pharmacy [Rx] or emergency care [EC]). Table D-1 presents a summary of HSAG's assessment of the CCO's compliance based on the analysis of treatment limitations applied, including the CCO's parity rating by treatment limitation type.

Table D-1—Overall Treatment Limitation Review Results by Treatment Limitation Type

OR 2023 MHP Treatment Limitation Review Element	CCO Compliance Rating
Financial Requirements (FRs)	*NA*
Aggregate Lifetime and Annual Dollar Limits (AL/ADLs)	*NA*
Quantitative Treatment Limitations (QTLs)	*NA*
Non-Quantitative Treatment Limitations (NQTLs)	*Compliant*
Availability of Information	*Compliant*
Overall Compliance Rating	***Compliant***

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the compliance rating is not applicable.

Overall, the CCO demonstrated compliance with MHP requirements and standards related to treatment limitations used by the organizations to manage MH/SUD and M/S benefits. Key findings for each treatment limitation review element included:

Financial Requirements

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

Aggregate Lifetime and Annual Dollar Limits

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

Quantitative Treatment Limitations

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

Non-Quantitative Treatment Limitations

Table D-2 presents a summary of the NQTLs implemented by the CCO, including compliance with parity requirements.

Table D-2—Parity Results by Specific Treatment Limitation Types and Benefit and Service Type

NQTL	Applicable Benefit and Service Type								Parity Rating
	MH/SUD				M/S				
	IP	OP	Rx	EC	IP	OP	Rx	EC	
Medical Management	X	X	X		X	X	X		*Compliant*
Provider Network	X	X			X	X			*Compliant*
Pharmacy Management			X				X		*Compliant*
Other: Not Applicable									*NA*

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the parity rating is not applicable.

Medical Management

- Most of CPCCO's policies included standardized processes that applied to both MH/SUD and M/S benefits, including a Medical Necessity policy and Prior Authorization policy.
- For limits applied to IP, OP, and Rx health benefits, CPCCO used utilization management (UM) processes to manage MH/SUD and M/S benefits. The CCO's UM process was designed to ensure medical services and drugs rendered are consistent with the benefits and are medically appropriate. CPCCO reported that the evidence used to apply UM to MH/SUD and M/S benefits included OARs; the HERC Prioritized List of Health Services and guidelines; InterQual guidelines; and CMS' NCD and LCD criteria guidelines as well as Drug Compendia. The processes, strategies, and evidentiary standards used in applying Medical Management NQTLs to MH/SUD benefits in the three classifications (i.e., IP, OP, and Rx) were comparable to the evidentiary standards used in administering NQTLs to M/S benefits in the same classifications. The CCO used nationally recognized, evidence-based medical necessity criteria for MH/SUD and M/S benefits in the three classifications to administer its processes with equivalent stringency.

Provider Network

- CPCCO's processes for credentialing new providers and recredentialing existing providers, including frequency, was in alignment with State and federal regulations. The standards and processes for conducting credentialing and recredentialing activities were comparable and no more stringently applied for MH/SUD providers than M/S providers.

Pharmacy Management

- CPCCO identified the use of a formulary for prescription drugs which included formulary restrictions, such as PA requirements, step therapy restrictions, age restrictions, and quantity limits. There were no tiers or cost-sharing for prescription drug benefits. The CCO's pharmacy PA guidelines for MH/SUD prescription drugs were comparable and no more stringently applied than for M/S prescription drugs.

Other NQTLs

- No additional NQTLs were identified by the CCO.

Availability of Information

CPCCO disseminated medical necessity criteria through the member handbook, provider handbook, and the CCO's website. The member handbook informed members that OHP's covered benefits and treatments are based on a list of conditions and services named the Prioritized List of Health Services, which is ranked by the HERC. The CCO's Notice of Adverse Benefit Determination informed members of their ability to request free copies of the criteria and standards used in making coverage determinations.

Administrative Data Profile

Claims

Table D-3 presents a summary of the results from the analysis of paid claims by service and benefit type. In general, CPCCO showed a minimal difference (2.1 percentage points) in the percentage of paid claims between MH/SUD (90.8 percent) and M/S (88.7 percent) services. Similar differences were noted among the individual IP and OP paid claims. A negligible difference (0.8 percentage points) was seen between MH/SUD OON paid claims (81.3 percent) and M/S (80.5 percent) OON paid claims.

Table D-3—Number and Percentage of Claims by Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims[1]		Out-of-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	5,131	4,301	83.8%	1,028	80.1%
	M/S	28,661	24,684	86.1%	3,886	78.1%

Service Type	Benefit Type	Total Claims	Paid Claims[1]		Out-of-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
OP	MH/SUD	118,810	108,199	91.1%	13,328	81.4%
	M/S	360,406	320,285	88.9%	31,092	80.8%
Total	**MH/SUD**	**123,941**	**112,500**	**90.8%**	**14,356**	**81.3%**
	M/S	**389,067**	**344,969**	**88.7%**	**34,978**	**80.5%**

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.

Utilization Management

Table D-4 presents a summary of the results from the analysis of PAs by service and benefit type. Across all service types, a greater percentage of M/S PAs were denied compared to MH/SUD PAs. The CCO reported there were no PA denials appealed for MH/SUD services. Due to the low number of PA denials that were appealed (excluding Rx), results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity.

Table D-4—Prior Authorization Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals[1]		Hearings[1]	
		Total	Denied		Total Percent[2]	Overturned Percent	Total Percent	Overturned Percent
			Number	Percent[2]				
IP	**MH/SUD**	230	1	0.4%	0.0%	NA	0.0%	NA
	M/S	208	69	33.2%	100%	75.0%	0.0%	NA
OP	**MH/SUD**	465	11	2.4%	0.0%	NA	0.0%	NA
	M/S	13,270	911	6.9%	100%	64.2%	0.0%	NA
Rx	**MH/SUD**	198	132	66.7%	0.0%	NA	0.0%	NA
	M/S	2,142	1,524	71.1%	100%	50.0%	0.0%	NA

[1] NA—indicates a denominator of zero; results could not be calculated

[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.

Provider Enrollment

Table D-5 presents a summary of the results from the analysis of provider enrollment and terminations. CPCCO showed a negligible difference (0.2 percentage points) between the percentage of MH/SUD (100 percent) and M/S (99.8 percent) provider applications approved in CY 2022. The CCO did not have any provider terminations for MH/SUD, but there was one termination for M/S in CY 2022.

Table D-5—CY 2022 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	103	100%	0	0.0%
M/S	413	99.8%	1	0.1%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table D-6 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Q2 2022 to Q1 2023 resulted in a substantial increase (i.e., ↑, or 10 percent) or decrease (i.e., ↓, or 10 percent)) in the total number of MH/SUD providers. The data represent a calendar difference of approximately nine months to one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

CPCCO showed a relatively stable MH and SUD provider network between Q2 2022 and Q1 2023. At the same time, the CCO's overall network was reduced by approximately 4,022 providers, mainly in the number of primary care providers. While the increase in provider counts was due to improved data quality, other factors likely contributed to the increase in MH and SUD provider numbers, including efforts described by the CCO to increase enrollment of MH/SUD providers in response to network gaps, changes to study methodology, and taxonomic transitions.

Table D-6—Number and Percentage of MH/SUD Practitioners by Quarter and Provider Type

Provider Type	Q2 2022			Q1 2023			Difference	
	All Providers (N)	Provider (N)	Providers (%)	All Providers (N)	Provider (N)	Providers (%)	Provider (N)	Percent Change
MH	16,003	2,255	14.1%	11,981	2,409	20.1%	154	6.8%
SUD	16,003	486	3.0%	11,981	528	4.4%	42	8.6%

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

Provider-to-Member Ratios

Table D-7 presents the provider-to-member ratios for MH and SUD providers in Q1 2023.

Table D-7—Provider-to-Member Ratios by Benefit and Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	2,409	6,837	1:3
SUD	528	1,940	1:4

Time and Distance

Table D-8 presents the average time and distance to the nearest three MH and SUD providers by setting urbanicity (i.e., urban or rural). The state-established time and distance standards are 30 minutes/30 miles in urban settings and 60 minutes/60 miles in rural settings for at least 95.0 percent of members. The CCO met the rural time and distance access requirements for average time and distance to the nearest three MH and SUD providers.

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

Provider Type	Urban						Rural					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	6.2	6.2	12.6	5.7	5.7	11.6	4.0	4.3	5.4	3.7	3.9	5.0
SUD	15.8	16.3	16.3	14.5	15	15	6.0	6.1	11.8	5.5	5.6	10.8

Table D-9 presents the percentages of CCO members (restricted to the member population with an associated MH and/or SUD claim in 2022) with access to MH and SUD services by urbanicity. Results showing less than 95.0 percent of members meeting the state-defined time and distance access standards are shaded red.

The CCO did not meet the urban access standard for SUD providers. However, the CCO was nearly compliant with the access standard at 92.6 percent (i.e., representing 16 members without timely access). When considering the CCO's full membership (i.e., those with and without an MH or SUD diagnosis in 2022), results were similar at 92.3 percent compliance and 371 members impacted. Additionally, the CCO's sole urban setting within its otherwise rural service region is a small, remote community that had been classified under OHA's methodology as urban due to the community's proximity to a sufficiently populous town located just across the Washington state border. CPCCO's results for rural time and distance access indicate 100 percent access for both restricted and unrestricted member populations. As such, CPCCO's urban setting results should not necessarily be interpreted to mean that members lacked access to SUD services as measured by time and distance.

Table D-9—Time and Distance Results by Geography

MH		SUD	
Urban	Rural	Urban	Rural
100%	100%	92.6%	100%

Appointment Availability

It could not be determined from the submitted evidence whether CPCCO monitored appointment availability for either M/S or MH/SUD providers. This resulted in a finding of noncompliance in the 2023 DSN Evaluation. The monitoring activities identified but not sufficiently described or demonstrated by the CCO as part of its DSN Provider Narrative Template included:

- Provider surveys subdivided by provider type, including behavioral health.
- Site visits.

Access-Related Grievances

Table D-10 presents the percentage of access-related grievances compared to the overall number of grievances for MH and SUD services. The CCO showed a low percentage of grievances (2.6 percent) that were associated with MH/SUD services and benefits. Of those grievances, more than 20.0 percent were related to access issues. Although these results suggest access as a potential focus for MH/SUD grievances, the results should be interpreted with caution due to the low overall total numbers of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.[D-1]

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

Total Grievances	MH/SUD		MH/SUD Access-Related Grievances	
	Number	Percent	Number	Percent
309	8	2.6%	2	25.0%

[D-1] It is important to note that grievances are an inherently limited monitoring tool for CCOs, given that members must have both the means and the inclination to file a grievance. These results reinforce OHA's guidance that grievance monitoring, while required and valuable, likely captures only a fraction of members' overall experiences and should not be used as the only mechanism for monitoring network adequacy and decision making.

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2023 MHP Evaluation, MH/SUD and M/S benefits administration was found to be in parity for CPCCO. Individual CCO results were used to identify the following strengths, weaknesses, and recommendations with respect to the quality, timeliness, and accessibility of health care services.

Strength/ Weakness	Description	Domain(s)
⊕	**Strength:** CPCCO achieved full compliance with parity requirements for NQTLs applied to MH/SUD and M/S benefits.	🔑

= Quality, = Timeliness, = Access

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

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the CCO to manage the administration of MH/SUD and M/S covered benefits, and assess whether documentation demonstrated compliance with MHP requirements in how they were applied to MH/SUD and M/S services and benefits. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency.* A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria. In contrast, a *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both. In general, *Partially Compliant* findings resulted from insufficient information or clear evidence of parity associated with selection of the NQTLs and the consistency and stringency with which the treatment limitations were applied to MH/SUD and M/S benefits across service types (i.e., inpatient [IP], outpatient [OP], pharmacy [Rx] or emergency care [EC]). Table E-1 presents a summary of HSAG's assessment of the CCO's compliance based on the analysis of treatment limitations applied, including the CCO's parity rating by treatment limitation type.

Table E-1—Overall Treatment Limitation Review Results by Treatment Limitation Type

OR 2023 MHP Treatment Limitation Review Element	CCO Compliance Rating
Financial Requirements (FRs)	*NA*
Aggregate Lifetime and Annual Dollar Limits (AL/ADLs)	*NA*
Quantitative Treatment Limitations (QTLs)*	*NA*
Non-Quantitative Treatment Limitations (NQTLs)	*Partially Compliant*
Availability of Information	*Compliant*
Overall Compliance Rating	***Partially Compliant***

N/A—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits, therefore, the compliance rating is not applicable.

*QTLs identified by the CCO were soft limits based on medical necessity or medical appropriates and were subsequently reviewed as NQTLs.

Overall, the CCO demonstrated compliance with most MHP requirements and standards related to treatment limitations used by the organizations to manage MH/SUD and M/S benefits. However, these results did not identify any systemic issues that negatively affected parity between the administration of MH/SUD and M/S services. Rather, EOCCO's findings highlighted general regulatory compliance issues related to documentation and demonstration of implementation that affected both MH/SUD and M/S benefits uniformly. Key findings for each treatment limitation review element included:

Financial Requirements

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

Aggregate Lifetime and Annual Dollar Limits

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

Quantitative Treatment Limitations

EOCCO listed quantity limits on medications as a QTL for MH/SUD benefits in its *2023 MHP Treatment Limitation Review Tool*. However, the QTL was not a strict limit on medications made available to members, since the coverage determination process allowed for an individual to exceed numerical limits based on medical necessity. Therefore, the QTL identified by the CCO was evaluated for parity as an NQTL.

Non-Quantitative Treatment Limitations

Table E-2 presents a summary of the NQTLs implemented by the CCO, including compliance with parity requirements.

Table E-2—Parity Results by Specific Treatment Limitation Types and Benefit and Service Type

NQTL	Applicable Benefit and Service Type								Parity Rating
	MH/SUD				M/S				
	IP	OP	Rx	EC	IP	OP	Rx	EC	
Medical Management	X	X			X	X	X		*Partially Compliant*
Provider Network	X	X			X	X			*Compliant*
Pharmacy Management			X				X		*Partially Compliant*
Other: Not applicable									*NA*

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the parity rating is not applicable.

Medical Management

- Most of EOCCO's policies included standardized processes that applied to both MH/SUD and M/S benefits, including a Service Authorization/Referral Request policy, UM Medical Necessity policy, and Medical Management Program and Clinical Decisions policy.

- For limits applied to IP and OP health benefits, EOCCO used utilization management (UM) processes to manage MH/SUD and M/S benefits. The CCO's UM processes were designed to ensure that members get the right services at the right time to support progress toward treatment of a specific diagnosis or symptomatology. EOCCO reported that the evidence used to apply UM to MH/SUD and M/S benefits included OARs, the HERC Prioritized List of Health Services and guidelines, Milliman Care Guidelines, and CMS' NCD and LCDs.
- EOCCO reported that the NQTL of concurrent review (CR) was applied to MH/SUD benefits for IP and OP classifications and to M/S benefits for the IP classification only. The CCO did not demonstrate that the processes and requirements used to apply the NQTL by benefit and service classification to MH/SUD benefits were applied with no more stringency than to the M/S benefits in the same classification. The NQTL of CR for the OP service classification is *Partially Compliant* with parity requirements. The CCO should review its implementation of CR for OP MH/SUD services to ensure that the additional limitation based on the benefit does not impede the member's ability to access OP care more so than M/S.
- EOCCO reported that the NQTL of step therapy was applied to both MH/SUD prescription drugs that are not included in the carve-out list and M/S prescription drugs to promote utilization of clinically appropriate lower-cost alternatives. However, the CCO did not demonstrate that the processes, strategies, evidentiary standards, and other factors used in the assignment of step therapy for prescription drugs were not applied more stringently for MH/SUD benefits compared to M/S benefits. The NQTL of step therapy for the Rx service classification is *Partially Compliant* with parity requirements.

Provider Network

- EOCCO's processes for credentialing new providers and recredentialing existing providers, including frequency, were in alignment with State and federal regulations. The standards and processes for conducting credentialing and recredentialing activities were comparable and no more stringently applied for MH/SUD providers than M/S providers.

Pharmacy Management

- EOCCO identified the use of a formulary for prescription drugs which included formulary restrictions, such as PA requirements, step therapy restrictions, age restrictions, quantity limits, and specialty drugs. The CCO's pharmacy PA guidelines for MH/SUD prescription drugs were comparable and no more stringently applied than for M/S prescription drugs.
- EOCCO identified the use of prescription drug benefit tiers within the CCO's formulary. The formulary included a generic tier and a brand tier for both retail and specialty pharmacies. The tiers were not representative of cost restrictions and there was no cost-sharing for prescription drug benefits. However, the CCO did not demonstrate that the processes, strategies, evidentiary standards, and other factors used in formulary tiering for prescription drugs were not applied more stringently to the MH/SUD benefits that are not included in the carve-out list compared to M/S benefits, resulting in a *Partially Compliant* finding.

Other NQTLs

- No additional NQTLs were identified by the CCO.

Availability of Information

EOCCO disseminated medical necessity criteria through the member handbook, provider handbook, and the CCO's website. The member handbook informed the member that OHP's covered benefits and treatments would be based on a list of conditions and services named the Prioritized List of Health Services which is ranked by the HERC. The CCO's Notice of Adverse Benefit Determination informed members of their ability to request free copies of the criteria and standards used in making coverage determinations.

Administrative Data Profile

Claims

Table E-3 presents a summary of the results from the analysis of paid claims by service and benefit type. In general, EOCCO showed a minimal difference (2.2 percentage points) in the percentage of paid claims between MH/SUD (88.3 percent) and M/S (86.1 percent) services. A minimal difference (4.8 percentage points) was also noted between MH/SUD (69.8 percent) and M/S (65.0 percent) OON paid claims. This difference was driven primarily by the percentages and differences exhibited in OON OP claims. Across all service types, a greater percentage of MH/SUD claims were paid compared to M/S claims.

Table E-3—Number and Percentage of Claims by Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims[1]		Out-of-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	6,294	5,005	79.5%	1,317	64.7%
	M/S	103,059	79,627	77.3%	23,756	64.6%
OP	MH/SUD	237,613	210,283	88.5%	28,760	70.0%
	M/S	827,138	721,291	87.2%	57,235	65.2%
Total	**MH/SUD**	**243,907**	**215,288**	**88.3%**	**30,077**	**69.8%**
	M/S	**930,197**	**800,918**	**86.1%**	**80,991**	**65.0%**

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.

Utilization Management

Table E-4 presents a summary of the results from the analysis of PAs by service and benefit type. No substantial differences in the percentage of denied M/S and MH/SUD PAs were found that would have suggested an MH parity concern. Due to the low number of PA denials that were appealed (excluding

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

Table E-4—Prior Authorization Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals[1]		Hearings[1]	
		Total	Denied		Total Percent[2]	Overturned Percent	Total Percent	Overturned Percent
			Number	Percent[2]				
IP	MH/SUD	1,104	65	5.9%	84.8%	71.4%	0.0%	NA
	M/S	2,631	75	2.9%	15.2%	40.0%	0.0%	NA
OP	MH/SUD	1,625	33	2.0%	4.1%	25.0%	0.0%	NA
	M/S	30,813	2,240	7.3%	95.9%	25.8%	0.0%	NA
Rx	MH/SUD	544	190	34.9%	100%	100%	0.0%	NA
	M/S	5,099	2,750	53.9%	0.0%	NA	0.0%	NA

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

[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.

Provider Enrollment

Table E-5 presents a summary of the results from the analysis of provider enrollment and terminations. EOCCO showed no difference (0.0 percentage points) between the percentage of MH/SUD and M/S provider applications approved in CY 2022. The CCO exhibited a negligible difference (0.2 percentage points) between the percentage of terminated providers.

Table E-5—Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	255	100%	12	0.7%
M/S	761	100%	32	0.5%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table E-6 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD

providers. The table also indicates whether the change from Q2 2022 to Q1 2023 resulted in a substantial increase (i.e., ↑, or 10 percent) or decrease (i.e., ↓, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately nine months to one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

EOCCO showed a relatively stable MH network and a substantial decrease in SUD providers between Q2 2022 and Q1 2023. At the same time, the CCO's overall network decreased by approximately 5,841 providers. The significant decrease in SUD providers and providers overall may have been related to data issues, corrected reporting, or may represent a loss of providers. Further analysis of EOCCO's data showed that most of the CCO's SUD provider decreases were in SUD providers serving pediatric members; however, HSAG found that EOCCO reported nearly all its providers as serving strictly either adult or pediatric populations, with few providers documented as serving both. It was unclear from the analysis whether these practice characteristics were accurately reported in EOCCO's quarterly provider capacity data files.

Table E-6—Number and Percentage of MH/SUD Practitioners by Quarter and Provider Type

Provider Type	Q2 2022			Q1 2023			Difference	
	All Providers (N)	Provider (N)	Providers (%)	All Providers (N)	Provider (N)	Providers (%)	Provider (N)	Percent Change
MH	15,194	1,373	9.0%	9,353	1,358	14.5%	-15	-1.1%
SUD	15,194	337	2.2%	9,353	292	3.1%	-45	-13.4% ↓

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

Provider-to-Member Ratios

Table E-7 presents the provider-to-member ratios for MH and SUD providers in Q1 2023.

Table E-7—Provider-to-Member Ratios by Benefit and Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	1,358	11,438	1:9
SUD	292	3,639	1:13

Time and Distance

Table E-8 presents the average time and distance to the nearest three MH and SUD providers by setting urbanicity (i.e., urban or rural). The state-established time and distance standards are 30 minutes/30 miles in urban settings and 60 minutes/60 miles in rural settings for at least 95.0 percent of members. The CCO met the rural time and distance access requirements for average time and distance to the nearest three MH and SUD providers. For urban time and distance standards, however, the third-closest

SUD provider did not meet the standards. Since the first- and second-closest providers were within two minutes/two miles in an urban setting, this was not considered a SUD access issue.

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

Provider Type	Urban						Rural					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	1.5	1.5	1.5	1.5	1.5	1.5	5.8	7.0	7.4	5.3	6.4	6.8
SUD	1.7	1.8	33.3	1.6	1.7	30.6	6.4	6.7	7.0	5.9	6.2	6.5

Table E-9 presents the percentages of CCO members (restricted to the member population with an associated MH and/or SUD claim in 2022) with access to MH and SUD services by urbanicity. The CCO demonstrated 100 percent or nearly 100 percent (i.e., within 1.0 percent) access to MH and SUD providers in urban and rural settings.

Table E-9—Time and Distance Results by Geography

MH		SUD	
Urban	Rural	Urban	Rural
100%	99.6%	100%	99.0%

Appointment Availability

EOCCO monitored appointment availability for both M/S and MH/SUD providers. However, for all service categories (excluding dental) evidence suggested that quarterly grievance monitoring remained the primary appointment availability monitoring method, which suggested an insufficient monitoring process. Monitoring activities described and demonstrated by the CCO as part of its *DSN Provider Narrative Template* included:

- Quarterly provider surveys subdivided by provider type.
- Quarterly grievance monitoring.

Access-Related Grievances

Table E-10 presents the percentage of access-related grievances compared to the overall number of grievances for MH and SUD services. The CCO showed a low percentage of grievances (5.3 percent) that were associated with MH/SUD services and benefits. Of those grievances, more than 20.0 percent were related to access issues. Although these results suggest access as a potential focus for MH/SUD grievances, the results should be interpreted with caution due to the low overall total numbers of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD

diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.[E-1]

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

Total Grievances	MH/SUD		MH/SUD Access-Related Grievances	
	Number	Percent	Number	Percent
809	43	5.3%	10	23.3%

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2023 MHP Evaluation, MH/SUD and M/S benefits administration was found to be in parity for EOCCO. While the evaluation identified several opportunities for improvement, results did not identify any systemic issues that negatively affected parity between MH/SUD and M/S services. Rather, findings frequently highlighted general regulatory compliance issues affecting both MH/SUD and M/S benefits uniformly. Individual CCO results were used to identify the following strengths, weaknesses, and recommendations with respect to the quality, timeliness, and accessibility of health care services.

Strength/ Weakness	Description	Domain(s)
−	**Weakness:** EOCCO was partially compliant with the Medical Management–Concurrent Review NQTL requirement. **Why the weakness exists:** The CCO did not provide its rationale for the assignment of the NQTL to both the IP and OP classifications for MH/SUD benefits and only to the IP classification for the M/S benefits. **Recommendations:** The CCO should review its implementation of CR for OP MH/SUD services to ensure that the additional limitation based on the benefit does not impede the member's ability to access OP care more so than M/S.	🔑
−	**Weakness:** EOCCO was partially compliant with the Medical Management–Fail-first Requirements or Step Therapy NQTL requirement. **Why the weakness exists:** The CCO did not provide its rationale for the assignment of the NQTL (i.e., lower cost options), procedures related to step therapy (e.g., individuals involved,	🔑

[E-1] It is important to note that grievances are an inherently limited monitoring tool for CCOs, given that members must have both the means and the inclination to file a grievance. These results reinforce OHA's guidance that grievance monitoring, while required and valuable, likely captures only a fraction of members' overall experiences and should not be used as the only mechanism for monitoring network adequacy and decision making.

Strength/ Weakness	Description	Domain(s)
	factors used, professional guidelines used etc.), or how frequently or strictly the NQTL is applied (e.g., decision-making process). **Recommendations:** The CCO should identify processes, strategies, evidentiary standards, and other factors used in step therapy assignment for prescription drugs.	
−	**Weakness:** EOCCO was partially compliant with the Pharmacy Management– Prescription Drug Benefit Tiers NQTL requirement. **Why the weakness exists:** The CCO did not provide its rationale for the assignment of the NQTL (i.e., formulary drug tiering), procedures related to formulary tiering (e.g., individuals involved, factors used to determine tier placement, professional guidelines used), or how frequently or strictly the NQTL is applied (e.g., decision-making process). **Recommendations:** The CCO should identify processes, strategies, evidentiary standards, and other factors used in formulary tiering.	

= Quality, = Timeliness, = Access

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

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the CCO to manage the administration of MH/SUD and M/S covered benefits, and assess whether documentation demonstrated compliance with MHP requirements in how they were applied to MH/SUD and M/S services and benefits. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency.* A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria. In contrast, a *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both. In general, *Partially Compliant* findings resulted from insufficient information or clear evidence of parity associated with selection of the NQTLs and the consistency and stringency with which the treatment limitations were applied to MH/SUD and M/S benefits across service types (i.e., inpatient [IP], outpatient [OP], pharmacy [Rx] or emergency care [EC]). Table F-1 presents a summary of HSAG's assessment of the CCO's compliance based on the analysis of treatment limitations applied, including the CCO's parity rating by treatment limitation type.

Table F-1—Overall Treatment Limitation Review Results by Treatment Limitation Type

OR 2023 MHP Treatment Limitation Review Element	CCO Compliance Rating
Financial Requirements (FRs)	*NA*
Aggregate Lifetime and Annual Dollar Limits (AL/ADLs)	*NA*
Quantitative Treatment Limitations (QTLs)	*NA*
Non-Quantitative Treatment Limitations (NQTLs)	*Partially Compliant*
Availability of Information	*Compliant*
Overall Compliance Rating	***Partially Compliant***

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the compliance rating is not applicable.

In the absence of sufficient information and complete responses from each of the CCO's subcontractors, the evaluation of parity between processes, evidentiary standards, and other factors used in the application of treatment limitations in the administration of MH/SUD and M/S benefits was limited and inconclusive. The CCO received a less than *Compliant* rating for any treatment limitation review element that did not demonstrate parity between MH/SUD and M/S or that did not contain sufficient information to make a determination. However, these results did not identify any systemic issues that negatively affected parity between the administration of MH/SUD and M/S services. Rather, Health Share's findings highlighted general regulatory compliance issues related to documentation and

demonstration of implementation that affected both MH/SUD and M/S benefits uniformly. Key findings for each treatment limitation review element included:

Financial Requirements

Health Share reported the CCO does not apply any FRs or payments from members for services received that are in addition to payments made by the State (e.g., copayments, coinsurance, deductibles, or out-of-pocket maximums) for IP, OP, Rx, or EC for MH/SUD or M/S benefits.

Aggregate Lifetime and Annual Dollar Limits

Health Share reported the CCO does not apply AL/ADLs on the total amount of a specified benefit over a lifetime or annually for IP, OP, Rx, or EC for MH/SUD or M/S benefits.

Quantitative Treatment Limitations

Health Share reported the CCO does not apply any QTLs or limits on the scope or duration of a benefit that are expressed numerically (e.g., day or visit limits) for IP, OP, Rx, or EC for MH/SUD or M/S benefits.

Non-Quantitative Treatment Limitations

Table F-2 presents a summary of the NQTLs implemented by the CCO, including compliance with parity requirements.

Table F-2—Parity Results by Specific Treatment Limitation Types and Benefit and Service Type

NQTL	Applicable Benefit and Service Type								Parity Rating
	MH/SUD				M/S				
	IP	OP	Rx	EC	IP	OP	Rx	EC	
Medical Management	X	X	X		X	X	X		*Partially Compliant*
Provider Network	X	X			X	X			*Partially Compliant*
Pharmacy Management			X				X		*Partially Compliant*
Other: Not applicable									*NA*

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the parity rating is not applicable.

Medical Management

- Most of Health Share's subcontractors included standardized processes that applied to both MH/SUD and M/S benefits.

- For limits applied to IP and OP health benefits, Health Share's subcontractors used utilization management (UM) processes to manage MH/SUD and M/S benefits. The CCO's UM processes were designed to ensure that physical and behavioral health services that are medically necessary, medically appropriate, and consistent with the OHP benefit package are delivered to members. Health Share's subcontractors reported that the evidence used to apply UM to MH/SUD and M/S benefits included OARs, the HERC Prioritized List of Health Services and guidelines along with other nationally recognized, evidence-based medical criteria. For the subcontractors that were assessed, the processes, strategies, and evidentiary standards used in applying medical management NQTLs to MH/SUD benefits in the three classifications (i.e., IP, OP, and Rx) were comparable to the evidentiary standards used in administering NQTLs to M/S benefits in the same classifications.
- The NQTLs of practice guideline criteria, concurrent review, and fail-first requirements or step therapy were unable to be fully evaluated for parity with MHP requirements due to lack of sufficient information and/or supporting documentation explaining how each subcontractor is applying the treatment limitations, including the rationale for the NQTL; procedures, processes, and requirements used to apply the NQTL; frequency and strictness of the NQTL; and evidentiary standards to support the rationale for how frequently and strictly the NQTL is applied. In the absence of a description with supporting documentation from each subcontractor, the evaluation could not be fully met, resulting in a *Partially Compliant* finding.

Provider Network

- Health Share's subcontractor processes for credentialing new providers and recredentialing existing providers, including frequency, were in alignment with State and federal regulations. The standards and processes for conducting credentialing and recredentialing activities were comparable and no more stringently applied for MH/SUD providers than M/S providers.
- The NQTL of out-of-network/out-of-state access requirements was unable to be fully evaluated for parity with MHP requirements due to lack of sufficient information and/or supporting documentation explaining how each subcontractor is applying the treatment limitations including the rationale for the NQTL; procedures, processes, and requirements used to apply the NQTL; frequency and strictness of the NQTL; and evidentiary standards to support the rationale for how frequently and strictly the NQTL is applied. In the absence of a description with supporting documentation from each subcontractor, the evaluation could not be fully met, resulting in a *Partially Compliant* finding.

Pharmacy Management

- Health Share's subcontractors identified the use of a formulary for prescription drugs which included formulary restrictions, such as PA requirements, step therapy restrictions, age restrictions, and quantity limits. There are no tiers or cost-sharing for prescription drug benefits. The NQTL of formulary design for prescription drugs along with prescription drug benefit tiers, and quantity limits was unable to be fully evaluated for parity with MHP requirements due to lack of sufficient information and/or supporting documentation explaining how each subcontractor is applying the treatment limitations including the rationale for the NQTL; procedures, processes, and requirements used to apply the NQTL; frequency and strictness of the NQTL; and evidentiary standards to support the rationale for how frequently and strictly the NQTL is applied. In the absence of a description

with supporting documentation from each subcontractor, the evaluation could not be fully met, resulting in a *Partially Compliant* finding.

Other NQTLs

- No additional NQTLs were identified by the CCO.

Availability of Information

Health Share disseminated medical necessity criteria through the member handbook. The member handbook informed members that OHP's covered benefits and treatments would be based on a list of conditions and services, the Prioritized List of Health Services, which is ranked by the HERC. The CCO's Notice of Adverse Benefit Determination informed members of their ability to request free copies of the criteria and standards used in making coverage determinations. The CCO's subcontractors make their medical necessity criteria available upon request to members through their Customer Service teams and to providers through a Subcontractor's Provider Relations team.

Administrative Data Profile

Claims

Table F-3 presents a summary of the results from the analysis of paid claims by service and benefit type. In general, Health Share showed a negligible difference (1.0 percentage points) in the percentage of paid claims between MH/SUD (90.7 percent) and M/S (89.7 percent) services. A minimal difference (1.4 percentage points) was noted between MH/SUD OON paid claims (81.1 percent) and M/S (79.7 percent) OON paid claims. However, a substantial difference (13.1 percentage points) was noted for the percentage of paid claims for OON MH/SUD IP claims (63.7 percent) compared to out-of-network M/S IP claims (76.8 percent).

Table F-3—Number and Percentage of Claims by Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims[1]		Out-of-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	71,495	57,366	80.2%	7,582	63.7%
	M/S	253,218	217,862	86.0%	25,255	76.8%
OP	MH/SUD	1,803,023	1,642,463	91.1%	247,228	81.8%
	M/S	4,223,466	3,799,651	90.0%	341,789	79.9%
Total	**MH/SUD**	**1,874,518**	**1,699,829**	**90.7%**	**254,810**	**81.1%**
	M/S	**4,476,684**	**4,017,513**	**89.7%**	**367,044**	**79.7%**

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.

Utilization Management

Table F-4 presents a summary of the results from the analysis of PAs by service and benefit type. No substantial differences in the percentage of denied M/S and MH/SUD PAs s were found that would have suggested an MH parity concern. Due to the low number of PA denials that were appealed (excluding Rx), results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity.

Table F-4—Prior Authorization Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals[1]		Hearings[1]	
			Denied					
		Total	Number	Percent[2]	Total Percent[2]	Overturned Percent	Total Percent	Overturned Percent
IP	MH/SUD	6,150	8	0.1%	5.3%	100%	0.0%	NA
	M/S	9,381	510	5.4%	94.7%	27.8%	5.3%	0.0%
OP	MH/SUD	110,935	280	0.3%	0.9%	33.3%	0.0%	NA
	M/S	146,772	13,013	8.9%	99.1%	38.6%	2.1%	9.1%
Rx	MH/SUD	3,004	1,725	57.4%	100%	44.8%	0.0%	NA
	M/S	20,148	11,355	56.4%	0.0%	NA	8.6%	20.0%

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

[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.

Provider Enrollment

Table F-5 presents a summary of the results from the analysis of provider enrollment and terminations. Health Share showed no difference (0.0 percentage points) between the percentage of MH/SUD and M/S provider applications approved in CY 2022. The CCO exhibited a minimal difference (4.4 percentage points) in the percentage of terminated providers; however, in this case, M/S providers were terminated at a higher rate (24.3 percent) than MH/SUD (19.9 percent).

Table F-5—CY 2022 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	1,284	99.8%	138	19.9%
M/S	6,303	99.8%	2,140	24.3%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table F-6 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Q2 2022 to Q1 2023 resulted in a substantial increase (i.e., ↑, or 10 percent) or decrease (i.e., ↓, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately nine months to one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

Health Share showed substantial increases in both MH and SUD providers between Q2 2022 and Q1 2023. At the same time, the CCO's overall network decreased by approximately 2,419 providers. While the increase in provider counts was due to improved data quality, other factors likely contributed to the increase in MH and SUD provider numbers, including efforts described by the CCO to increase enrollment of MH/SUD providers in response to network gaps, changes to study methodology, and taxonomic transitions.

Table F-6—Number and Percentage of MH/SUD Practitioners by Quarter and Provider Type

Provider Type	Q2 2022			Q1 2023			Difference	
	All Providers (N)	Provider (N)	Providers (%)	All Providers (N)	Provider (N)	Providers (%)	Provider (N)	Percent Change
MH	16,791	1,902	11.3%	14,372	2,503	17.4%	601	31.6% ↑
SUD	16,791	522	3.1%	14,372	582	4.0%	60	11.5% ↑

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

Provider-to-Member Ratios

Table F-7 presents the provider-to-member ratios for MH and SUD providers in Q1 2023.

Table F-7—Provider-to-Member Ratios by Benefit and Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	2,503	85,559	1:35
SUD	582	20,323	1:35

Time and Distance

Table F-8 presents the average time and distance to the nearest three MH and SUD providers by setting urbanicity (i.e., urban or rural). The state-established time and distance standards are 30 minutes/30 miles in urban settings and 60 minutes/60 miles in rural settings for at least 95.0 percent of members. The CCO met the urban and rural time and distance access requirements for average time and distance to the nearest three MH and SUD providers.

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

Provider Type	Urban						Rural					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	1.3	1.5	1.6	0.8	0.9	1	5.1	5.1	8.3	4.7	4.7	7.7
SUD	2.2	2.9	3.2	1.4	1.8	2	12.9	18.6	18.9	11.9	16.6	16.8

Table F-9 presents the percentages of CCO members with access to MH and SUD services by urbanicity. The CCO demonstrated 100 percent access to MH and SUD providers in urban and rural settings.

Table F-9—Time and Distance Results by Geography

MH		SUD	
Urban	Rural	Urban	Rural
1000%	100%	100%	100%

Appointment Availability

Health Share monitored appointment availability for both M/S and MH/SUD providers. However, subcontractor monitoring methods varied greatly, making the overall comparison difficult across plans and for Health Share overall. Additionally, behavioral health monitoring only focused on outpatient appointments. Monitoring activities conducted by subcontractors and described by the CCO as part of its *DSN Provider Narrative Template* included:

- Provider surveys for next available appointments (varying frequencies and methodologies).
- Site visits.
- Grievance monitoring.

Access-Related Grievances

Table F-10 presents the percentage of access-related grievances compared to the overall number of grievances for MH and SUD services. The CCO showed a low percentage of grievances (2.0 percent) that were associated with MH/SUD services and benefits. Of those grievances, more than 20.0 percent were related to access issues. Although these results suggest access as a potential focus for MH/SUD grievances, the results should be interpreted with caution due to the low overall total numbers of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.[F-1]

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

Total Grievances	MH/SUD		MH/SUD Access-Related Grievances	
	Number	Percent	Number	Percent
7,414	149	2.0%	31	20.8%

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2023 MHP Evaluation, MH/SUD and M/S benefits administration was found to be in parity for Health Share. While the evaluation identified several opportunities for improvement, results did not identify any systemic issues that negatively affected parity between MH/SUD and M/S services. Rather, findings frequently highlighted general regulatory compliance issues affecting both MH/SUD and M/S benefits uniformly. Individual CCO results were used to identify the following strengths, weaknesses, and recommendations with respect to the quality, timeliness, and accessibility of health care services.

Strength/ Weakness	Description	Domain(s)
–	**Weakness:** Many of the NQTLs reported by the CCO were unable to be fully evaluated for parity with MHP requirements. **Why the weakness exists:** The CCO did not provide sufficient information and/or supporting documentation to explain how each subcontractor applies the treatment limitations, including the rationale for the NQTL; procedures, processes, and requirements used to apply the NQTL; frequency and strictness of the NQTL; and evidentiary	

[F-1] It is important to note that grievances are an inherently limited monitoring tool for CCOs, given that members must have both the means and the inclination to file a grievance. These results reinforce OHA's guidance that grievance monitoring, while required and valuable, likely captures only a fraction of members' overall experiences and should not be used as the only mechanism for monitoring network adequacy and decision making.

Strength/ Weakness	Description	Domain(s)
	standards to support the rationale for how frequently and strictly the NQTL is applied. **Recommendations:** The CCO should describe or provide supporting documentation for the reported NQTLs for each subcontractor.	

= Quality, = Timeliness, = Access

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

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the CCO to manage the administration of MH/SUD and M/S covered benefits, and assess whether documentation demonstrated compliance with MHP requirements in how they were applied to MH/SUD and M/S services and benefits. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency.* A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria. In contrast, a *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both. In general, *Partially Compliant* findings resulted from insufficient information or clear evidence of parity associated with selection of the NQTLs and the consistency and stringency with which the treatment limitations were applied to MH/SUD and M/S benefits across service types (i.e., inpatient [IP], outpatient [OP], pharmacy [Rx] or emergency care [EC]). Table G-1 presents a summary of HSAG's assessment of the CCO's compliance based on the analysis of treatment limitations applied, including the CCO's parity rating by treatment limitation type.

Table G-1—Overall Treatment Limitation Review Results by Treatment Limitation Type

OR 2023 MHP Treatment Limitation Review Element	CCO Compliance Rating
Financial Requirements (FRs)	*NA*
Aggregate Lifetime and Annual Dollar Limits (AL/ADLs)	*NA*
Quantitative Treatment Limitations (QTLs)*	*NA*
Non-Quantitative Treatment Limitations (NQTLs)	*Compliant*
Availability of Information	*Compliant*
Overall Compliance Rating	***Compliant***

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the compliance rating is not applicable.

*QTLs identified by the CCO were soft limits based on medical necessity or medical appropriateness and were subsequently reviewed as NQTLs.

Overall, the CCO demonstrated compliance with MHP requirements and standards related to treatment limitations used by the organizations to manage MH/SUD and M/S benefits. Key findings for each treatment limitation review element included:

Financial Requirements

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

Aggregate Lifetime and Annual Dollar Limits

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

Quantitative Treatment Limitations

IHN listed QTLs for MH/SUD benefits in its *2023 MHP Treatment Limitation Review Tool*, including medication-assisted treatment, quantity limits on medications per fill, and step therapy criteria for medications. However, the QTLs for the services listed were not a hard limit on medication-assisted treatment or the medications made available to members, since the coverage determination process allows for an individual to exceed numerical limits and receive an exemption based on medical necessity. Therefore, the QTLs identified by the CCO were evaluated for parity as NQTLs.

Non-Quantitative Treatment Limitations

Table G-2 presents a summary of the NQTLs implemented by the CCO, including compliance with parity requirements.

Table G-2—Parity Results by Specific Treatment Limitation Type and Benefit and Service Type

NQTL	Applicable Benefit and Service Type								Parity Rating
	MH/SUD				M/S				
	IP	OP	Rx	EC	IP	OP	Rx	EC	
Medical Management	X	X	X		X	X	X		*Compliant*
Provider Network	X	X			X	X			*Compliant*
Pharmacy Management			X				X		*Compliant*
Other: Not Applicable									*NA*

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the parity rating is not applicable.

Medical Management

- IHN's policies included standardized processes that applied to both MH/SUD and M/S benefits, including a Utilization Management and Service Authorization Handbook, Criteria for Utilization Management Decision Making policy, and an Authorization Requests policy.

- For limits applied to IP, OP, and Rx health benefits, IHN used utilization management (UM) processes to manage MH/SUD and M/S benefits. The CCO's utilization management (UM) processes were designed to ensure appropriate provision of services and benefits; to increase cost efficiency while improving health outcomes for members; to optimize member function by providing quality services in the most efficient and effective manner to members; and to promote timely access of medically appropriate care across a network of providers, treatment facilities, and services through medical management. IHN reported that the evidence used to apply UM to MH/SUD and M/S benefits included OARs, the HERC Prioritized List of Health Services and guidelines, Milliman Care Guidelines, American Society of Addiction Medicine (ASAM) criteria, and CMS' NCD and LCD criteria guidelines. The processes, strategies, and evidentiary standards used in applying Medical Management NQTLs to MH/SUD benefits in the three classifications (i.e., IP, OP, and Rx) were comparable to the evidentiary standards used in administering NQTLs to M/S benefits in the same classifications. The CCO used nationally recognized, evidence-based medical necessity criteria for MH/SUD and M/S benefits in the three classifications to administer its processes with equivalent stringency.

Provider Network

- IHN reported that access to OON providers, including out-of-state providers is subject to prior authorization (PA) for both MH/SUD and M/S, and that alternate provider agreements may be established for approved medically appropriate and necessary services. The standards and processes for accessing OON providers were comparable between MH/SUD and M/S and no more stringently applied for MH/SUD benefits than for M/S benefits.

Pharmacy Management

- IHN identified the use of a formulary for prescription drugs which included formulary restrictions, such as PA requirements, step therapy restrictions, and quantity limits. There are no tiers or cost-sharing for prescription drug benefits. The CCO's pharmacy PA guidelines for MH/SUD prescription drugs were comparable to and no more stringently applied than M/S prescription drugs.

Other NQTLs

- No additional NQTLs were identified by the CCO.

Availability of Information

IHN disseminated medical necessity criteria through the member handbook, provider handbook, and the CCO's website. The member handbook informed the member that OHP's covered benefits and treatments are based on a list of conditions and services named the Prioritized List of Health Services which is ranked by the HERC. The CCO's Notice of Adverse Benefit Determination informed members of their ability to request free copies of the criteria and standards used in making coverage determinations.

Administrative Data Profile

Claims

Table G-3 presents a summary of the results from the analysis of paid claims by service and benefit type. In general, IHN showed a negligible difference (0.7 percentage points) in the percentage of paid claims between MH/SUD (94.1 percent) and M/S (93.4 percent) services. However, a substantial difference (10.5 percentage points) was noted between MH/SUD (86.8 percent) and M/S (76.3 percent) OON paid claims. A moderate difference (8.6 percentage points) was reflected in the IP out-of-network paid claims.

Table G-3—Number and Percentage of Claims by Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims[1]		Out-of-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	12,024	10,846	90.2%	1,455	73.7%
	M/S	58,158	52,245	89.8%	6,411	82.3%
OP	MH/SUD	344,961	324,919	94.2%	20,410	87.9%
	M/S	828,703	776,463	93.7%	27,894	75.0%
Total	**MH/SUD**	**356,985**	**335,765**	**94.1%**	**21,865**	**86.8%**
	M/S	**886,861**	**828,708**	**93.4%**	**34,305**	**76.3%**

NA—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.

Utilization Management

Table G-4 presents a summary of the results from the analysis of PAs by service and benefit type. Across all service types, a greater percentage of M/S PAs were denied compared to MH/SUD PAs. Due to the low number of PA denials that were appealed (excluding Rx), results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity.

Table G-4—Prior Authorization Results Service Type and by Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals[1]		Hearings[1]	
		Total	Denied		Total Percent[2]	Overturned Percent	Total Percent	Overturned Percent
			Number	Percent[2]				
IP	**MH/SUD**	203	3	1.5%	0.0%	NA	0.0%	NA
	M/S	984	87	8.8%	100%	77.8%	0.0%	NA
OP	**MH/SUD**	7,190	146	2.0%	2.9%	66.7%	0.0%	NA

Service Type	Benefit Type	Prior Authorization			Appeals[1]		Hearings[1]	
		Total	Denied		Total Percent[2]	Overturned Percent	Total Percent	Overturned Percent
			Number	Percent[2]				
	M/S	33,687	3,473	10.3%	97.1%	58.0%	1.0%	0.0%
Rx	MH/SUD	1,089	352	32.3%	15.9%	45.7%	0.0%	NA
	M/S	12,241	5,061	41.3%	84.1%	43.9%	0.7%	50.0%

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

[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.

Provider Enrollment

Table G-5 presents a summary of the results from the analysis of provider enrollment and terminations. IHN showed no difference (0.0 percentage points) between the percentage of MH/SUD and M/S provider applications approved in CY 2022. The CCO exhibited a minimal difference (3.3 percentage points) in the percentage of terminated providers; however, in this case, MH/SUD providers were terminated at higher rates (5.6 percent) than M/S (2.3 percent).

Table G-5—CY 2022 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	722	99.7%	127	5.6%
M/S	1,004	99.7%	337	2.3%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table G-6 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Q2 2022 to Q1 2023 resulted in a substantial increase (i.e., ↑, or 10 percent) or decrease (i.e., ↓, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately nine months to one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

IHN showed substantial increases in both MH and SUD providers between Q2 2022 and Q1 2023. Several factors likely contributed to these increases, including efforts described by the CCO to increase enrollment of MH/SUD providers in response to network gaps, changes to study methodology, taxonomic transitions, and improved quality of provider data.

Table G-6—Number and Percentage of MH/SUD Practitioners by Quarter and Provider Type

Provider Type	Q2 2022			Q1 2023			Difference	
	All Providers (N)	Provider (N)	Providers (%)	All Providers (N)	Provider (N)	Providers (%)	Provider (N)	Percent Change
MH	5,811	1,271	21.9%	6,878	1,608	23.4%	337	26.5% ↑
SUD	5,811	334	5.7%	6,878	412	6.0%	78	23.4% ↑

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

Provider-to-Member Ratios

Table G-7 presents the provider-to-member ratios for MH and SUD providers in Q1 2023.

Table G-7—Provider-to-Member Ratios by Benefit and Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	1,608	19,147	1:12
SUD	412	14,632	1:36

Time and Distance

Table G-8 presents the average time and distance to the nearest three MH and SUD providers by setting urbanicity (i.e., urban or rural). The state-established time and distance standards are 30 minutes/30 miles in urban settings and 60 minutes/60 miles in rural settings for at least 95.0 percent of members. The CCO met the rural time and distance access requirements for average time and distance to the nearest three MH and SUD providers.

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

Provider Type	Urban						Rural					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	0.8	1	1.1	0.8	0.9	1.1	2.3	3.2	3.8	2.2	2.9	3.5
SUD	1.8	2	2.1	1.7	1.8	1.9	12.8	13.1	13.2	11.7	12.1	12.1

Table G-9 presents the percentages of CCO members with access to MH and SUD services by urbanicity. The CCO demonstrated 100 percent access to MH and SUD providers in urban and rural settings.

Table G-9—Time and Distance Results by Geography

MH		SUD	
Urban	Rural	Urban	Rural
100%	100%	100%	100%

Appointment Availability

IHN monitored appointment availability for both M/S and MH/SUD providers. Monitoring activities described and demonstrated by the CCO as part of its *DSN Provider Narrative Template* included:

- Annual provider surveys subdivided by provider type.
- Grievance monitoring.

Access-Related Grievances

Table G-10 presents the percentage of access-related grievances compared to the overall number of grievances for MH and SUD services. The CCO showed a low percentage of grievances (1.2 percent) that were associated with MH/SUD services and benefits. Of those grievances, more than 40.0 percent were related to access issues. Although these results suggest access as a potential focus for MH/SUD grievances, the results should be interpreted with caution due to the low overall total numbers of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.[G-1]

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

Total Grievances	MH/SUD		MH/SUD Access-Related Grievances	
	Number	Percent	Number	Percent
743	9	1.2%	4	44.4%

[G-1] It is important to note that grievances are an inherently limited monitoring tool for CCOs, given that members must have both the means and the inclination to file a grievance. These results reinforce OHA's guidance that grievance monitoring, while required and valuable, likely captures only a fraction of members' overall experiences and should not be used as the only mechanism for monitoring network adequacy and decision making.

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2023 MHP Evaluation, MH/SUD and M/S benefits administration was found to be in parity for IHN. Individual CCO results were used to identify the following strengths, weaknesses, and recommendations with respect to the quality, timeliness, and accessibility of health care services.

Strength/ Weakness	Description	Domain(s)
	**Strength:** IHN achieved full compliance with parity requirements for NQTLs applied to MH/SUD and M/S benefits.	

= Quality, = Timeliness, = Access

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

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the CCO to manage the administration of MH/SUD and M/S covered benefits, and assess whether documentation demonstrated compliance with MHP requirements in how they were applied to MH/SUD and M/S services and benefits. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency.* A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria. In contrast, a *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both. In general, *Partially Compliant* findings resulted from insufficient information or clear evidence of parity associated with selection of the NQTLs and the consistency and stringency with which the treatment limitations were applied to MH/SUD and M/S benefits across service types (i.e., inpatient [IP], outpatient [OP], pharmacy [Rx] or emergency care [EC]). Table H-1 presents a summary of HSAG's assessment of the CCO's compliance based on the analysis of treatment limitations applied, including the CCO's parity rating by treatment limitation type.

Table H-1—Overall Treatment Limitation Review Results by Treatment Limitation Type

OR 2023 MHP Treatment Limitation Review Element	CCO Compliance Rating
Financial Requirements (FRs)	*NA*
Aggregate Lifetime and Annual Dollar Limits (AL/ADLs)	*NA*
Quantitative Treatment Limitations (QTLs)	*NA*
Non-Quantitative Treatment Limitations (NQTLs)	*Compliant*
Availability of Information	*Compliant*
Overall Compliance Rating	***Compliant***

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the compliance rating is not applicable.

Overall, the CCO demonstrated compliance with MHP requirements and standards related to treatment limitations used by the organizations to manage MH/SUD and M/S benefits. Key findings for each treatment limitation review element included:

Financial Requirements

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

Aggregate Lifetime and Annual Dollar Limits

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

Quantitative Treatment Limitations

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

Non-Quantitative Treatment Limitations

Table H-2 presents a summary of the NQTLs implemented by the CCO, including compliance with parity requirements.

Table H-2—Parity Results by Specific Treatment Limitation Types and Benefit and Service Type

NQTL	Applicable Benefit and Service Type								Parity Rating
	MH/SUD				M/S				
	IP	OP	Rx	EC	IP	OP	Rx	EC	
Medical Management	X	X	X		X	X	X		*Compliant*
Provider Network	X	X			X	X			*Compliant*
Pharmacy Management			X				X		*Compliant*
Other: Not Applicable									*NA*

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the parity rating is not applicable.

Medical Management

- Most of JCC's policies included standardized processes that applied to both MH/SUD and M/S benefits, including a Medical Necessity policy and Prior Authorization policy.
- For limits applied to IP, OP, and Rx health benefits, JCC used utilization management (UM) processes to manage MH/SUD and M/S benefits. The CCO's UM process was designed to ensure medical services and drugs rendered are consistent with the benefits and are medically appropriate. JCC reported that the evidence used to apply UM to MH/SUD and M/S benefits included OARs; the HERC Prioritized List of Health Services and guidelines; InterQual guidelines; and CMS' NCD and LCD criteria guidelines as well as Drug Compendia. The processes, strategies, and evidentiary standards used in applying Medical Management NQTLs to MH/SUD benefits in the three classifications (i.e., IP, OP, and Rx) were comparable to the evidentiary standards used in administering NQTLs to M/S benefits in the same classifications. The CCO used nationally recognized, evidence-based medical necessity criteria for MH/SUD and M/S benefits in the three classifications to administer its processes with equivalent stringency.

Provider Network

- JCC's processes for credentialing new providers and recredentialing existing providers, including frequency, was in alignment with State and federal regulations. The standards and processes for conducting credentialing and recredentialing activities were comparable and no more stringently applied for MH/SUD providers than M/S providers.

Pharmacy Management

- JCC identified the use of a formulary for prescription drugs which included formulary restrictions, such as PA requirements, step therapy restrictions, age restrictions, and quantity limits. There were no tiers or cost-sharing for prescription drug benefits. The CCO's pharmacy PA guidelines for MH/SUD prescription drugs were comparable and no more stringently applied than for M/S prescription drugs.

Other NQTLs

- No additional NQTLs were identified by the CCO.

Availability of Information

JCC disseminated medical necessity criteria through the member handbook, provider handbook, and the CCO's website. The member handbook informed members that OHP's covered benefits and treatments are based on a list of conditions and services named the Prioritized List of Health Services, which is ranked by the HERC. The CCO's Notice of Adverse Benefit Determination informed members of their ability to request free copies of the criteria and standards used in making coverage determinations.

Administrative Data Profile

Claims

Table H-3 presents a summary of the results from the analysis of paid claims by service and benefit type. In general, JCC showed a moderate difference (5.0 percentage points) in the percentage of paid claims between MH/SUD (95.3 percent) and M/S (90.3 percent) services. However, a substantial difference (11.8 percentage points) was noted between the total percentage of MH/SUD OON paid claims (94.0 percent) and M/S OON paid claims (82.2 percent). Across all service types, a greater percentage of MH/SUD claims were paid compared to M/S claims.

Table H-3—Number and Percentage of Claims by Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims[1]		Out-of-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	15,403	14,982	97.3%	674	86.9%
	M/S	44,232	39,663	89.7%	3,214	79.9%

Service Type	Benefit Type	Total Claims	Paid Claims[1]		Out-of-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
OP	MH/SUD	283,112	269,521	95.2%	66,608	94.1%
	M/S	728,170	657,911	90.4%	41,811	82.4%
Total	**MH/SUD**	**298,515**	**284,503**	**95.3%**	**67,282**	**94.0%**
	M/S	**772,402**	**697,574**	**90.3%**	**45,025**	**82.2%**

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.

Utilization Management

Table H-4 presents a summary of the results from the analysis of PAs by service and benefit type. Across all service types, a greater percentage of M/S PAs were denied compared to MH/SUD PAs. Due to the low number of PA denials that were appealed (excluding Rx), results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity.

Table H-4—Prior Authorization Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals[1]		Hearings[1]	
		Total	Denied		Total Percent[2]	Overturned Percent	Total Percent	Overturned Percent
			Number	Percent[2]				
IP	**MH/SUD**	411	1	0.2%	0.0%	NA	0.0%	NA
	M/S	398	83	20.9%	100%	44.4%	11.1%	0.0%
OP	**MH/SUD**	792	10	1.3%	0.6%	100%	0.0%	NA
	M/S	33,272	2,385	7.2%	99.4%	37.7%	1.1%	0.0%
Rx	**MH/SUD**	370	239	64.6%	3.7%	0.0%	0.0%	NA
	M/S	3,520	2,642	75.1%	96.3%	42.3%	0.0%	NA

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

[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.

Provider Enrollment

Table H-5 presents a summary of the results from the analysis of provider enrollment and terminations. JCC showed no difference (0.0 percentage points) between the percentage of provider applications approved in CY 2022 and no difference (0.0 percentage points) between the percentage of terminated providers in CY 2022.

Table H-5—CY 2022 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	197	100%	0	0.0%
M/S	510	100%	0	0.0%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table H-6 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Q2 2022 to Q1 2023 resulted in a substantial increase (i.e., ↑, or 10 percent) or decrease (i.e., ↓, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately nine months to one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

JCC showed a substantial increase in the MH and SUD provider network between Q2 2022 and Q1 2023. At the same time, the CCO's overall network was reduced by approximately 3,659 providers, mainly in primary care providers. While the increase in provider counts was due to improved data quality, other factors likely contributed to the increase in MH and SUD provider numbers, including efforts described by the CCO to increase enrollment of MH/SUD providers in response to network gaps, changes to study methodology, and taxonomic transitions.

Table H-6—Number and Percentage of MH/SUD Practitioners by Quarter and Provider Type

Provider Type	Q2 2022			Q1 2023			Difference	
	All Providers (N)	Provider (N)	Providers (%)	All Providers (N)	Provider (N)	Providers (%)	Provider (N)	Percent Change
MH	15,894	2,258	14.2%	12,235	2,528	20.7%	270	12.0% ↑
SUD	15,894	486	3.1%	12,235	534	4.4%	48	9.9%

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

Provider-to-Member Ratios

Table H-7 presents the provider-to-member ratios for MH and SUD providers in Q1 2023.

Table H-7—Provider-to-Member Ratios by Benefit and Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	2,528	12,866	1:6
SUD	534	3,230	1:7

Time and Distance

Table H-8 presents the average time and distance to the nearest three MH and SUD providers by setting urbanicity (i.e., urban or rural). The state-established time and distance standards are 30 minutes/30 miles in urban settings and 60 minutes/60 miles in rural settings for at least 95.0 percent of members. The CCO met the rural time and distance access requirements for average time and distance to the nearest three MH and SUD providers.

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

Provider Type	Urban						Rural					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	1.1	1.2	1.4	1	1.1	1.2	4.6	5.1	5.2	4.3	4.7	4.8
SUD	2.5	2.9	2.9	2.1	2.6	2.6	12.1	17.6	17.6	10.3	15.0	15.0

Table H-9 presents the percentages of CCO members (restricted to the member population with an associated MH and/or SUD claim in 2022) with access to MH and SUD services by urbanicity. The CCO demonstrated 100 percent access to MH and SUD providers in urban and rural settings.

Table H-9—Time and Distance Results by Geography

MH		SUD	
Urban	Rural	Urban	Rural
100%	100%	100%	100%

Appointment Availability

It could not be determined from the submitted evidence whether JCC monitored appointment availability for either M/S or MH/SUD providers. This resulted in a finding of noncompliance in the 2023 DSN Evaluation. The monitoring activities identified but not sufficiently described or demonstrated by the CCO as part of its DSN Provider Narrative Template included:

- Provider surveys subdivided by provider type, including behavioral health.
- Site visits.

Access-Related Grievances

Table H-10 presents the percentage of access-related grievances compared to the overall number of grievances for MH and SUD services. The CCO showed a low percentage of grievances (1.2 percent) that were associated with MH/SUD services and benefits. Of those grievances, more than 20.0 percent were related to access issues. Although these results suggest access as a potential focus for MH/SUD grievances, the results should be interpreted with caution due to the low overall total numbers of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.[H-1]

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

Total Grievances	MH/SUD		MH/SUD Access-Related Grievances	
	Number	Percent	Number	Percent
332	4	1.2%	1	25.0%

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2023 MHP Evaluation, MH/SUD and M/S benefits administration was found to be in parity for JCC. Individual CCO results were used to identify the following strengths, weaknesses, and recommendations with respect to the quality, timeliness, and accessibility of health care services.

Strength/ Weakness	Description	Domain(s)
	**Strength:** JCC achieved full compliance with parity requirements for application of NQTLs applied to MH/SUD and M/S benefits.	

 = Quality,  = Timeliness,  = Access

[H-1] It is important to note that grievances are an inherently limited monitoring tool for CCOs, given that members must have both the means and the inclination to file a grievance. These results reinforce OHA's guidance that grievance monitoring, while required and valuable, likely captures only a fraction of members' overall experiences and should not be used as the only mechanism for monitoring network adequacy and decision making.

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

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the CCO to manage the administration of MH/SUD and M/S covered benefits, and assess whether documentation demonstrated compliance with MHP requirements in how they were applied to MH/SUD and M/S services and benefits. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency.* A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria. In contrast, a *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both. In general, *Partially Compliant* findings resulted from insufficient information or clear evidence of parity associated with selection of the NQTLs and the consistency and stringency with which the treatment limitations were applied to MH/SUD and M/S benefits across service types (i.e., inpatient [IP], outpatient [OP], pharmacy [Rx] or emergency care [EC]). Table I-1 presents a summary of HSAG's assessment of the CCO's compliance based on the analysis of treatment limitations applied, including the CCO's parity rating by treatment limitation type.

Table I-1—Overall Treatment Limitation Review Results by Treatment Limitation Type

OR 2023 MHP Treatment Limitation Review Element	CCO Compliance Rating
Financial Requirements (FRs)	*NA*
Aggregate Lifetime and Annual Dollar Limits (AL/ADLs)	*NA*
Quantitative Treatment Limitations (QTLs)*	*NA*
Non-Quantitative Treatment Limitations (NQTLs)	*Partially Compliant*
Availability of Information	*Compliant*
Overall Compliance Rating	***Partially Compliant***

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the compliance rating is not applicable.

*QTLs identified by the CCO were soft limits based on medical necessity or medical appropriateness and were subsequently reviewed as NQTLs.

Overall, the CCO demonstrated compliance with most MHP requirements and standards related to treatment limitations used by the organization to manage MH/SUD and M/S benefits. However, these results did not identify any systemic issues that negatively affected parity between the administration of MH/SUD and M/S services. Rather, PCS-CO's findings highlighted general regulatory compliance issues related to documentation and demonstration of implementation that affected both MH/SUD and M/S benefits uniformly. Key findings for each treatment limitation review element included:

Financial Requirements

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

Aggregate Lifetime and Annual Dollar Limits

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

Quantitative Treatment Limitations

PCS-CO listed quantity limits on medications as a QTL for MH/SUD benefits in its *2023 MHP Treatment Limitation Review Tool*. However, the QTL for the service listed was not a strict limit on the medications made available to members, since the coverage determination process allowed for an individual to exceed numerical limits based on medical necessity. Therefore, the QTL identified by the CCO was evaluated for parity as an NQTL.

Non-Quantitative Treatment Limitations

Table I-2 presents a summary of the NQTLs implemented by the CCO, including compliance with parity requirements.

Table I-2—Parity Result by Specific Treatment Limitation Types and Benefit and Service Type

NQTL	Applicable Benefit and Service Type								Parity Rating
	MH/SUD				M/S				
	IP	OP	Rx	EC	IP	OP	Rx	EC	
Medical Management	X	X	X	X	X	X	X	X	*Compliant*
Provider Network	X	X		X	X	X		X	*Compliant*
Pharmacy Management			X				X		*Partially Compliant*
Other: Not Applicable									*NA*

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the parity rating is not applicable.

Medical Management

- Most of PCS-CO's policies included standardized processes that applied to both MH/SUD and M/S benefits, including a Medicaid Utilization and Management—Service Authorization Handbook, Clinical Criteria Used in UM Decisions policy, and Medical Necessity Reviews policy.

- PCS-CO identified prior authorization (PA) requirements for EC; however, the CCO further explained the PA NQTL was applied to non-emergency inpatient services only.
- For limits applied to IP, OP, and Rx health benefits, PCS-CO used utilization management (UM) processes to manage MH/SUD and M/S benefits. The CCO's UM process was designed to ensure coverage, medical necessity, to prevent unnecessary overutilization, to ensure appropriate treatment setting, and appropriate length of stay. PCS-CO reported that the evidence used to apply UM to MH/SUD and M/S benefits included OARs, the HERC Prioritized List of Health Services and guidelines, Milliman Care Guidelines, American Society of Addiction Medicine (ASAM) criteria, and CMS' NCD and LCD criteria guidelines. The processes, strategies, and evidentiary standards used in applying Medical Management NQTLs to MH/SUD benefits in the three classifications (i.e., IP, OP, and Rx) were comparable to the evidentiary standards used in administering NQTLs to M/S benefits in the same classifications. The CCO used nationally recognized, evidence-based medical necessity criteria for MH/SUD and M/S benefits in the three classifications to administer its processes with equivalent stringency.

Provider Network

- PCS-CO's processes for credentialing new providers and recredentialing existing providers, including frequency, was in alignment with State and federal regulations. The standards and processes for conducting credentialing and recredentialing activities were comparable and no more stringently applied for MH/SUD providers than for M/S providers.

Pharmacy Management

- PCS-CO identified the use of a formulary for prescription drugs which included formulary restrictions, such as PA requirements, step therapy restrictions, age restrictions, quantity limits, and specialty drugs. The CCO's pharmacy PA guidelines for MH/SUD prescription drugs were comparable and no more stringently applied than M/S prescription drugs. However, the CCO did not include processes, strategies, evidentiary standards, and other factors used in formulary design for prescription drugs, resulting in a *Partially Compliant* finding.
- PCS-CO identified the use of prescription drug benefit tiers in the CCO's formulary. The formulary includes a generic tier, a brand tier, and a specialty tier. The tiers are not representative of cost restrictions and there is no cost-sharing for prescription drug benefits. However, the CCO did not demonstrate that the processes, strategies, evidentiary standards, and other factors used in formulary tiering for prescription drugs are not applied more stringently for MH/SUD benefits that are not included in the carve-out list compared to M/S benefits, resulting in a *Partially Compliant* finding.

Other NQTLs

- No additional NQTLs were identified by the CCO.

Availability of Information

PCS-CO disseminated medical necessity criteria through the member handbook, provider handbook, and the CCO's website. The member handbook informed the members that OHP's covered benefits and treatments would be based on a list of conditions and services, the Prioritized List of Health Services,

which is ranked by the HERC. The CCO's Notice of Adverse Benefit Determination informed members of their ability to request free copies of the criteria and standards used in making coverage determinations.

Administrative Data Profile

Claims

Table I-3 presents a summary of the results from the analysis of paid claims by service and benefit type. In general, PCS-CO showed a negligible difference (4.3 percentage points) in the percentage of paid claims between MH/SUD (92.2 percent) and M/S (87.9) services. A moderate difference (9.2 percentage points) was noted between MH/SUD (56.8 percent) and M/S (47.6 percent) OON paid claims. Across all service types, a greater percentage of MH/SUD claims were paid compared to M/S claims.

Table I-3—Number and Percentage of Claims by Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims[1]		Out-of-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	1,809	1,501	83.0%	130	38.6%
	M/S	6,896	5,659	82.1%	80	11.2%
OP	MH/SUD	401,314	370,294	92.3%	10,870	57.1%
	M/S	1,611,010	1,417,147	88.0%	29,790	48.0%
Total	**MH/SUD**	**403,123**	**371,795**	**92.2%**	**11,000**	**56.8%**
	M/S	**1,617,906**	**1,422,806**	**87.9%**	**29,870**	**47.6%**

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.

Utilization Management

Table I-4 presents a summary of the results from the analysis of PAs by service and benefit type. A greater percentage of M/S PAs were denied for the OP and Rx service types compared to MH/SUD PAs for the same service type. Overall, a low percentage of appeals resulted in a hearing. Due to the low number of PA denials that were appealed (excluding Rx), results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity.

Table I-4—Prior Authorization Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals[1]		Hearings[1]	
		Total	Denied		Total Percent[2]	Overturned Percent	Total Percent	Overturned Percent
			Number	Percent[2]				
IP	MH/SUD	2,022	1	0.0%	100%	0.0%	0.0%	NA
	M/S	3,337	1	0.0%	0.0%	NA	0.0%	NA
OP	MH/SUD	594	70	11.8%	1.8%	33.3%	0.0%	NA
	M/S	32,506	5,928	18.2%	98.2%	44.5%	2.0%	0.0%
Rx	MH/SUD	527	236	44.8%	8.2%	45.2%	0.0%	NA
	M/S	4,920	3,000	61.0%	91.8%	28.1%	0.2%	0.0%

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

[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.

Provider Enrollment

Table I-5 presents a summary of the results from the analysis of provider enrollment and terminations. PCS-CO showed no difference (0.0 percentage points) between the percentage of MH/SUD and M/S provider applications approved in CY 2022. The CCO exhibited a minimal difference (3.3 percentage points) between MH/SUD and M/S in the percentage of terminated providers; however, in this case, M/S providers were terminated at higher rates (12.1 percent) than MH/SUD (8.8 percent).

Table I-5—CY 2022 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	1,978	99.9%	562	8.8%
M/S	1,666	99.9%	1,475	12.1%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table I-6 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Q2 2022 to Q1 2023 resulted in a substantial

increase (i.e., ↑, or 10 percent) or decrease (i.e., ↓, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately nine months to one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

PCS-CO showed a substantial increase in the number of MH providers and maintained a stable SUD network, with nearly substantial increases between Q2 2022 and Q1 2023. Several factors likely contributed to these increases, including efforts described by the CCO to increase enrollment of MH/SUD providers in response to network gaps, changes to study methodology, taxonomic transitions, and improved quality of provider data. However, these increases should be considered in the context that PCS reports nearly all providers across its four affiliated CCOs globally, meaning that many providers reported as in the available network would be geographically distant (i.e., by hundreds of miles). Additionally, PCS reported a somewhat higher percentage of its provider workforce as MH providers in comparison to other CCOs (i.e., approximately 30.0 percent for PCS compared to approximately 20.0 to 25.0 percent overall), which may indicate a data issue.

Table I-6—Number and Percentage of MH/SUD Practitioners by Quarter and Provider Type

Provider Type	Q2 2022			Q1 2023			Difference	
	All Providers (N)	Provider (N)	Providers (%)	All Providers (N)	Provider (N)	Providers (%)	Provider (N)	Percent Change
MH	11,852	3,608	30.4%	13,520	4,251	31.4%	643	17.8% ↑
SUD	11,852	505	4.3%	13,520	551	4.1%	46	9.1%

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

Provider-to-Member Ratios

Table I-7 presents the provider-to-member ratios for MH and SUD providers in Q1 2023. When compared to other CCOs, PCS-CO's results represented a notable outlier with the CCO reporting one provider for every one to two members. However, this result is due, in part, to PCS-CO including all contracted providers within the PCS global network and not limiting the pool of providers to those available to members in the PCS-CO service area. However, this finding may represent a data issue rather than a member access issue, as time and distance analysis demonstrated full access to MH and SUD providers overall.

Table I-7—Provider-to-Member Ratios by Benefit and Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	4,251	18,512	1:5
SUD	551	4,137	1:8

Time and Distance

Table I-8 presents the average time and distance to the nearest three MH and SUD providers by setting urbanicity (i.e., urban or rural). The state-established time and distance standards are 30 minutes/30 miles in urban settings and 60 minutes/60 miles in rural settings for at least 95.0 percent of members. The CCO met the rural time and distance access requirements for average time and distance to the nearest three MH and SUD providers.

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

Provider Type	Urban						Rural					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	1.2	1.3	1.5	1.1	1.2	1.4	3.7	4.1	4.3	3.4	3.8	4.0
SUD	2.2	2.6	2.8	2.1	2.5	2.6	6.5	6.8	7.1	6.0	6.3	6.6

Table I-9 presents the percentages of CCO members with access to MH and SUD services by urbanicity. The CCO demonstrated 100 percent access to MH and SUD providers in urban and rural settings.

Table I-9—Time and Distance Results by Geography

MH		SUD	
Urban	Rural	Urban	Rural
100%	100%	100%	100%

Appointment Availability

PCS-CO monitored appointment availability for both M/S and MH/SUD providers. Monitoring activities described and demonstrated by the CCO as part of its *DSN Provider Narrative Template* included:

- Monthly provider surveys subdivided by provider type and service region.
- Monthly survey of 4,000 members, identified through claims data to include representative percentages of service regions and members with MH/SUD-related claims.
- Grievance monitoring.

Access-Related Grievances

Table I-10 presents the percentage of access-related grievances compared to the overall number of grievances for MH and SUD services. The CCO showed a low percentage of grievances (1.0 percent) that were associated with MH/SUD services and benefits. Of those grievances, none were related to access issues. These low results should be interpreted with caution due to the low overall total numbers

of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low rate of grievances and thereby underestimating these results.[I-1]

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

Total Grievances	MH/SUD		MH/SUD Access-Related Grievances	
	Number	Percent	Number	Percent
730	7	1.0%	0	0.0%

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2023 MHP Evaluation, MH/SUD and M/S benefits administration was found to be in parity for PCS-CO. While the evaluation identified several opportunities for improvement, results did not identify any systemic issues that negatively affected parity between MH/SUD and M/S services. Rather, findings frequently highlighted general regulatory compliance issues affecting both MH/SUD and M/S benefits uniformly. Individual CCO results were used to identify the following strengths, weaknesses, and recommendations with respect to the quality, timeliness, and accessibility of health care services.

Strength/ Weakness	Description	Domain(s)
–	**Weakness:** PCS-CO was partially compliant with the Pharmacy Management–Formulary Design NQTL requirement. **Why the weakness exists:** The CCO did not provide its rationale for the assignment of the NQTL (i.e., prescription drug formulary), procedures used for the development of the formulary (e.g., individuals involved in formulary development; professional guidelines used; and how often the formulary is reviewed and updated or by whom), or how frequently or strictly the NQTL is applied (e.g., ability of the provider to request an exception). **Recommendations:** The CCO should identify processes, strategies, evidentiary standards, and other factors that are used in formulary design and the application for prescription drugs.	🔑
–	**Weakness:** PCS-CO was partially compliant with the Pharmacy Management– Prescription Drug Benefit Tiers NQTL requirement. **Why the weakness exists:** The CCO did not provide its rationale for the assignment of the NQTL (i.e., formulary drug tiering), procedures related to	🔑

[I-1] It is important to note that grievances are an inherently limited monitoring tool for CCOs, given that members must have both the means and the inclination to file a grievance. These results reinforce OHA's guidance that grievance monitoring, while required and valuable, likely captures only a fraction of members' overall experiences and should not be used as the only mechanism for monitoring network adequacy and decision making.

Strength/ Weakness	Description	Domain(s)
	formulary tiering (e.g., individuals involved, factors used to determine tier placement, or professional guidelines used), or how frequently or strictly the NQTL is applied (e.g., decision-making process). **Recommendations:** The CCO should identify processes, strategies, evidentiary standards, and other factors that are used in formulary tiering.	

= Quality, = Timeliness, = Access

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

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the CCO to manage the administration of MH/SUD and M/S covered benefits, and assess whether documentation demonstrated compliance with MHP requirements in how they were applied to MH/SUD and M/S services and benefits. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency.* A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria. In contrast, a *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both. In general, *Partially Compliant* findings resulted from insufficient information or clear evidence of parity associated with selection of the NQTLs and the consistency and stringency with which the treatment limitations were applied to MH/SUD and M/S benefits across service types (i.e., inpatient [IP], outpatient [OP], pharmacy [Rx] or emergency care [EC]). Table J-1 presents a summary of HSAG's assessment of the CCO's compliance based on the analysis of treatment limitations applied, including the CCO's parity rating by treatment limitation type.

Table J-1—Overall Treatment Limitation Review Results by Treatment Limitation Type

OR 2023 MHP Treatment Limitation Review Element	CCO Compliance Rating
Financial Requirements (FRs)	*NA*
Aggregate Lifetime and Annual Dollar Limits (AL/ADLs)	*NA*
Quantitative Treatment Limitations (QTLs)*	*NA*
Non-Quantitative Treatment Limitations (NQTLs)	*Partially Compliant*
Availability of Information	*Compliant*
Overall Compliance Rating	***Partially Compliant***

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the compliance rating is not applicable.

*QTLs identified by the CCO were soft limits based on medical necessity or medical appropriateness and were subsequently reviewed as NQTLs.

Overall, the CCO demonstrated compliance with most MHP requirements and standards related to treatment limitations used by the organization to manage MH/SUD and M/S benefits. However, these results did not identify any systemic issues that negatively affected parity between the administration of MH/SUD and M/S services Rather, PCS-CG's findings highlighted general regulatory compliance issues related to documentation and demonstration of implementation that affected both MH/SUD and M/S benefits uniformly. Key findings for each treatment limitation review element included:

Financial Requirements

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

Aggregate Lifetime and Annual Dollar Limits

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

Quantitative Treatment Limitations

PCS-CG listed quantity limits on medications as a QTL for MH/SUD benefits in its *2023 MHP Treatment Limitation Review Tool*. However, the QTL for the service listed was not a strict limit on the medications made available to members, since the coverage determination process allowed for an individual to exceed numerical limits based on medical necessity. Therefore, the QTL identified by the CCO was evaluated for parity as an NQTL.

Non-Quantitative Treatment Limitations

Table J-2 presents a summary of the NQTLs implemented by the CCO, including compliance with parity requirements.

Table J-2—Parity Result by Specific Treatment Limitation Types and Benefit and Service Type

NQTL	Applicable Benefit and Service Type								Parity Rating
	MH/SUD				M/S				
	IP	OP	Rx	EC	IP	OP	Rx	EC	
Medical Management	X	X	X	X	X	X	X	X	*Compliant*
Provider Network	X	X		X	X	X		X	*Compliant*
Pharmacy Management			X				X		*Partially Compliant*
Other: Not Applicable									*NA*

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the parity rating is not applicable.

Medical Management

- Most of PCS-CG's policies included standardized processes that applied to both MH/SUD and M/S benefits, including a Medicaid Utilization and Management—Service Authorization Handbook, Clinical Criteria Used in UM Decisions policy, and Medical Necessity Reviews policy.

- PCS-CG identified prior authorization (PA) requirements for EC; however, the CCO further explained the PA NQTL was applied to non-emergency inpatient services only.
- For limits applied to IP, OP, and Rx health benefits, PCS-CG used utilization management (UM) processes to manage MH/SUD and M/S benefits. The CCO's UM process was designed to ensure coverage, medical necessity, to prevent unnecessary overutilization, to ensure appropriate treatment setting, and appropriate length of stay. PCS-CG reported that the evidence used to apply UM to MH/SUD and M/S benefits included OARs, the HERC Prioritized List of Health Services and guidelines, Milliman Care Guidelines, American Society of Addiction Medicine (ASAM) criteria, and CMS' NCD and LCD criteria guidelines. The processes, strategies, and evidentiary standards used in applying Medical Management NQTLs to MH/SUD benefits in the three classifications (i.e., IP, OP, and Rx) were comparable to the evidentiary standards used in administering NQTLs to M/S benefits in the same classifications. The CCO used nationally recognized, evidence-based medical necessity criteria for MH/SUD and M/S benefits in the three classifications to administer its processes with equivalent stringency.

Provider Network

- PCS-CG's processes for credentialing new providers and recredentialing existing providers, including frequency, was in alignment with State and federal regulations. The standards and processes for conducting credentialing and recredentialing activities were comparable and no more stringently applied for MH/SUD providers than for M/S providers.

Pharmacy Management

- PCS-CG identified the use of a formulary for prescription drugs which included formulary restrictions, such as PA requirements, step therapy restrictions, age restrictions, quantity limits, and specialty drugs. The CCO's pharmacy PA guidelines for MH/SUD prescription drugs were comparable and no more stringently applied than M/S prescription drugs. However, the CCO did not include processes, strategies, evidentiary standards, and other factors used in formulary design for prescription drugs, resulting in a *Partially Compliant* finding.
- PCS-CG identified the use of prescription drug benefit tiers in the CCO's formulary. The formulary includes a generic tier, a brand tier, and a specialty tier. The tiers are not representative of cost restrictions and there is no cost-sharing for prescription drug benefits. However, the CCO did not demonstrate that the processes, strategies, evidentiary standards, and other factors used in formulary tiering for prescription drugs are not applied more stringently for MH/SUD benefits that are not included in the carve-out list compared to M/S benefits, resulting in a *Partially Compliant* finding.

Other NQTLs

- No additional NQTLs were identified by the CCO.

Availability of Information

PCS-CG disseminated medical necessity criteria through the member handbook, provider handbook, and the CCO's website. The member handbook informed the members that OHP's covered benefits and treatments would be based on a list of conditions and services, the Prioritized List of Health Services,

which is ranked by the HERC. The CCO's Notice of Adverse Benefit Determination informed members of their ability to request free copies of the criteria and standards used in making coverage determinations.

Administrative Data Profile

Claims

Table J-3 presents a summary of the results from the analysis of paid claims by service and benefit type. In general, PCS-CG showed a negligible difference (0.8 percentage points) in the percentage of paid claims between MH/SUD (88.2 percent) and M/S (87.4 percent) services. However, a substantial difference (38.9 percentage points) was noted between the total percentage of OON MH/SUD paid claims (29.9 percent) and OON M/S claims (68.8 percent), as well as for OON OP claims individually (39.9 percentage points).

Table J-3—Number and Percentage of Claims by Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims[1]		Out-of-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	214	155	72.4%	65	79.3%
	M/S	1,948	1,435	73.7%	70	58.3%
OP	MH/SUD	54,070	47,730	88.3%	1,092	28.9%
	M/S	341,817	298,980	87.5%	17,426	68.8%
Total	**MH/SUD**	**54,284**	**47,885**	**88.2%**	**1,157**	**29.9%**
	M/S	**343,765**	**300,415**	**87.4%**	**17,496**	**68.8%**

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.

Utilization Management

Table J-4 presents a summary of the results from the analysis of PAs by service and benefit type. Across all service types, a greater percentage of M/S PAs were denied compared to MH/SUD PAs. Due to the low number of PA denials that were appealed (excluding Rx), results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity.

Table J-4—Prior Authorization Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals[1]		Hearings[1]	
		Total	Denied		Total Percent[2]	Overturned Percent	Total Percent	Overturned Percent
			Number	Percent[2]				
IP	MH/SUD	231	0	0.0%	NA	NA	NA	NA
	M/S	688	1	0.1%	NA	NA	NA	NA
OP	MH/SUD	133	11	8.3%	1.7%	0.0%	0.0%	NA
	M/S	5,161	1,392	27.0%	98.3%	28.7%	1.7%	0.0%
Rx	MH/SUD	63	26	41.3%	8.0%	62.5%	0.0%	NA
	M/S	944	550	58.3%	92.0%	33.7%	1.0%	0.0%

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

[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.

Provider Enrollment

Table J-5 presents a summary of the results from the analysis of provider enrollment and terminations. PCS-CG showed no difference (0.0 percentage points) between the percentage of MH/SUD and M/S provider applications approved in CY 2022. The CCO exhibited a minimal difference (3.3 percentage points) between MH/SUD and M/S in the percentage of terminated providers; however, in this case, M/S providers were terminated at higher rates (12.1 percent) than MH/SUD (8.8 percent).

Table J-5—CY 2022 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	1,978	99.9%	562	8.8%
M/S	1,666	99.9%	1,475	12.1%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table J-6 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Q2 2022 to Q1 2023 resulted in a substantial

increase (i.e., ↑, or 10 percent) or decrease (i.e., ↓, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately nine months to one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

PCS-CG showed a substantial increase in the number of MH providers and maintained a stable SUD network, with nearly substantial increases between Q2 2022 and Q1 2023. Several factors likely contributed to these increases, including efforts described by the CCO to increase enrollment of MH/SUD providers in response to network gaps, changes to study methodology, taxonomic transitions, and improved quality of provider data. However, these increases should be considered in the context that PCS reports nearly all providers across its four affiliated CCOs globally, meaning that many providers reported as in the available network would be geographically distant (i.e., by hundreds of miles). Additionally, PCS reported a somewhat higher percentage of its provider workforce as MH providers in comparison to other CCOs (i.e., approximately 30.0 percent for PCS compared to approximately 20.0 to 25.0 percent overall), which may indicate a data issue.

Table J-6—Number and Percentage of MH/SUD Practitioners by Quarter and Provider Type

Provider Type	Q2 2022			Q1 2023			Difference	
	All Providers (N)	Provider (N)	Providers (%)	All Providers (N)	Provider (N)	Providers (%)	Provider (N)	Percent Change
MH	11,488	3,607	31.4%	13,203	4,250	32.2%	643	17.8% ↑
SUD	11,488	505	4.4%	13,203	551	4.2%	46	9.1%

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

Provider-to-Member Ratios

Table J-7 presents the provider-to-member ratios for MH and SUD providers in Q1 2023. When compared to other CCOs, PCS-CG's results represented a notable outlier with the CCO reporting one provider for every one to two members. However, this result is due, in part, to PCS-CG including all contracted providers within the PCS global network and not limiting the pool of providers to those available to members in the PCS-CG service area. However, this finding may represent a data issue rather than a member access issue, as time and distance analysis demonstrated full access to MH and SUD providers overall.

Table J-7—Provider-to-Member Ratios by Benefit and Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	4,250	3,221	1:1
SUD	551	595	1:2

Time and Distance

Table J-8 presents the average time and distance to the nearest three MH and SUD providers by setting urbanicity (i.e., urban or rural). The state-established time and distance standards are 30 minutes/30 miles in urban settings and 60 minutes/60 miles in rural settings for at least 95.0 percent of members. The CCO met the rural time and distance access requirements for average time and distance to the nearest three MH and SUD providers. The CCO had no urban settings within its service area as defined by state-established urbanicity parameters.

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

Provider Type	Urban						Rural					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	NA	NA	NA	NA	NA	NA	3.4	3.9	4.2	3.1	3.6	3.9
SUD	NA	NA	NA	NA	NA	NA	11.8	11.8	11.8	10.8	10.8	10.8

Table J-9 presents the percentages of CCO members with access to MH and SUD services by urbanicity. The CCO demonstrated 100 percent access to MH and SUD providers in rural settings. The CCO had no urban settings within its service region as defined by state-established urbanicity parameters.

Table J-9—Time and Distance Results by Geography

MH		SUD	
Urban	Rural	Urban	Rural
NA	100%	NA	100%

Appointment Availability

PCS-CG monitored appointment availability for both M/S and MH/SUD providers. Monitoring activities described and demonstrated by the CCO as part of its *DSN Provider Narrative Template* included:

- Monthly provider surveys subdivided by provider type and service region.
- Monthly survey of 4,000 members, identified through claims data to include representative percentages of service regions and members with MH/SUD-related claims.
- Grievance monitoring.

Access-Related Grievances

Table J-10 presents the percentage of access-related grievances compared to the overall number of grievances for MH and SUD services. The CCO showed a low percentage of grievances (0.8 percent)

that were associated with MH/SUD services and benefits. Of those grievances, none were related to access issues. These low results should be interpreted with caution due to the low overall total numbers of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.[J-1]

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

Total Grievances	MH/SUD		MH/SUD Access-Related Grievances	
	Number	Percent	Number	Percent
118	1	0.8%	0	0.0%

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2023 MHP Evaluation, MH/SUD and M/S benefits administration was found to be in parity for PCS-CG. While the evaluation identified several opportunities for improvement, results did not identify any systemic issues that negatively affected parity between MH/SUD and M/S services. Rather, findings frequently highlighted general regulatory compliance issues affecting both MH/SUD and M/S benefits uniformly. Individual CCO results were used to identify the following strengths, weaknesses, and recommendations with respect to the quality, timeliness, and accessibility of health care services.

Strength/ Weakness	Description	Domain(s)
–	**Weakness:** PCS-CG was partially compliant with the Pharmacy Management–Formulary Design NQTL requirement. **Why the weakness exists:** The CCO did not provide its rationale for the assignment of the NQTL (i.e., prescription drug formulary), procedures used for the development of the formulary (e.g., individuals involved in formulary development; professional guidelines used; and how often the formulary is reviewed and updated or by whom), or how frequently or strictly the NQTL is applied (e.g., ability of the provider to request an exception). **Recommendations:** The CCO should identify processes, strategies, evidentiary standards, and other factors that are used in formulary design and the application for prescription drugs.	🔑

[J-1] It is important to note that grievances are an inherently limited monitoring tool for CCOs, given that members must have both the means and the inclination to file a grievance. These results reinforce OHA's guidance that grievance monitoring, while required and valuable, likely captures only a fraction of members' overall experiences and should not be used as the only mechanism for monitoring network adequacy and decision making.

Strength/ Weakness	Description	Domain(s)
–	**Weakness:** PCS-CG was partially compliant with the Pharmacy Management–Prescription Drug Benefit Tiers NQTL requirement. **Why the weakness exists:** The CCO did not provide its rationale for the assignment of the NQTL (i.e., formulary drug tiering), procedures related to formulary tiering (e.g., individuals involved, factors used to determine tier placement, or professional guidelines used), or how frequently or strictly the NQTL is applied (e.g., decision-making process). **Recommendations:** The CCO should identify processes, strategies, evidentiary standards, and other factors that are used in formulary tiering.	🔑
–	**Weakness:** PCS-CG showed a substantial difference in the percentage of paid, OON MH/SUD OP claims compared to M/S OP claims. Although the difference in the percentage of paid claims may be legitimate, they may also highlight procedural or network differences, indicating potential barriers to for members accessing MH/SUD services. **Why the weakness exists:** OON OP MH/SUD claims were paid less frequently than M/S claims. **Recommendations:** PCS-CG should review OON claim denials to understand the factors affecting the lower percentage of paid MH/SUD OP claims compared to M/S OP claims. The CCO should assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside of the CCO's network (e.g., appointment availability).	⏱️🔑

= Quality, ⏱️ = Timeliness, 🔑 = Access

Appendix K. MHP PacificSource Community Solutions—Lane (PCS-Lane)

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the CCO to manage the administration of MH/SUD and M/S covered benefits, and assess whether documentation demonstrated compliance with MHP requirements in how they were applied to MH/SUD and M/S services and benefits. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency.* A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria. In contrast, a *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both. In general, *Partially Compliant* findings resulted from insufficient information or clear evidence of parity associated with selection of the NQTLs and the consistency and stringency with which the treatment limitations were applied to MH/SUD and M/S benefits across service types (i.e., inpatient [IP], outpatient [OP], pharmacy [Rx] or emergency care [EC]). Table K-1 presents a summary of HSAG's assessment of the CCO's compliance based on the analysis of treatment limitations applied, including the CCO's parity rating by treatment limitation type.

Table K-1—Overall Treatment Limitation Review Results by Treatment Limitation Type

OR 2023 MHP Treatment Limitation Review Element	CCO Compliance Rating
Financial Requirements (FRs)	*NA*
Aggregate Lifetime and Annual Dollar Limits (AL/ADLs)	*NA*
Quantitative Treatment Limitations (QTLs)*	*NA*
Non-Quantitative Treatment Limitations (NQTLs)	*Partially Compliant*
Availability of Information	*Compliant*
Overall Compliance Rating	***Partially Compliant***

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the compliance rating is not applicable.

*QTLs identified by the CCO were soft limits based on medical necessity or medical appropriateness and were subsequently reviewed as NQTLs.

Overall, the CCO demonstrated compliance with most MHP requirements and standards related to treatment limitations used by the organization to manage MH/SUD and M/S benefits. However, these results did not identify any systemic issues that negatively affected parity between the administration of MH/SUD and M/S services. Rather, PCS-Lane's findings highlighted general regulatory compliance issues related to documentation and demonstration of implementation that affected both MH/SUD and M/S benefits uniformly. Key findings for each treatment limitation review element included:

Financial Requirements

PCS-Lane reported the CCO does not apply any FRs or payments from members for services received that are in addition to payments made by the State (e.g., copayments, coinsurance, deductibles, or out-of-pocket maximums) for IP, OP, Rx, or EC for MH/SUD or M/S benefits.

Aggregate Lifetime and Annual Dollar Limits

PCS-Lane reported the CCO does not apply AL/ADLs on the total amount of a specified benefit over a lifetime or annually for IP, OP, Rx, or EC for MH/SUD or M/S benefits.

Quantitative Treatment Limitations

PCS-Lane listed quantity limits on medications as a QTL for MH/SUD benefits in its *2023 MHP Treatment Limitation Review Tool*. However, the QTL for the service listed was not a strict limit on the medications made available to members, since the coverage determination process allowed for an individual to exceed numerical limits based on medical necessity. Therefore, the QTL identified by the CCO was evaluated for parity as an NQTL.

Non-Quantitative Treatment Limitations

Table K-2 presents a summary of the NQTLs implemented by the CCO, including compliance with parity requirements.

Table K-2—Parity Result by Specific Treatment Limitation Types and Benefit and Service Type

NQTL	Applicable Benefit and Service Type								Parity Rating
	MH/SUD				M/S				
	IP	OP	Rx	EC	IP	OP	Rx	EC	
Medical Management	X	X	X	X	X	X	X	X	*Compliant*
Provider Network	X	X		X	X	X		X	*Compliant*
Pharmacy Management			X				X		*Partially Compliant*
Other: Not Applicable									*NA*

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the parity rating is not applicable.

Medical Management

- Most of PCS-Lane's policies included standardized processes that applied to both MH/SUD and M/S benefits, including a Medicaid Utilization and Management—Service Authorization Handbook, Clinical Criteria Used in UM Decisions policy, and Medical Necessity Reviews policy.

- PCS-Lane identified prior authorization (PA) requirements for EC; however, the CCO further explained the PA NQTL was applied to non-emergency inpatient services only.
- For limits applied to IP, OP, and Rx health benefits, PCS-Lane used utilization management (UM) processes to manage MH/SUD and M/S benefits. The CCO's UM process was designed to ensure coverage, medical necessity, to prevent unnecessary overutilization, to ensure appropriate treatment setting, and appropriate length of stay. PCS-Lane reported that the evidence used to apply UM to MH/SUD and M/S benefits included OARs, the HERC Prioritized List of Health Services and guidelines, Milliman Care Guidelines, American Society of Addiction Medicine (ASAM) criteria, and CMS' NCD and LCD criteria guidelines. The processes, strategies, and evidentiary standards used in applying Medical Management NQTLs to MH/SUD benefits in the three classifications (i.e., IP, OP, and Rx) were comparable to the evidentiary standards used in administering NQTLs to M/S benefits in the same classifications. The CCO used nationally recognized, evidence-based medical necessity criteria for MH/SUD and M/S benefits in the three classifications to administer its processes with equivalent stringency.

Provider Network

- PCS-Lane's processes for credentialing new providers and recredentialing existing providers, including frequency, was in alignment with State and federal regulations. The standards and processes for conducting credentialing and recredentialing activities were comparable and no more stringently applied for MH/SUD providers than for M/S providers.

Pharmacy Management

- PCS-Lane identified the use of a formulary for prescription drugs which included formulary restrictions, such as PA requirements, step therapy restrictions, age restrictions, quantity limits, and specialty drugs. The CCO's pharmacy PA guidelines for MH/SUD prescription drugs were comparable and no more stringently applied than M/S prescription drugs. However, the CCO did not include processes, strategies, evidentiary standards, and other factors used in formulary design for prescription drugs, resulting in a *Partially Compliant* finding.
- PCS-Lane identified the use of prescription drug benefit tiers in the CCO's formulary. The formulary includes a generic tier, a brand tier, and a specialty tier. The tiers are not representative of cost restrictions and there is no cost-sharing for prescription drug benefits. However, the CCO did not demonstrate that the processes, strategies, evidentiary standards, and other factors used in formulary tiering for prescription drugs are not applied more stringently for MH/SUD benefits that are not included in the carve-out list compared to M/S benefits, resulting in a *Partially Compliant* finding.

Other NQTLs

- No additional NQTLs were identified by the CCO.

Availability of Information

PCS-Lane disseminated medical necessity criteria through the member handbook, provider handbook, and the CCO's website. The member handbook informed the members that OHP's covered benefits and

treatments would be based on a list of conditions and services, the Prioritized List of Health Services, which is ranked by the HERC. The CCO's Notice of Adverse Benefit Determination informed members of their ability to request free copies of the criteria and standards used in making coverage determinations.

Administrative Data Profile

Claims

Table K-3 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 (4.8 percentage points) in the percentage of paid claims between MH/SUD (93.1 percent) and M/S (88.3 percent) services. However, a substantial difference (15.7 percentage points) was noted between the percentage of OON MH/SUD paid claims (57.7 percent) and M/S claims (73.4 percent), as well as for OON IP claims (14.4 percentage points) and OON OP claims (15.7 percentage points) individually.

Table K-3—Number and Percentage of Claims by Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims[1]		Out-of-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	3,728	3,232	86.7%	185	51.5%
	M/S	9,798	8,257	84.3%	418	65.9%
OP	MH/SUD	564,279	525,336	93.1%	19,764	57.7%
	M/S	2,240,814	1,979,152	88.3%	86,775	73.4%
Total	**MH/SUD**	**568,007**	**528,568**	**93.1%**	**19,949**	**57.7%**
	M/S	**2,250,612**	**1,987,409**	**88.3%**	**87,193**	**73.4%**

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.

Utilization Management

Table K-4 presents a summary of the results from the analysis of PAs by service and benefit type. No substantial differences in the percent of denied M/S and MH/SUD PAs were found that would have suggested an MH parity concern. Due to the low number of PA denials that were appealed (excluding Rx), results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity.

Table K-4—Prior Authorization Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals[1]		Hearings[1]	
		Total	Denied		Total Percent[2]	Overturned Percent	Total Percent	Overturned Percent
			Number	Percent[2]				
IP	MH/SUD	2,964	3	0.1%	NA	NA	NA	NA
	M/S	4,033	9	0.2%	NA	NA	NA	NA
OP	MH/SUD	1,128	138	12.2%	2.2%	80.0%	0.0%	NA
	M/S	27,637	6,788	24.6%	97.8%	59.4%	3.7%	0.0%
Rx	MH/SUD	941	554	58.9%	16.9%	40.5%	0.0%	NA
	M/S	6,563	3,831	58.4%	83.1%	34.5%	0.8%	0.0%

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

[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.

Provider Enrollment

Table K-5 presents a summary of the results from the analysis of provider enrollment and terminations. PCS-Lane showed no difference (0.0 percentage points) between the percentage of MH/SUD and M/S provider applications approved in CY 2022. The CCO exhibited a minimal difference (3.3 percentage points) between MH/SUD and M/S in the percentage of terminated providers; however, in this case, M/S providers were terminated at higher rates (12.1 percent) than MH/SUD (8.8 percent).

Table K-5—CY 2022 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	1,978	99.9%	562	8.8%
M/S	1,666	99.9%	1,475	12.1%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table K-6 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Q2 2022 to Q1 2023 resulted in a substantial

increase (i.e., ↑, or 10 percent) or decrease (i.e., ↓, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately nine months to one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

PCS-Lane showed a substantial increase in the number of MH providers and maintained a stable SUD network, with nearly substantial increases between Q2 2022 and Q1 2023. Several factors likely contributed to these increases, including efforts described by the CCO to increase enrollment of MH/SUD providers in response to network gaps, changes to study methodology, taxonomic transitions, and improved quality of provider data. However, these increases should be considered in the context that PCS reports nearly all providers across its four affiliated CCOs globally, meaning that many providers reported as in the available network would be geographically distant (i.e., by hundreds of miles). Additionally, PCS reported a somewhat higher percentage of its provider workforce as MH providers in comparison to other CCOs (i.e., approximately 30.0 percent for PCS compared to approximately 20.0 to 25.0 percent overall), which may indicate a data issue.

Table K-6—Number and Percentage of MH/SUD Practitioners by Quarter and Provider Type

Provider Type	Q2 2022			Q1 2023			Difference	
	All Providers (N)	Provider (N)	Providers (%)	All Providers (N)	Provider (N)	Providers (%)	Provider (N)	Percent Change
MH	12,155	3,610	29.7%	13,823	4,250	30.7%	640	17.7% ↑
SUD	12,155	505	4.2%	13,823	551	4.0%	46	9.1%

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

Provider-to-Member Ratios

Table K-7 presents the provider-to-member ratios for MH and SUD providers in Q1 2023. When compared to other CCOs, PCS-Lane's results represented a notable outlier with the CCO reporting one provider for every one to two members. However, this result is due, in part, to PCS-Lane including all contracted providers within the PCS global network and not limiting the pool of providers to those available to members in the PCS-Lane service area. However, this finding may represent a data issue rather than a member access issue, as time and distance analysis demonstrated full access to MH and SUD providers overall.

Table K-7—Provider-to-Member Ratios by Benefit and Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	4,250	22,986	1:6
SUD	551	5,106	1:10

Time and Distance

Table K-8 presents the average time and distance to the nearest three MH and SUD providers by setting urbanicity (i.e., urban or rural). The state-established time and distance standards are 30 minutes/30 miles in urban settings and 60 minutes/60 miles in rural settings for at least 95.0 percent of members. The CCO met the rural time and distance access requirements for average time and distance to the nearest three MH and SUD providers.

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

Provider Type	Urban						Rural					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	1	1.3	1.4	0.8	1	1.2	3.3	3.8	3.9	3.1	3.5	3.6
SUD	2.7	2.9	3.4	2.3	2.4	2.9	10.2	30.4	32.0	9.4	27.6	29.0

Table K-9 presents the percentages of CCO members with access to MH and SUD services by urbanicity. The CCO demonstrated 100 percent access to MH and SUD providers in urban and rural settings.

Table K-9—Time and Distance Results by Geography

MH		SUD	
Urban	Rural	Urban	Rural
100%	100%	100%	100%

Appointment Availability

PCS-Lane monitored appointment availability for both M/S and MH/SUD providers. Monitoring activities described and demonstrated by the CCO as part of its *DSN Provider Narrative Template* included:

- Monthly provider surveys subdivided by provider type and service region.
- Monthly survey of 4,000 members, identified through claims data to include representative percentages of service regions and members with MH/SUD-related claims.
- Grievance monitoring.

Access-Related Grievances

Table K-10 presents the percentage of access-related grievances compared to the overall number of grievances for MH and SUD services. The CCO showed a low percentage of grievances (0.4 percent)

that were associated with MH/SUD services and benefits. Of those grievances, a low percentage (11.1 percent) were related to access issues. These low results should be interpreted with caution due to the low overall total numbers of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low rate of grievances and thereby underestimating these results.[K-1]

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

Total Grievances	MH/SUD		MH/SUD Access-Related Grievances	
	Number	Percent	Number	Percent
2,044	9	0.4%	1	11.1%

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2023 MHP Evaluation, MH/SUD and M/S benefits administration was found to be in parity for PCS-Lane. While the evaluation identified several opportunities for improvement, results did not identify any systemic issues that negatively affected parity between MH/SUD and M/S services. Rather, findings frequently highlighted general regulatory compliance issues affecting both MH/SUD and M/S benefits uniformly. Individual CCO results were used to identify the following strengths, weaknesses, and recommendations with respect to the quality, timeliness, and accessibility of health care services.

Strength/ Weakness	Description	Domain(s)
–	**Weakness:** PCS-Lane was partially compliant with the Pharmacy Management–Formulary Design NQTL requirement. **Why the weakness exists:** The CCO did not provide its rationale for the assignment of the NQTL (i.e., prescription drug formulary), procedures used for the development of the formulary (e.g., individuals involved in formulary development; professional guidelines used; and how often the formulary is reviewed and updated or by whom), or how frequently or strictly the NQTL is applied (e.g., ability of the provider to request an exception). **Recommendations:** The CCO should identify processes, strategies, evidentiary standards, and other factors that are used in formulary design and the application for prescription drugs.	

[K-1] It is important to note that grievances are an inherently limited monitoring tool for CCOs, given that members must have both the means and the inclination to file a grievance. These results reinforce OHA's guidance that grievance monitoring, while required and valuable, likely captures only a fraction of members' overall experiences and should not be used as the only mechanism for monitoring network adequacy and decision making.

Strength/ Weakness	Description	Domain(s)
–	**Weakness:** PCS-Lane was partially compliant with the Pharmacy Management–Prescription Drug Benefit Tiers NQTL requirement. **Why the weakness exists:** The CCO did not provide its rationale for the assignment of the NQTL (i.e., formulary drug tiering), procedures related to formulary tiering (e.g., individuals involved, factors used to determine tier placement, or professional guidelines used), or how frequently or strictly the NQTL is applied (e.g., decision making process). **Recommendations:** The CCO should identify processes, strategies, evidentiary standards, and other factors that are used in formulary tiering.	🔑
–	**Weakness:** PCS-Lane showed substantial differences in the percentage of paid, OON MH/SUD IP and OP claims compared to M/S IP and OP claims. Although the difference in the percentage of paid claims may be legitimate, they may also highlight procedural or network differences, indicating potential barriers to for members accessing MH/SUD services. **Why the weakness exists:** OON IP and OP MH/SUD claims were paid less frequently than M/S claims. **Recommendations:** PCS-Lane should review OON claim denials to understand the factors affecting the lower percentage of paid MH/SUD OP claims compared to M/S OP claims. The CCO should assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside of the CCO's network (e.g., appointment availability).	⏱️🔑

= Quality, ⏱️ = Timeliness, 🔑 = Access

Appendix L. MHP Results for PacificSource Community Solutions—Marion Polk (PCS-MP)

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the CCO to manage the administration of MH/SUD and M/S covered benefits, and assess whether documentation demonstrated compliance with MHP requirements in how they were applied to MH/SUD and M/S services and benefits. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency.* A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria. In contrast, a *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both. In general, *Partially Compliant* findings resulted from insufficient information or clear evidence of parity associated with selection of the NQTLs and the consistency and stringency with which the treatment limitations were applied to MH/SUD and M/S benefits across service types (i.e., inpatient [IP], outpatient [OP], pharmacy [Rx] or emergency care [EC]). Table L-1 presents a summary of HSAG's assessment of the CCO's compliance based on the analysis of treatment limitations applied, including the CCO's parity rating by treatment limitation type.

Table L-1—Overall Treatment Limitation Review Results by Treatment Limitation Type

OR 2023 MHP Treatment Limitation Review Element	CCO Compliance Rating
Financial Requirements (FRs)	*NA*
Aggregate Lifetime and Annual Dollar Limits (AL/ADLs)	*NA*
Quantitative Treatment Limitations (QTLs)*	*NA*
Non-Quantitative Treatment Limitations (NQTLs)	*Partially Compliant*
Availability of Information	*Compliant*
Overall Compliance Rating	***Partially Compliant***

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the compliance rating is not applicable.

*QTLs identified by the CCO were soft limits based on medical necessity or medical appropriateness and were subsequently reviewed as NQTLs.

Overall, the CCO demonstrated compliance with most MHP requirements and standards related to treatment limitations used by the organization to manage MH/SUD and M/S benefits. However, these results did not identify any systemic issues that negatively affected parity between the administration of MH/SUD and M/S services. Rather, PCS-MP's findings highlighted general regulatory compliance issues related to documentation and demonstration of implementation that affected both MH/SUD and M/S benefits uniformly. Key findings for each treatment limitation review element included:

Financial Requirements

PCS-MP reported the CCO does not apply any FRs or payments from members for services received that are in addition to payments made by the State (e.g., copayments, coinsurance, deductibles, or out-of-pocket maximums) for IP, OP, Rx, or EC for MH/SUD or M/S benefits.

Aggregate Lifetime and Annual Dollar Limits

PCS-MP reported the CCO does not apply AL/ADLs on the total amount of a specified benefit over a lifetime or annually for IP, OP, Rx, or EC for MH/SUD or M/S benefits.

Quantitative Treatment Limitations

PCS-MP listed quantity limits on medications as a QTL for MH/SUD benefits in its *2023 MHP Treatment Limitation Review Tool*. However, the QTL for the service listed was not a strict limit on the medications made available to members, since the coverage determination process allowed for an individual to exceed numerical limits based on medical necessity. Therefore, the QTL identified by the CCO was evaluated for parity as an NQTL.

Non-Quantitative Treatment Limitations

Table L-2 presents a summary of the NQTLs implemented by the CCO, including compliance with parity requirements.

Table L-2—Parity Result by Specific Treatment Limitation Types and Benefit and Service Type

NQTL	Applicable Benefit and Service Type								Parity Rating
	MH/SUD				M/S				
	IP	OP	Rx	EC	IP	OP	Rx	EC	
Medical Management	X	X	X	X	X	X	X	X	*Compliant*
Provider Network	X	X		X	X	X		X	*Compliant*
Pharmacy Management			X				X		*Partially Compliant*
Other: Not Applicable									*NA*

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the parity rating is not applicable.

Medical Management

- Most of PCS-MP's policies included standardized processes that applied to both MH/SUD and M/S benefits, including a Medicaid Utilization and Management—Service Authorization Handbook, Clinical Criteria Used in UM Decisions policy, and Medical Necessity Reviews policy.

- PCS-MP identified prior authorization (PA) requirements for EC; however, the CCO further explained the PA NQTL was applied to non-emergency inpatient services only.
- For limits applied to IP, OP, and Rx health benefits, PCS-MP used utilization management (UM) processes to manage MH/SUD and M/S benefits. The CCO's UM process was designed to ensure coverage, medical necessity, to prevent unnecessary overutilization, to ensure appropriate treatment setting, and appropriate length of stay. PCS-MP reported that the evidence used to apply UM to MH/SUD and M/S benefits included OARs, the HERC Prioritized List of Health Services and guidelines, Milliman Care Guidelines, American Society of Addiction Medicine (ASAM) criteria, and CMS' NCD and LCD criteria guidelines. The processes, strategies, and evidentiary standards used in applying Medical Management NQTLs to MH/SUD benefits in the three classifications (i.e., IP, OP, and Rx) were comparable to the evidentiary standards used in administering NQTLs to M/S benefits in the same classifications. The CCO used nationally recognized, evidence-based medical necessity criteria for MH/SUD and M/S benefits in the three classifications to administer its processes with equivalent stringency.

Provider Network

- PCS-MP's processes for credentialing new providers and recredentialing existing providers, including frequency, was in alignment with State and federal regulations. The standards and processes for conducting credentialing and recredentialing activities were comparable and no more stringently applied for MH/SUD providers than for M/S providers.

Pharmacy Management

- PCS-MP identified the use of a formulary for prescription drugs which included formulary restrictions, such as PA requirements, step therapy restrictions, age restrictions, quantity limits, and specialty drugs. The CCO's pharmacy PA guidelines for MH/SUD prescription drugs were comparable and no more stringently applied than M/S prescription drugs. However, the CCO did not include processes, strategies, evidentiary standards, and other factors used in formulary design for prescription drugs, resulting in a *Partially Compliant* finding.
- PCS-MP identified the use of prescription drug benefit tiers in the CCO's formulary. The formulary includes a generic tier, a brand tier, and a specialty tier. The tiers are not representative of cost restrictions and there is no cost-sharing for prescription drug benefits. However, the CCO did not demonstrate that the processes, strategies, evidentiary standards, and other factors used in formulary tiering for prescription drugs are not applied more stringently for MH/SUD benefits that are not included in the carve-out list compared to M/S benefits, resulting in a *Partially Compliant* finding.

Other NQTLs

- No additional NQTLs were identified by the CCO.

Availability of Information

PCS-MP disseminated medical necessity criteria through the member handbook, provider handbook, and the CCO's website. The member handbook informed the members that OHP's covered benefits and treatments would be based on a list of conditions and services, the Prioritized List of Health Services,

which is ranked by the HERC. The CCO's Notice of Adverse Benefit Determination informed members of their ability to request free copies of the criteria and standards used in making coverage determinations.

Administrative Data Profile

Claims

Table L-3 presents a summary of the results from the analysis of paid claims by service and benefit type. In general, PCS-MP showed a minimal difference (4.4 percentage points) in the percentage of paid claims between MH/SUD (92.3 percent) and M/S (87.9 percent) services. However, a moderate difference (6.0 percentage points) was noted between the total percentage of OON MH/SUD paid claims (48.1 percent) and OON M/S claims (54.1 percent), as well as for OON OP claims individually (6.1 percentage points).

Table L-3—Number and Percentage of Claims by Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims[1]		Out-of-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	4,441	3,979	89.6%	295	76.6%
	M/S	14,582	12,300	84.4%	936	60.1%
OP	MH/SUD	717,678	662,522	92.3%	18,824	47.9%
	M/S	2,873,787	2,527,674	88.0%	46,352	54.0%
Total	**MH/SUD**	**722,119**	**666,501**	**92.3%**	**19,119**	**48.1%**
	M/S	**2,888,369**	**2,539,974**	**87.9%**	**47,288**	**54.1%**

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.

Utilization Management

Table L-4 presents a summary of the results from the analysis of PAs by service and benefit type. No substantial differences in the percentages of denied M/S and MH/SUD PAs were found that would have suggested an MH parity concern. Due to the low number of PA denials that were appealed (excluding Rx), results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity.

Table L-4—Prior Authorization Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals[1]		Hearings[1]	
		Total	Denied		Total Percent[2]	Overturned Percent	Total Percent	Overturned Percent
			Number	Percent[2]				
IP	MH/SUD	2,505	5	0.2%	0.0%	NA	0.0%	NA
	M/S	5,972	17	0.3%	100%	100%	0.0%	NA
OP	MH/SUD	1,041	134	12.9%	1.7%	28.6%	0.0%	NA
	M/S	46,674	10,200	21.9%	98.3%	41.3%	3.2%	0.0%
Rx	MH/SUD	573	335	58.5%	6.7%	39.0%	0.0%	NA
	M/S	7,571	4,266	56.3%	93.3%	29.6%	0.3%	0.0%

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

[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.

Provider Enrollment

Table L-5 presents a summary of the results from the analysis of provider enrollment and terminations. PCS-MP showed no difference (0.0 percentage points) between the percentage of MH/SUD and M/S provider applications approved in CY 2022. The CCO exhibited a minimal difference (3.3 percentage points) between MH/SUD and M/S in the percentage of terminated providers; however, in this case, M/S providers were terminated at higher rates (12.1 percent) than MH/SUD (8.8 percent).

Table L-5—CY 2022 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	1,978	99.9%	562	8.8%
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Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table L-6 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Q2 2022 to Q1 2023 resulted in a substantial

increase (i.e., ↑, or 10 percent) or decrease (i.e., ↓, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately nine months to one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

PCS-MP showed a substantial increase in the number of MH providers and maintained a stable SUD network, with nearly substantial increases between Q2 2022 and Q1 2023. Several factors likely contributed to these increases, including efforts described by the CCO to increase enrollment of MH/SUD providers in response to network gaps, changes to study methodology, taxonomic transitions, and improved quality of provider data. However, these increases should be considered in the context that PCS reports nearly all providers across its four affiliated CCOs globally, meaning that many providers reported as in the available network would be geographically distant (i.e., by hundreds of miles). Additionally, PCS reported a somewhat higher percentage of its provider workforce as MH providers in comparison to other CCOs (i.e., approximately 30.0 percent for PCS compared to approximately 20.0 to 25.0 percent overall), which may indicate a data issue.

Table L-6—Number and Percentage of MH/SUD Practitioners by Quarter and Provider Type

Provider Type	Q2 2022			Q1 2023			Difference	
	All Providers (N)	Provider (N)	Providers (%)	All Providers (N)	Provider (N)	Providers (%)	Provider (N)	Percent Change
MH	12,132	3,612	29.8%	13,751	4,253	30.9%	641	17.7% ↑
SUD	12,132	505	4.2%	13,751	551	4.0%	46	9.1%

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

Provider-to-Member Ratios

Table L-7 presents the provider-to-member ratios for MH and SUD providers in Q1 2023. When compared to other CCOs, PCS-MP's results represented a notable outlier with the CCO reporting one provider for every one to two members. However, this result is due, in part, to PCS-MP including all contracted providers within the PCS global network and not limiting the pool of providers to those available to members in the PCS-MP service area. However, this finding may represent a data issue rather than a member access issue, as time and distance analysis demonstrated full access to MH and SUD providers overall.

Table L-7—Provider-to-Member Ratios by Benefit and Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	4,253	26,498	1:7
SUD	551	6,095	1:12

Time and Distance

Table L-8 presents the average time and distance to the nearest three MH and SUD providers by setting urbanicity (i.e., urban or rural). The state-established time and distance standards are 30 minutes/30 miles in urban settings and 60 minutes/60 miles in rural settings for at least 95.0 percent of members. The CCO met the rural time and distance access requirements for average time and distance to the nearest three MH and SUD providers.

Table L-8—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Geography

Provider Type	Urban						Rural					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	1	1.5	1.7	0.9	1.3	1.5	3.0	3.5	3.8	2.7	3.2	3.5
SUD	2.1	3.4	4.1	1.7	2.9	3.4	4.6	6.7	7.6	4.2	6.2	6.9

Table L-9 presents the percentages of CCO members with access to MH and SUD services by urbanicity. The CCO demonstrated 100 percent access to MH and SUD providers in urban and rural settings.

Table L-9—Time and Distance Results by Geography

MH		SUD	
Urban	Rural	Urban	Rural
100%	100%	100%	100%

Appointment Availability

PCS-MP monitored appointment availability for both M/S and MH/SUD providers. Monitoring activities described and demonstrated by the CCO as part of its *DSN Provider Narrative Template* included:

- Monthly provider surveys subdivided by provider type and service region.
- Monthly survey of 4,000 members, identified through claims data to include representative percentages of service regions and members with MH/SUD-related claims.
- Grievance monitoring.

Access-Related Grievances

Table L-10 presents the percentage of access-related grievances compared to the overall number of grievances for MH and SUD services. The CCO showed a low percentage of grievances (1.3 percent) that were associated with MH/SUD services and benefits. Of those grievances, 14.3 percent were related

to access issues. These low results should be interpreted with caution due to the low overall total numbers of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low rate of grievances and thereby underestimating these results.[L-1]

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

Total Grievances	MH/SUD		MH/SUD Access-Related Grievances	
	Number	Percent	Number	Percent
1,675	21	1.3%	3	14.3%

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2023 MHP Evaluation, MH/SUD and M/S benefits administration was found to be in parity for PCS-MP. While the evaluation identified several opportunities for improvement, results did not identify any systemic issues that negatively affected parity between MH/SUD and M/S services. Rather, findings frequently highlighted general regulatory compliance issues affecting both MH/SUD and M/S benefits uniformly. Individual CCO results were used to identify the following strengths, weaknesses, and recommendations with respect to the quality, timeliness, and accessibility of health care services.

Strength/ Weakness	Description	Domain(s)
–	**Weakness:** PCS-MP was partially compliant with the Pharmacy Management–Formulary Design NQTL requirement. **Why the weakness exists:** The CCO did not provide its rationale for the assignment of the NQTL (i.e., prescription drug formulary), procedures used for the development of the formulary (e.g., individuals involved in formulary development; professional guidelines used; and how often the formulary is reviewed and updated or by whom), or how frequently or strictly the NQTL is applied (e.g., ability of the provider to request an exception). **Recommendations:** The CCO should identify processes, strategies, evidentiary standards, and other factors that are used in formulary design and the application for prescription drugs.	🔑

[L-1] It is important to note that grievances are an inherently limited monitoring tool for CCOs, given that members must have both the means and the inclination to file a grievance. These results reinforce OHA's guidance that grievance monitoring, while required and valuable, likely captures only a fraction of members' overall experiences and should not be used as the only mechanism for monitoring network adequacy and decision making.

Strength/ Weakness	Description	Domain(s)
–	**Weakness:** PCS-MP was partially compliant with the Pharmacy Management–Prescription Drug Benefit Tiers NQTL requirement. **Why the weakness exists:** The CCO did not provide its rationale for the assignment of the NQTL (i.e., formulary drug tiering), procedures related to formulary tiering (e.g., individuals involved, factors used to determine tier placement, or professional guidelines used), or how frequently or strictly the NQTL is applied (e.g., decision making process). **Recommendations:** The CCO should identify processes, strategies, evidentiary standards, and other factors that are used in formulary tiering.	🔑
–	**Weakness:** PCS-MP showed moderate differences in the percentage of paid, OON MH/SUD OP claims compared to M/S OP claims. Although differences in the percentage of paid claims may be legitimate, they may also highlight procedural or network differences indicating potential barriers to members' access to MH/SUD services. **Why the weakness exists:** OON OP MH/SUD claims were paid less frequently than M/S claims. **Recommendations:** PCS-MP should review OON claim denials to understand factors affecting the lower percentage of paid MH/SUD OP claims compared to M/S OP claims. The CCO should assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside of the CCO's network (e.g., appointment availability).	⏱️🔑

= Quality, ⏱️ = Timeliness, 🔑 = Access

Appendix M. MHP Results for Trillium Community Health Plan, Inc.—North (TCHP-North)

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the CCO to manage the administration of MH/SUD and M/S covered benefits, and assess whether documentation demonstrated compliance with MHP requirements in how they were applied to MH/SUD and M/S services and benefits. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency.* A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria. In contrast, a *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both. In general, *Partially Compliant* findings resulted from insufficient information or clear evidence of parity associated with selection of the NQTLs and the consistency and stringency with which the treatment limitations were applied to MH/SUD and M/S benefits across service types (i.e., inpatient [IP], outpatient [OP], pharmacy [Rx] or emergency care [EC]). Table M-1 presents a summary of HSAG's assessment of the CCO's compliance based on the analysis of treatment limitations applied, including the CCO's parity rating by treatment limitation type.

Table M-1—Overall Treatment Limitation Review Results by Treatment Limitation Type

OR 2023 MHP Treatment Limitation Review Element	CCO Compliance Rating
Financial Requirements (FRs)	*NA*
Aggregate Lifetime and Annual Dollar Limits (AL/ADLs)	*NA*
Quantitative Treatment Limitations (QTLs)	*NA*
Non-Quantitative Treatment Limitations (NQTLs)	*Compliant*
Availability of Information	*Compliant*
Overall Compliance Rating	***Compliant***

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the compliance rating is not applicable.

Overall, the CCO demonstrated compliance with MHP requirements and standards related to treatment limitations used by the organization to manage MH/SUD and M/S benefits. Key findings for each treatment limitation review element included:

Financial Requirements

TCHP-N reported the CCO does not apply any FRs or payments from members for services received that are in addition to payments made by the State (e.g., copayments, coinsurance, deductibles, or out-of-pocket maximums) for IP, OP, Rx, or EC for MH/SUD or M/S benefits.

Aggregate Lifetime and Annual Dollar Limits

TCHP-N reported the CCO does not apply AL/ADLs on the total amount of a specified benefit over a lifetime or annually for IP, OP, Rx, or EC for MH/SUD or M/S benefits.

Quantitative Treatment Limitations

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

Non-Quantitative Treatment Limitations

Table M-2 presents a summary of the NQTLs implemented by the CCO, including compliance with parity requirements.

Table M-2—Parity Result by Specific Treatment Limitation Types and Benefit and Service Type

NQTL	Applicable Benefit and Service Type								Parity Rating
	MH/SUD				M/S				
	IP	OP	Rx	EC	IP	OP	Rx	EC	
Medical Management	X	X			X	X		X	*Compliant*
Provider Network									*NA*
Pharmacy Management			X				X		*Compliant*
Other: Not Applicable									*NA*

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the parity rating is not applicable.

Medical Management

- TCHP-N's policies included standardized processes that applied to both MH/SUD and M/S benefits, including a Medicaid Utilization Management Handbook, Service Authorization Decision policy and Clinical Decision Criteria and Application policy.
- TCHP-N identified prior authorization (PA) requirements for EC; however, the CCO further explained the PA NQTL was applied to nonemergency inpatient services only.
- For limits applied to IP and OP health benefits, TCHP-N used utilization management (UM) processes to manage MH/SUD and M/S benefits. TCHP-N reported that the evidence used to apply

UM to MH/SUD and M/S benefits included OARs, the HERC Prioritized List of Health Services and guidelines, American Society of Addiction Medicine (ASAM) criteria, InterQual criteria, and Milliman Care Guidelines. The processes, strategies, and evidentiary standards used in applying Medical Management NQTLs to MH/SUD benefits in the IP and OP classifications were comparable to the evidentiary standards used in administering NQTLs to M/S benefits in the same classifications. The CCO used nationally recognized, evidence-based medical necessity criteria for MH/SUD and M/S benefits in the two classifications to administer its processes with equivalent stringency.

Provider Network

- TCHP-N reported the CCO does not apply NQTLs related to the provider network, including admission standards, reimbursement rates, restrictions based on geographic location/specialty requirements/facility types, network tiers, or OON providers for IP, OP, Rx, or EC for MH/SUD or M/S benefits.

Pharmacy Management

- TCHP-N identified the use of a formulary design for prescription drugs, which is applied to both MH/SUD that are not included in the carve-out list and M/S benefits. The CCO's formulary was designed to promote clinically appropriate utilization of high-risk and/or high-cost medications. Formulary decisions and decisions regarding pharmaceutical management edits, including PA, quantity limits, age and gender edits, and step therapy, were made using applicable nationally recognized medical standards and were consistent with applicable governmental guidelines. The CCO's formulary design and UM processes for MH/SUD prescription drugs were comparable and were no more stringently applied than for M/S prescription drugs.

Other NQTLs

- No additional NQTLs were identified by the CCO.

Availability of Information

TCHP-N reported that they informed providers of medical necessity criteria through the provider manual, the CCO website, and provider newsletters. The member handbook informed the members that OHP's covered benefits and treatments are based on a list of conditions and services named the Prioritized List of Health Services, which is ranked by the HERC. The CCO's Notice of Adverse Benefit Determination informed members of their ability to request free copies of the criteria and standards used in making coverage determinations.

Administrative Data Profile

Claims

Table M-3 presents a summary of the results from the analysis of paid claims by service and benefit type. In general, TCHP-N showed a moderate difference (5.2 percentage points) in the percentage of paid claims between MH/SUD (85.7 percent) and M/S (80.5 percent) services. A minimal difference (1.2 percentage points) was noted between MH/SUD OON paid claims (68.1 percent) and M/S OON paid claims (66.9 percent). A minimal difference (2.9 percentage points) was also noted for the percentage of paid claims for MH/SUD OON IP claims (66.6 percent) compared to M/S OON IP claims (69.5 percent).

Table M-3—Number and Percentage of Claims by Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims[1]		Out-of-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	4,350	3,300	75.9%	1,018	66.6%
	M/S	23,136	16,755	72.4%	6,673	69.5%
OP	MH/SUD	74,441	64,257	86.3%	10,418	68.2%
	M/S	208,349	169,492	81.4%	30,355	66.4%
Total	**MH/SUD**	**78,791**	**67,557**	**85.7%**	**11,436**	**68.1%**
	M/S	**231,485**	**186,247**	**80.5%**	**37,028**	**66.9%**

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.

Utilization Management

Table M-4 presents a summary of the results from the analysis of PAs by service and benefit type. Across all service types, a greater percentage of M/S PAs were denied compared to MH/SUD PAs. Due to the low number of PA denials that were appealed (excluding Rx), results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity.

Table M-4—Prior Authorization Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals[1]		Hearings[1]	
		Total	Denied		Total Percent[2]	Overturned Percent	Total Percent	Overturned Percent
			Number	Percent[2]				
IP	**MH/SUD**	185	22	11.9%	0.0%	NA	0.0%	NA
	M/S	1,021	234	22.9%	100%	33.3%	0.0%	NA

Service Type	Benefit Type	Prior Authorization			Appeals[1]		Hearings[1]	
		Total	Denied		Total Percent[2]	Overturned Percent	Total Percent	Overturned Percent
			Number	Percent[2]				
OP	MH/SUD	1,280	40	3.1%	3.4%	75.0%	0.0%	NA
	M/S	3,757	936	24.9%	96.6%	52.7%	0.0%	NA
Rx	MH/SUD	231	102	44.2%	9.1%	100%	0.0%	NA
	M/S	1,703	861	50.6%	90.9%	67.5%	0.0%	NA

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

[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.

Provider Enrollment

Table M-5 presents a summary of the results from the analysis of provider enrollment and terminations. TCHP-N showed a moderate difference (8.2 percentage points) between the percentage of MH/SUD (77.4 percent) and M/S (85.6 percent) provider applications approved in CY 2022. The CCO exhibited a greater percentage of M/S provider terminations (15.2 percent) compared to MH/SUD providers (13.8 percent), but the difference was minimal at 1.4 percentage points.

Table M-5—CY 2022 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	603	77.4%	613	13.8%
M/S	1,633	85.6%	1,121	15.2%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table M-6 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Q2 2022 to Q1 2023 resulted in a substantial increase (i.e., ↑, or 10 percent) or decrease (i.e., ↓, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately nine months to one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

TCHP-N showed a stable MH/SUD network between Q2 2022 and Q1 2023. At the same time, the CCO's overall network was reduced by approximately 4,231 providers, mainly in primary care providers While this was primarily due to improved data quality, other factors likely contributed to the stability of MH and SUD provider numbers, including efforts described by the CCO to increase enrollment of MH/SUD providers in response to network gaps, changes to study methodology, and taxonomic transitions.

Table M-6—Number and Percentage of MH/SUD Practitioners by Quarter and Provider Type

Provider Type	Q2 2022			Q1 2023			Difference	
	All Providers (N)	Provider (N)	Providers (%)	All Providers (N)	Provider (N)	Providers (%)	Provider (N)	Percent Change
MH	12,014	1,971	16.4%	7,783	1,993	25.6%	22	1.1%
SUD	12,014	293	2.4%	7,783	293	3.8%	0	0.0%

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

Provider-to-Member Ratios

Table M-7 presents the provider-to-member ratios for MH and SUD providers in Q1 2023.

Table M-7—Provider-to-Member Ratios by Benefit and Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	1,993	4,072	1:3
SUD	293	1,205	1:5

Time and Distance

Table M-8 presents the average time and distance to the nearest three MH and SUD providers by setting urbanicity (i.e., urban or rural). The state-established time and distance standards are 30 minutes/30 miles in urban settings and 60 minutes/60 miles in rural settings for at least 95.0 percent of members. The CCO met the rural time and distance access requirements for average time and distance to the nearest three MH and SUD providers.

Table M-8—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Geography

Provider Type	Urban						Rural					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	1.4	1.6	1.8	0.8	1	1.1	6.2	8.0	8.0	5.7	7.4	7.4
SUD	3	3.4	3.6	1.9	2.2	2.3	19.1	19.2	19.3	17.0	17.2	17.2

Table M-9 presents the percentages of CCO members with access to MH and SUD services by urbanicity. The CCO demonstrated 100 percent access to MH and SUD providers in urban and rural settings.

Table M-9—Time and Distance Results by Geography

MH		SUD	
Urban	Rural	Urban	Rural
100%	100%	100%	100%

Appointment Availability

TCHP-N monitored appointment availability for both M/S and MH/SUD providers. Monitoring activities described and demonstrated by the CCO as part of its *DSN Provider Narrative Template* included:

- Annual provider surveys subdivided by provider type.
- Grievance monitoring.

Access-Related Grievances

Table M-10 presents the percentage of access-related grievances compared to the overall number of grievances for MH and SUD services. The CCO showed a low percentage of grievances (2.2 percent) that were associated with MH/SUD services and benefits. Of those grievances, none were related to access issues. Although these results suggest access as a potential focus for MH/SUD grievances, the results should be interpreted with caution due to the low overall total numbers of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.[M-1]

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

Total Grievances	MH/SUD		MH/SUD Access-Related Grievances	
	Number	Percent	Number	Percent
356	8	2.2%	0	0.0%

[M-1] It is important to note that grievances are an inherently limited monitoring tool for CCOs, given that members must have both the means and the inclination to file a grievance. These results reinforce OHA's guidance that grievance monitoring, while required and valuable, likely captures only a fraction of members' overall experiences and should not be used as the only mechanism for monitoring network adequacy and decision making.

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2023 MHP Evaluation, MH/SUD and M/S benefits administration was found to be in parity for TCHP-N. Individual CCO results were used to identify the following strengths, weaknesses, and recommendations with respect to the quality, timeliness, and accessibility of health care services.

Strength/ Weakness	Description	Domain(s)
+	**Strength:** TCHP-N achieved full compliance with parity requirements for application of NQTLs applied to MH/SUD and M/S benefits.	🔑

= Quality, = Timeliness, 🔑 = Access

Appendix N. MHP Results for Trillium Community Health Plan, Inc.—South (TCHP-South)

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the CCO to manage the administration of MH/SUD and M/S covered benefits, and assess whether documentation demonstrated compliance with MHP requirements in how they were applied to MH/SUD and M/S services and benefits. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency.* A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria. In contrast, a *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both. In general, *Partially Compliant* findings resulted from insufficient information or clear evidence of parity associated with selection of the NQTLs and the consistency and stringency with which the treatment limitations were applied to MH/SUD and M/S benefits across service types (i.e., inpatient [IP], outpatient [OP], pharmacy [Rx] or emergency care [EC]). Table N-1 presents a summary of HSAG's assessment of the CCO's compliance based on the analysis of treatment limitations applied, including the CCO's parity rating by treatment limitation type.

Table N-1—Overall Treatment Limitation Review Results by Treatment Limitation Type

OR 2023 MHP Treatment Limitation Review Element	CCO Compliance Rating
Financial Requirements (FRs)	*NA*
Aggregate Lifetime and Annual Dollar Limits (AL/ADLs)	*NA*
Quantitative Treatment Limitations (QTLs)	*NA*
Non-Quantitative Treatment Limitations (NQTLs)	*Compliant*
Availability of Information	*Compliant*
Overall Compliance Rating	***Compliant***

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the compliance rating is not applicable.

Overall, the CCO demonstrated compliance with MHP requirements and standards related to treatment limitations used by the organization to manage MH/SUD and M/S benefits. Key findings for each treatment limitation review element included:

Financial Requirements

TCHP-S reported the CCO does not apply any FRs or payments from members for services received that are in addition to payments made by the State (e.g., copayments, coinsurance, deductibles, or out-of-pocket maximums) for IP, OP, Rx, or EC for MH/SUD or M/S benefits.

Aggregate Lifetime and Annual Dollar Limits

TCHP-S reported the CCO does not apply AL/ADLs on the total amount of a specified benefit over a lifetime or annually for IP, OP, Rx, or EC for MH/SUD or M/S benefits.

Quantitative Treatment Limitations

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

Non-Quantitative Treatment Limitations

Table N-2 presents a summary of the NQTLs implemented by the CCO, including compliance with parity requirements.

Table N-2—Parity Result by Specific Treatment Limitation Types and Benefit and Service Type

NQTL	Applicable Benefit and Service Type								Parity Rating
	MH/SUD				M/S				
	IP	OP	Rx	EC	IP	OP	Rx	EC	
Medical Management	X	X			X	X		X	*Compliant*
Provider Network									*NA*
Pharmacy Management			X				X		*Compliant*
Other: Not Applicable									*NA*

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the parity rating is not applicable.

Medical Management

- TCHP-S's policies included standardized processes that applied to both MH/SUD and M/S benefits, including a Medicaid Utilization Management Handbook, Service Authorization Decision policy and Clinical Decision Criteria and Application policy.
- TCHP-S identified prior authorization (PA) requirements for EC; however, the CCO further explained the PA NQTL was applied to non-emergency inpatient services only.
- For limits applied to IP and OP health benefits, TCHP-S used utilization management (UM) processes to manage MH/SUD and M/S benefits. TCHP-S reported that the evidence used to apply

UM to MH/SUD and M/S benefits included OARs, the HERC Prioritized List of Health Services and guidelines, American Society of Addiction Medicine (ASAM) criteria, InterQual criteria, and Milliman Care Guidelines. The processes, strategies, and evidentiary standards used in applying Medical Management NQTLs to MH/SUD benefits in the IP and OP classifications were comparable to the evidentiary standards used in administering NQTLs to M/S benefits in the same classifications. The CCO used nationally recognized, evidence-based medical necessity criteria for MH/SUD and M/S benefits in the two classifications to administer its processes with equivalent stringency.

Provider Network

- TCHP-S reported the CCO does not apply NQTLs related to the provider network, including admission standards, reimbursement rates, restrictions based on geographic location/specialty requirements/facility types, network tiers, or OON providers for IP, OP, Rx, or EC for MH/SUD or M/S benefits.

Pharmacy Management

- TCHP-S identified the use of a formulary design for prescription drugs, which is applied to both MH/SUD that are not included in the carve-out list and M/S benefits. The CCO's formulary was designed to promote clinically appropriate utilization of high-risk and/or high-cost medications. Formulary decisions and decisions regarding pharmaceutical management edits, including PA, quantity limits, age and gender edits, and step therapy, were made using applicable nationally recognized medical standards and were consistent with applicable governmental guidelines. The CCO's formulary design and UM processes for MH/SUD prescription drugs were comparable and were no more stringently applied than for M/S prescription drugs.

Other NQTLs

- No additional NQTLs were identified by the CCO.

Availability of Information

TCHP-S reported that they informed providers of medical necessity criteria through the provider manual, the CCO website, and provider newsletters. The member handbook informed the member that OHP's covered benefits and treatments are based on a list of conditions and services named the Prioritized List of Health Services, which is ranked by the HERC. The CCO's Notice of Adverse Benefit Determination informed members of their ability to request free copies of the criteria and standards used in making coverage determinations.

Administrative Data Profile

Claims

Table N-3 presents a summary of the results from the analysis of paid claims by service and benefit type. In general, TCHP-S showed a substantial difference (15.0 percentage points) in the percentage of paid claims between MH/SUD (89.1 percent) and M/S (74.1 percent) services, as well as individually for IP and OP claims (14.3 percentage points and 14.9 percent, respectively). A substantial difference (11.5 percentage points) was noted between MH/SUD OON paid claims (59.5 percent) and M/S OON paid claims (48.0 percent). Across all service types, a greater percentage of MH/SUD claims were paid compared to M/S claims. Similar differences were noted among OON paid claims.

Table N-3—Number and Percentage of Claims by Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims[1]		Out-of-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	10,127	8,230	81.3%	2,705	70.1%
	M/S	35,662	23,877	67.0%	8,800	58.5%
OP	MH/SUD	178,853	160,163	89.6%	8,191	56.7%
	M/S	394,735	295,053	74.7%	26,523	45.3%
Total	**MH/SUD**	**188,980**	**168,393**	**89.1%**	**10,896**	**59.5%**
	M/S	**430,397**	**318,930**	**74.1%**	**35,323**	**48.0%**

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.

Utilization Management

Table N-4 presents a summary of the results from the analysis of PAs by service and benefit type. Across all service types, a greater percentage of M/S PAs were denied compared to MH/SUD PAs. Due to the low number of PA denials that were appealed (excluding Rx), results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity.

Table N-4—Prior Authorization Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals[1]		Hearings[1]	
		Total	Denied		Total Percent[2]	Overturned Percent	Total Percent	Overturned Percent
			Number	Percent[2]				
IP	**MH/SUD**	318	34	10.7%	50.0%	50.0%	0.0%	NA
	M/S	2,470	523	21.2%	50.0%	0.0%	0.0%	NA

Service Type	Benefit Type	Prior Authorization			Appeals[1]		Hearings[1]	
		Total	Denied		Total Percent[2]	Overturned Percent	Total Percent	Overturned Percent
			Number	Percent[2]				
OP	MH/SUD	2,387	29	1.2%	5.1%	50.0%	0.0%	NA
	M/S	8,653	1,145	13.2%	94.9%	54.5%	0.0%	NA
Rx	MH/SUD	317	124	39.1%	7.3%	75.0%	0.0%	NA
	M/S	3,039	1,372	45.1%	92.7%	80.4%	0.0%	NA

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

[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.

Provider Enrollment

Table N-5 presents a summary of the results from the analysis of provider enrollment and terminations. TCHP-S showed a moderate difference (8.2 percentage points) between the percentage of MH/SUD (77.4 percent) and M/S (85.6 percent) provider applications approved in CY 2022. The CCO exhibited a greater percentage of M/S provider terminations (15.2 percent) compared to MH/SUD providers (13.8 percent), but the difference was minimal at 1.4 percentage points.

Table N-5—CY 2022 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	603	77.4%	613	13.8%
M/S	1,633	85.6%	1,121	15.2%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table N-6 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Q2 2022 to Q1 2023 resulted in a substantial increase (i.e., ↑, or 10 percent) or decrease (i.e., ↓, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately nine months to one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

TCHP-South showed substantial increases to its MH and SUD provider counts between Q2 2022 and Q1 2023. At the same time, the CCO's overall network was reduced by approximately 1,005 providers, mainly among primary care providers. While the increase in provider counts was due to improved data quality, other factors likely contributed to the increase in MH and SUD provider numbers, including efforts described by the CCO to increase enrollment of MH/SUD providers in response to network gaps, changes to study methodology, and taxonomic transitions.`

Table N-6—Number and Percentage of MH/SUD Practitioners by Quarter and Provider Type

Provider Type	Q2 2022			Q1 2023			Difference	
	All Providers (N)	Provider (N)	Providers (%)	All Providers (N)	Provider (N)	Providers (%)	Provider (N)	Percent Change
MH	7,773	1,598	20.6%	6,768	1,814	26.8%	216	13.5% ↑
SUD	7,773	357	4.6%	6,768	415	6.1%	58	16.2% ↑

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

Provider-to-Member Ratios

Table N-7 presents the provider-to-member ratios for MH and SUD providers in Q1 2023.

Table N-7—Provider-to-Member Ratios by Benefit and Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	1,814	6,998	1:4
SUD	415	2,331	1:6

Time and Distance

Table N-8 presents the average time and distance to the nearest three MH and SUD providers by setting urbanicity (i.e., urban or rural). The state-established time and distance standards are 30 minutes/30 miles in urban settings and 60 minutes/60 miles in rural settings for at least 95.0 percent of members. The CCO met the rural time and distance access requirements for average time and distance to the nearest three MH and SUD providers.

Table N-8—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Geography

Provider Type	Urban						Rural					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	1.5	1.7	1.8	1.3	1.4	1.5	3.5	4.0	4.1	3.3	3.7	3.8
SUD	3	3.2	3.3	2.5	2.7	2.7	14.2	23.6	23.6	13.0	21.6	21.6

Table N-9 presents the percentages of CCO members with access to MH and SUD services by urbanicity. The CCO demonstrated 100 percent access to MH and SUD providers in urban and rural settings.

Table N-9—Time and Distance Results by Geography

MH		SUD	
Urban	Rural	Urban	Rural
100%	100%	100%	100%

Appointment Availability

TCHP-S monitored appointment availability for both M/S and MH/SUD providers. Monitoring activities described and demonstrated by the CCO as part of its *DSN Provider Narrative Template* included:

- Annual provider surveys subdivided by provider type.
- Grievance monitoring.

Access-Related Grievances

Table N-10 presents the percentage of access-related grievances compared to the overall number of grievances for MH and SUD services. The CCO showed a low percentage of grievances (2.2 percent) that were associated with MH/SUD services and benefits. Of those grievances, a low percentage (5.9 percent) were related to access issues. Although these results suggest access as a potential focus for MH/SUD grievances, the results should be interpreted with caution due to the low overall total numbers of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.[N-1]

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

Total Grievances	MH/SUD		MH/SUD Access-Related Grievances	
	Number	Percent	Number	Percent
716	17	2.4%	1	5.9%

[N-1] It is important to note that grievances are an inherently limited monitoring tool for CCOs, given that members must have both the means and the inclination to file a grievance. These results reinforce OHA's guidance that grievance monitoring, while required and valuable, likely captures only a fraction of members' overall experiences and should not be used as the only mechanism for monitoring network adequacy and decision making.

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2023 MHP Evaluation, MH/SUD and M/S benefits administration was found to be in parity for TCHP-S. Individual CCO results were used to identify the following strengths, weaknesses, and recommendations with respect to the quality, timeliness, and accessibility of health care services.

Strength/ Weakness	Description	Domain(s)
+	**Strength:** TCHP-S achieved full compliance with parity requirements for application of NQTLs applied to MH/SUD and M/S benefits.	🔑

= Quality, = Timeliness, 🔑 = Access

Appendix O. MHP Results for Umpqua Health Alliance, LLC (UHA)

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the CCO to manage the administration of MH/SUD and M/S covered benefits, and assess whether documentation demonstrated compliance with MHP requirements in how they were applied to MH/SUD and M/S services and benefits. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency.* A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria. In contrast, a *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both. In general, *Partially Compliant* findings resulted from insufficient information or clear evidence of parity associated with selection of the NQTLs and the consistency and stringency with which the treatment limitations were applied to MH/SUD and M/S benefits across service types (i.e., inpatient [IP], outpatient [OP], pharmacy [Rx] or emergency care [EC]). Table O-1 presents a summary of HSAG's assessment of the CCO's compliance based on the analysis of treatment limitations applied, including the CCO's parity rating by treatment limitation type.

Table O-1—Overall Treatment Limitation Review Results by Treatment Limitation Type

OR 2023 MHP Treatment Limitation Review Element	CCO Compliance Rating
Financial Requirements (FRs)	*NA*
Aggregate Lifetime and Annual Dollar Limits (AL/ADLs)	*NA*
Quantitative Treatment Limitations (QTLs)*	*NA*
Non-Quantitative Treatment Limitations (NQTLs)	*Partially Compliant*
Availability of Information	*Compliant*
Overall Compliance Rating	***Partially Compliant***

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the compliance rating is not applicable.

*QTLs identified by the CCO were soft limits based on medical necessity or medical appropriateness and were subsequently reviewed as NQTLs.

Overall, the CCO demonstrated partial compliance with MHP requirements and standards related to treatment limitations used by the organizations to manage MH/SUD and M/S benefits However, these results did not identify any systemic issues that negatively affected parity between the administration of MH/SUD and M/S services. Rather, UHA's findings highlighted general regulatory compliance issues related to documentation and demonstration of implementation that affected both MH/SUD and M/S benefits uniformly. Key findings for each treatment limitation review element included:

Financial Requirements

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

Aggregate Lifetime and Annual Dollar Limits

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

Quantitative Treatment Limitations

UHA listed QTLs for MH/SUD benefits within its *2023 MHP Treatment Limitation Review Tool* including acute/sub-acute IP, SUD withdrawal management, SUD residential treatment, subacute psychiatric residential treatment, OON MH/SUD services, applied behavioral analysis, intensive in-home behavioral health treatment, OON OP treatment, electroconvulsive therapy, transcranial magnetic stimulation, medication-assisted treatment, psychological and neuropsychological evaluations, and quantity limits on medications per fill. However, the QTLs for the services listed were not strict limits on services made available to members, but rather the maximum visit or time limits for a single authorization. Since these treatment limitations are based on medical management standards limiting or excluding benefits on the basis of medical necessity or medical appropriateness, the QTLs identified by the CCO were evaluated for parity as NQTLs.

Non-Quantitative Treatment Limitations

Table O-2 presents a summary of the NQTLs implemented by the CCO, including compliance with parity requirements.

Table O-2—Parity Result by Specific Treatment Limitation Type and Benefit and Service Type

NQTL	Applicable Benefit and Service Type								Parity Rating
	MH/SUD				M/S				
	IP	OP	Rx	EC	IP	OP	Rx	EC	
Medical Management	X	X	X		X	X	X		*Compliant*
Provider Network	X	X			X	X			*Compliant*
Pharmacy Management			X				X		*Partially Compliant*
Other: Not Applicable									*NA*

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the parity rating is not applicable.

Medical Management

- Most of UHA's policies included standardized processes that applied to both MH/SUD and M/S benefits, including a Utilization and Management and Service Authorization Handbook.
- For limits applied to IP and OP health benefits, UHA used utilization management (UM) processes to manage MH/SUD and M/S benefits. The CCO's UM processes were designed to ensure benefit coverage; medical necessity, appropriate treatment in the least restrictive environment that maintains the safety of the individual; compliance with federal and State requirements; and the prevention of unnecessary overutilization. UHA reported that the evidence used to apply UM to MH/SUD and M/S included OARs, the HERC Prioritized List of Health Services and guidelines, and InterQual guidelines. The processes, strategies, and evidentiary standards used in applying Medical Management NQTLs to MH/SUD benefits in the three classifications (i.e., IP, OP, and Rx) were comparable to the evidentiary standards used in administering NQTLs to M/S benefits in the same classifications. The CCO used nationally recognized, evidence-based medical necessity criteria for MH/SUD and M/S benefits in the three classifications to administer its processes with equivalent stringency.

Provider Network

- UHA's processes for credentialing new providers and recredentialing existing providers, including frequency, was in alignment with the State and federal regulations. The standards and processes for conducting credentialing and recredentialing activities were comparable and no more stringently applied for MH/SUD providers than for M/S providers.

Pharmacy Management

- UHA identified the use of a formulary for prescription drugs, which included formulary and nonformulary drugs as well as additional restrictions including PA requirements, step therapy restrictions, age restrictions, quantity limits, and specialty drugs. There were no tiers or cost-sharing for prescription drug benefits. The CCO's pharmacy PA guidelines for MH/SUD prescription drugs were comparable and no more stringently applied for M/S prescription drugs. However, the CCO did not include processes, strategies, evidentiary standards, and other factors used in formulary design for prescription drugs resulting in a *Partially Compliant* finding.

Other NQTLs

- No additional NQTLs were identified by the CCO.

Availability of Information

- UHA reported disseminating medical necessity criteria and supplemental information to members and potential members through the member handbook, the CCO's website, and a quarterly newsletter. The member handbook informed the member that OHP's covered benefits and treatments are based on a list of conditions and services, the Prioritized List of Health Services, which is ranked by the HERC. The member handbook also included information about covered services, MH/SUD and M/S, that require a PA and directs the member to call Customer Care for information on covered

benefits and directs the member to UHA's PA grid for more information on services requiring PA. The CCO's Notice of Adverse Benefit Determination informed members of their ability to request free copies of the criteria and standards used in making coverage determinations.

- UHA provided its Service Authorization and Utilization Management Handbook and provider manual to IN and OON providers through the CCO's website and through IN provider trainings, respectively. Providers were also sent a monthly newsletter with content including best practices, guidelines, or other updates as determined by the CCO. UHA facilitated training and events, such as the Provider Services Forum, to share information about guidelines and practices. Providers could request criteria and additional information from UHA at any time via email or phone. Providers could also request a peer-to-peer consult or inquire about the guidelines that were applied to a determination.

Administrative Data Profile

Claims

Table O-3 presents a summary of the results from the analysis of paid claims by service and benefit type. In general, UHA exhibited a moderate difference (5.9 percentage points) in the percentage of paid claims between MH/SUD (91.3 percent) and M/S (85.4 percent) services, as well as for OP claims individually (6.1 percentage points). However, a substantial difference (10.6 percentage points) was noted between the total percentage of MH/SUD OON paid claims (63.7 percent) and M/S OON paid claims (74.3 percent), as well as for OON OP claims individually (13.0 percentage points).

Table O-3—Number and Percentage of Claims by Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims[1]		Out-of-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	5,646	4,675	82.8%	1,555	71.0%
	M/S	3,311	2,630	79.4%	368	67.2%
OP	MH/SUD	135,891	124,478	91.6%	4,143	61.4%
	M/S	491,575	420,059	85.5%	87,580	74.4%
Total	**MH/SUD**	**141,537**	**129,153**	**91.3%**	**5,698**	**63.7%**
	M/S	**494,886**	**422,689**	**85.4%**	**87,948**	**74.3%**

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.

Utilization Management

Table O-4 presents a summary of the results from the analysis of PAs by service and benefit type. No substantial differences in the percentage of denied M/S and MH/SUD PAs were found that would have

suggested an MH parity concern. Only PA denials for IP services were greater among MH/SUD services (6.7 percent) compared to M/S services (3.1 percent). Due to the low number of PA denials that were appealed, results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity.

Table O-4—Prior Authorization Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals[1]		Hearings[1]	
			Denied					
		Total	Number	Percent[2]	Total Percent[2]	Overturned Percent	Total Percent	Overturned Percent
IP	MH/SUD	1,392	93	6.7%	71.4%	20.0%	0.0%	NA
	M/S	1,389	43	3.1%	28.6%	50.0%	0.0%	NA
OP	MH/SUD	1,110	93	8.4%	2.6%	20.0%	0.0%	NA
	M/S	22,929	3,446	15.0%	97.4%	61.4%	0.5%	0.0%
Rx	MH/SUD	1,707	357	20.9%	19.6%	66.7%	0.0%	NA
	M/S	5,451	2,331	42.8%	80.4%	29.7%	0.0%	NA

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

[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.

Provider Enrollment

Table O-5 presents a summary of the results from the analysis of provider enrollment and terminations. UHA showed a minimal difference (4.9 percent) in the percentages of MH/SUD (81.4 percent) and M/S (86.3 percent) provider applications approved in CY 2022. Although the CCO exhibited a higher percentage of MH/SUD provider terminations (6.4 percent) compared to M/S providers (5.7 percent), the difference was negligible, at less than one percentage point.

Table O-5—CY 2022 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	102	81.4%	19	6.4%
M/S	124	86.3%	34	5.7%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table O-6 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Q2 2022 to Q1 2023 resulted in a substantial increase (i.e., ↑, or 10 percent) or decrease (i.e., ↓, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately nine months to one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

UHA showed substantial increases in both MH and SUD provider counts between Q2 2022 and Q1 2023. At the same time, however, the CCO's overall network was reduced by approximately 305 providers, mainly in primary care providers. While this was primarily due to improved data quality, other factors likely contributed to the increase in MH and SUD provider numbers, including efforts described by the CCO to increase enrollment of MH/SUD providers in response to network gaps, changes to study methodology, and taxonomic transitions.

Table O-6—Number and Percentage of MH/SUD Practitioners by Quarter and Provider Type

Provider Type	Q2 2022			Q1 2023			Difference	
	All Providers (N)	Provider (N)	Providers (%)	All Providers (N)	Provider (N)	Providers (%)	Provider (N)	Percent Change
MH	1,206	147	12.2%	901	177	19.6%	30	20.4% ↑
SUD	1,206	82	6.8%	901	100	11.1%	18	22.0% ↑

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

Provider-to-Member Ratios

Table O-7 presents the provider-to-member ratios for MH and SUD providers in Q1 2023.

Table O-7—Provider-to-Member Ratios by Benefit and Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	177	5,707	1:33
SUD	100	1,562	1:16

Time and Distance

Table O-8 presents the average time and distance to the nearest three MH and SUD providers by setting urbanicity (i.e., urban or rural). The state-established time and distance standards are 30 minutes/30 miles in urban settings and 60 minutes/60 miles in rural settings for at least 95.0 percent of members. The CCO met the rural time and distance access requirements for average time and distance to the nearest three MH and SUD providers. The CCO had no urban settings within its service area as defined by state-established urbanicity parameters.

Table O-8—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Geography

Provider Type	Urban						Rural					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	NA	NA	NA	NA	NA	NA	3.1	3.9	4.0	2.9	3.7	3.7
SUD	NA	NA	NA	NA	NA	NA	4.0	5.7	8.4	3.7	5.3	7.7

Table O-9 presents the percentages of CCO members with access to MH and SUD services by urbanicity. The CCO demonstrated 100 percent access to MH and SUD providers in rural settings. The CCO had no urban settings within its service region as defined by state-established urbanicity parameters.

Table O-9—Time and Distance Results by Geography

MH		SUD	
Urban	Rural	Urban	Rural
NA	100%	NA	100%

Appointment Availability

UHA monitored appointment availability for both M/S and MH/SUD providers. Monitoring activities described and demonstrated by the CCO as part of its *DSN Provider Narrative Template* included:

- Quarterly provider surveys subdivided by provider type.
- Monthly secret shopper calls.
- Grievance monitoring.

Access-Related Grievances

Table O-10 presents the percentage of access-related grievances compared to the overall number of grievances for MH and SUD services. The CCO showed a low percentage of grievances (1.4 percent)

that were associated with MH/SUD services and benefits. Of those grievances, 20.0 percent were related to access issues. Although these results suggest access as a potential focus for MH/SUD grievances, the results should be interpreted with caution due to the low overall total numbers of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.[O-1]

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

Total Grievances	MH/SUD		MH/SUD Access-Related Grievances	
	Number	Percent	Number	Percent
695	10	1.4%	2	20.0%

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2023 MHP Evaluation, MH/SUD and M/S benefits administration was found to be in parity for UHA. While the evaluation identified several opportunities for improvement, results did not identify any systemic issues that negatively affected parity between MH/SUD and M/S services. Rather, findings frequently highlighted general regulatory compliance issues affecting both MH/SUD and M/S benefits uniformly. Individual CCO results were used to identify the following strengths, weaknesses, and recommendations with respect to the quality, timeliness, and accessibility of health care services.

Strength/ Weakness	Description	Domain(s)
+	**Strength:** UHA provided comprehensive responses in the OR 2023 MHP Treatment Limitations Review Tool, including narrative responses to the questionnaire and explanations in the subsections to clarify information as needed.	🔑
−	**Weakness:** UHA was partially compliant with the Pharmacy Management–Formulary Design NQTL requirement. **Why the weakness exists:** The CCO did not provide its rationale for the assignment of the NQTL (i.e., prescription drug formulary); procedures used for the development formulary (e.g., individuals involved in formulary development, professional guidelines used, or how often the formulary is reviewed and updated or by whom); or how frequently or strictly the NQTL is applied (e.g., ability of the provider to request an exception).	🔑

[O-1] It is important to note that grievances are an inherently limited monitoring tool for CCOs, given that members must have both the means and the inclination to file a grievance. These results reinforce OHA's guidance that grievance monitoring, while required and valuable, likely captures only a fraction of members' overall experiences and should not be used as the only mechanism for monitoring network adequacy and decision making.

Strength/ Weakness	Description	Domain(s)
	Recommendations: The CCO should identify processes, strategies, evidentiary standards, and other factors used in formulary design and the application for prescription drugs.	
−	**Weakness:** UHA showed substantial differences in the percentages of paid, OON MH/SUD OP claims compared to M/S OP claims. Although differences in the percentages of paid claims may be legitimate, they may also highlight procedural or network differences indicating potential barriers for members accessing MH/SUD services. **Why the weakness exists:** OON OP MH/SUD claims were paid less frequently than M/S claims. **Recommendations:** UHA should review OON claim denials to understand the factors affecting the lower percentage of paid MH/SUD OP claims compared to M/S OP claims. The CCO should assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside the CCO's network (e.g., appointment availability).	⏱️🔑

= Quality, ⏱️ = Timeliness, 🔑 = Access

Appendix P. MHP Results for Yamhill Community Care Organization (YCCO)

Treatment Limitation Review

The following results highlight the types of treatment limitations used by the CCO to manage the administration of MH/SUD and M/S covered benefits, and assess whether documentation demonstrated compliance with MHP requirements in how they were applied to MH/SUD and M/S services and benefits. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency.* A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria. In contrast, a *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both. In general, *Partially Compliant* findings resulted from insufficient information or clear evidence of parity associated with selection of the NQTLs and the consistency and stringency with which the treatment limitations were applied to MH/SUD and M/S benefits across service types (i.e., inpatient [IP], outpatient [OP], pharmacy [Rx] or emergency care [EC]). Table P-1 presents a summary of HSAG's assessment of the CCO's compliance based on the analysis of treatment limitations applied, including the CCO's parity rating by treatment limitation type.

Table P-1—Overall Treatment Limitation Review Results by Treatment Limitation Type

OR 2023 MHP Treatment Limitation Review Element	CCO Compliance Rating
Financial Requirements (FRs)	*NA*
Aggregate Lifetime and Annual Dollar Limits (AL/ADLs)	*NA*
Quantitative Treatment Limitations (QTLs)	*NA*
Non-Quantitative Treatment Limitations (NQTLs)	*Compliant*
Availability of Information	*Compliant*
Overall Compliance Rating	***Compliant***

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the compliance rating is not applicable.

Overall, the CCO demonstrated compliance with MHP requirements and standards related to treatment limitations used by the organization to manage MH/SUD and M/S benefits. Key findings for each treatment limitation review element included:

Financial Requirements

YCCO reported the CCO does not apply any FRs or payments from members for services received that are in addition to payments made by the State (e.g., copayments, coinsurance, deductibles, or out-of-pocket maximums) for IP, OP, Rx, or EC for MH/SUD or M/S benefits.

Aggregate Lifetime and Annual Dollar Limits

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

Quantitative Treatment Limitations

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

Non-Quantitative Treatment Limitations

Table P-2 presents a summary of the NQTLs implemented by the CCO, including compliance with parity requirements.

Table P-2—Parity Result by Specific Treatment Limitation Type and Benefit and Service Type

NQTL	Applicable Benefit and Service Type								Parity Rating
	MH/SUD				M/S				
	IP	OP	Rx	EC	IP	OP	Rx	EC	
Medical Management	X	X			X	X			*Compliant*
Provider Network									*NA*
Pharmacy Management			X				X		*Compliant*
Other: Not applicable									*NA*

NA—The CCO reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the parity rating is not applicable.

Medical Management

- YCCO's policies included standardized processes that applied to both MH/SUD and M/S benefits, including a Utilization Management Handbook and Level of Utilization Management Decision policy.
- The CCO indicated practice guideline criteria was not applicable for either MH/SUD or M/S benefits; however, the Availability of Information, Section 6, of the *2023 MHP Treatment Limitation Review Tool* listed the practice guideline criteria used for MH/SUD and M/S benefits.
- For limits applied to IP and OP health benefits, YCCO used utilization management (UM) processes to manage MH/SUD and M/S benefits. The CCO's UM processes were designed to ensure the delivery of services to members in a quality-oriented, timely, medically appropriate, and cost-efficient manner. YCCO reported that the evidence used to apply UM to MH/SUD and M/S benefits included OARs, the HERC Prioritized List of Health Services and guidelines, American Society of Addition Medicine (ASAM) criteria, and InterQual criteria. The processes, strategies, and evidentiary standards used in applying Medical Management NQTLs to MH/SUD benefits in the IP

and OP classifications were comparable to the evidentiary standards used in administering NQTLs to M/S benefits in the same classifications. The CCO used nationally recognized and evidence-based medical necessity criteria for MH/SUD and M/S benefits in the two classifications to administer its processes with equivalent stringency.

Provider Network

- YCCO reported the CCO does not apply NQTLs related to the provider network, including admission standards, reimbursement rates, restrictions based on geographic location/specialty requirements/facility types, network tiers, or OON providers for IP, OP, Rx, or EC for MH/SUD or M/S benefits.

Pharmacy Management

- YCCO identified the use of a formulary design for prescription drugs, which was applied to both MH/SUD that are not included in the carve-out list and M/S benefits. The CCO's formulary was designed to provide appropriate, safe, and cost-effective medications. There were no tiers or cost-sharing for prescription drug benefits. The CCO's formulary design decisions were consistent with applicable State and federal regulatory requirements. The CCO's formulary design for MH/SUD prescription drugs was comparable and no more stringently applied for M/S prescription drugs.

Other NQTLs

- No additional NQTLs were identified by the CCO.

Availability of Information

YCCO reported disseminating medical necessity criteria through the member handbook, provider handbook, the CCO's website, the annual member letter, YCCO member FAQ, and the provider portal. The member handbook informed the members that OHP's covered benefits and treatments are based on a list of conditions and services named the Prioritized List of Health Services, which is ranked by the Health Evidence Review Commission. The CCO's Notice of Adverse Benefit Determination informed members of their ability to request free copies of the criteria and standards used in making coverage determinations.

Administrative Data Profile

Claims

Table P-3 presents a summary of the results from the analysis of paid claims by service and benefit type. In general, YCCO showed a moderate difference (5.9 percentage points) in the percentage of paid claims between MH/SUD (87.8 percent) and M/S (81.9 percent) services. However, the percentage of paid claims for IP showed a moderate difference (6.9 percentage points), where MH/SUD claims were paid less frequently than M/S claims. In addition, substantial differences were noted in percentages of total paid, OON claims (20 percentage points) as well as in individual OON IP (22.1 percentage points)

and OP (20.1 percentage points) paid claims, where MH/SUD OON claims were paid less frequently than M/S claims.

Table P-3—Number and Percentage of Claims by Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims[1]		Out-of-Network Paid Claims[1]	
		Number	Number	Percent	Number	Percent
IP	MH/SUD	1,687	1,198	71.0%	26	28.0%
	M/S	26,071	20,317	77.9%	1,212	50.1%
OP	MH/SUD	137,036	120,633	88.0%	1,042	34.8%
	M/S	445,297	365,641	82.1%	25,636	54.9%
Total	**MH/SUD**	**138,723**	**121,831**	**87.8%**	**1,068**	**34.6%**
	M/S	**471,368**	**385,958**	**81.9%**	**26,848**	**54.6%**

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.

Utilization Management

Table P-4 presents a summary of the results from the analysis of PAs by service and benefit type. No substantial differences in the percentage of denied M/S and MH/SUD PAs were found that would have suggested an MH parity concern. Due to the low number of PA denials that were appealed (excluding Rx), results associated with the percentages of PA denials appealed, appeals overturned, hearings, and hearings overturned should be interpreted with caution, including any assessment of parity.

Table P-4—Prior Authorization Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals[1]		Hearings[1]	
		Total	Denied		Total Percent[2]	Overturned Percent	Total Percent	Overturned Percent
			Number	Percent[2]				
IP	**MH/SUD**	460	35	7.6%	0.0%	NA	0.0%	NA
	M/S	2,294	77	3.4%	100%	60.0%	20.0%	0.0%
OP	**MH/SUD**	438	55	12.6%	7.6%	30.8%	0.0%	NA
	M/S	7,677	1,082	14.1%	92.4%	21.4%	0.0%	NA
Rx	**MH/SUD**	502	218	43.4%	0.0%	NA	0.0%	NA
	M/S	1,610	920	57.1%	100%	35.5%	0.0%	NA

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

[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.

Provider Enrollment

Table P-5 presents a summary of the results from the analysis of provider enrollment and terminations. YCCO showed a negligible difference (0.1 percentage points) in the percentage of provider applications approved in CY 2022. The CCO exhibited a substantial difference (14.8 percentage points) in the percentages of terminated providers; however, in this case, M/S providers were terminated at higher rates (24.0 percent) than MH/SUD providers (10.8 percent).

Table P-5—CY 2022 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	218	100%	286	10.8%
M/S	2,440	99.9%	939	24.0%

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table P-6 presents the total number of providers in network, total number of MH/SUD providers contracted with the CCO, and the percentage of all providers in the network identified as MH/SUD providers. The table also indicates whether the change from Q2 2022 to Q1 2023 resulted in a substantial increase (i.e., ↑, or 10 percent) or decrease (i.e., ↓, or 10 percent) in the total number of MH/SUD providers. The data represent a calendar difference of approximately nine months to one year. Although a comparative review of the distribution of providers showed significant changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

YCCO showed substantial increases in both MH and SUD providers between Q2 2022 and Q1 2023. At the same time, the CCO's overall network increased by approximately 907 providers. While the increase in provider counts was due to improved data quality, other factors likely contributed to the increase in MH and SUD provider numbers, including efforts described by the CCO to increase enrollment of MH/SUD providers in response to network gaps, changes to study methodology, and taxonomic transitions.

Table P-6—Number and Percentage of MH/SUD Practitioners by Quarter and Provider Type

Provider Type	Q2 2022			Q1 2023			Difference	
	All Providers (N)	Provider (N)	Providers (%)	All Providers (N)	Provider (N)	Providers (%)	Provider (N)	Percent Change
MH	7,728	1,868	24.2%	8,635	2,382	27.6%	514	27.5% ↑
SUD	7,728	304	3.9%	8,635	417	4.8%	113	37.2% ↑

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

Provider-to-Member Ratios

Table P-7 presents the provider-to-member ratios for MH and SUD providers in Q1 2023

Table P-7—Provider-to-Member Ratios by Benefit and Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	2,382	8,996	1:4
SUD	417	3,947	1:10

Time and Distance

Table P-8 presents the average time and distance to the nearest three MH and SUD providers by setting urbanicity (i.e., urban or rural). The state-established time and distance standards are 30 minutes/30 miles in urban settings and 60 minutes/60 miles in rural settings for at least 95.0 percent of members. The CCO met the rural time and distance access requirements for average time and distance to the nearest three MH and SUD providers. The

Table P-8—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Geography

Provider Type	Urban						Rural					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	1.9	2.2	2.9	1.7	2	2.6	4.2	4.6	4.7	3.9	4.3	4.4
SUD	3.2	3.6	3.6	2.8	3.2	3.2	5.4	13.1	13.4	5.0	12.0	12.1

Table P-9 presents the percentages of CCO members with access to MH and SUD services by urbanicity. The CCO demonstrated 100 percent access to MH and SUD providers in urban and rural settings.

Table P-9—Time and Distance Results by Geography

MH		SUD	
Urban	Rural	Urban	Rural
100%	100%	100%	100%

Appointment Availability

AH monitored appointment availability for both M/S and MH/SUD providers. However, the CCO's evidence of implementation showed low survey efficacy, and the CCO explained it was working to correct the effectiveness of its survey Monitoring activities described and demonstrated by the CCO as part of its *DSN Provider Narrative Template* included:

- Quarterly provider surveys subdivided by provider type.
- Grievance monitoring.

Access-Related Grievances

Table P-10 presents the percentage of access-related grievances compared to the overall number of grievances for MH and SUD services. The CCO showed a low percentage of grievances (3.4 percent) that were associated with MH/SUD services and benefits. Of those grievances, less than 20.0 percent were related to access issues. These low results should be interpreted with caution due to the overall low number of MH/SUD grievances. Additionally, due to the nature of the clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan, contributing to the low number of grievances.[P-1]

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

Total Grievances	MH/SUD		MH/SUD Access-Related Grievances	
	Number	Percent	Number	Percent
322	11	3.4%	2	18.2%

[P-1] It t is important to note that grievances are an inherently limited monitoring tool for CCOs, given that members must have both the means and the inclination to file a grievance. These results reinforce OHA's guidance that grievance monitoring, while required and valuable, likely captures only a fraction of members' overall experiences and should not be used as the only mechanism for monitoring network adequacy and decision making.

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2023 MHP Evaluation, MH/SUD and M/S benefits administration was found to be in parity for YCCO. While the evaluation identified several opportunities for improvement, results did not identify any systemic issues that negatively affected parity between MH/SUD and M/S services. Rather, findings frequently highlighted general regulatory compliance issues affecting both MH/SUD and M/S benefits uniformly. Individual CCO results were used to identify the following strengths, weaknesses, and recommendations with respect to the quality, timeliness, and accessibility of health care services.

Strength/ Weakness	Description	Domain(s)
⊕	**Strength:** YCCO achieved full compliance with parity requirements for application of NQTLs applied to MH/SUD and M/S benefits.	🔑
⊖	**Weakness:** YCCO reported conflicting information in the *2023 MHP Treatment Limitation Review Tool.* **Why the weakness exists:** The CCO reported it has not applied the practice guideline criteria for treatment limitation to any service classification of MH/SUD benefits; however, the CCO listed that clinical practice guidelines are utilized to make medical necessity determinations for MH/SUD benefits in the Availability of Information, Section 6, of the *2023 MHP Treatment Limitation Review Tool*. **Recommendations:** YCCO should identify all treatment limitations applied to MH/SUD benefits.	🔑
⊖	**Weakness:** YCCO showed substantial differences in the percentages of paid, OON MH/SUD IP and OP claims compared to M/S IP and OP claims. Although differences in the percentage of paid claims may be legitimate, they may also highlight procedural or network differences indicating potential barriers to members' access to MH/SUD services. **Why the weakness exists:** OON IP and OP MH/SUD claims were paid less frequently than M/S claims. **Recommendations:** YCCO should review OON claim denials to understand the factors affecting the lower percentages of paid MH/SUD IP and OP claims compared to M/S IP and OP claims. The CCO should assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside the CCO's network (e.g., appointment availability).	⏱️🔑

= Quality, ⏱️ = Timeliness, 🔑 = Access

Appendix Q. MHP Results for Oregon Health Plan Fee-for-Service (OHP FFS)

Treatment Limitation Review

The following results highlight the types of treatment limitations used by OHP FFS to manage the administration of MH/SUD and M/S covered benefits and assess whether documentation demonstrated compliance with MHP requirements in how they were applied to MH/SUD and M/S services and benefits. A *Compliant* rating indicates the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency*. A *Not Compliant* rating indicates the organizational structure did not meet comparability or stringency criteria. In contrast, a *Partially Compliant* rating indicates the limitation was either comparable or applied with similar stringency, but not both. In general, *Partially Compliant* findings resulted from insufficient information or clear evidence of parity associated with selection of the NQTLs and the consistency and stringency with which the treatment limitations were applied to MH/SUD and M/S benefits across service types (i.e., inpatient [IP], outpatient [OP], pharmacy [Rx] or emergency care [EC]). Table Q-1 presents a summary of HSAG's assessment of Oregon Health Plan Fee-for-Service (OHP FFS) compliance based on the analysis of treatment limitations applied, including the organization's parity rating by treatment limitation type.

Table Q-1—Overall Treatment Limitation Review Results by Treatment Limitation Type

OR 2023 MHP Treatment Limitation Review Element	OHP FFS Compliance Rating
Financial Requirements (FRs)	*NA*
Aggregate Lifetime and Annual Dollar Limits (AL/ADLs)	*NA*
Quantitative Treatment Limitations (QTLs)*	*NA*
Non-Quantitative Treatment Limitations (NQTLs)	*Not Compliant*
Availability of Information	*Partially Compliant*
Overall Compliance Rating	***Partially Compliant***

NA—OHP FFS reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits, therefore, the compliance rating is not applicable.

*QTLs identified by OHP FFS were soft limits based on medical necessity or medical appropriateness and were subsequently reviewed as NQTLs.

OHP FFS demonstrated partial compliance with MHP requirements and standards related to treatment limitations used to manage MH/SUD and M/S benefits. However, these results did not identify any systemic issues that negatively affected parity between the administration of MH/SUD and M/S services. Rather, OHP FFS' findings highlighted general regulatory compliance issues related to documentation and demonstration of implementation that affected both MH/SUD and M/S benefits uniformly. Key findings for each treatment limitation review element included:

Financial Requirements

OHP FFS reported it does not apply any FRs or payments from members for services received that are in addition to payments made by the State (e.g., copayments, coinsurance, deductibles, or out-of-pocket maximums) for IP, OP, Rx, or EC for MH/SUD or M/S benefits.

Aggregate Lifetime and Annual Dollar Limits

OHP FFS reported it does not apply AL/ADLs on the total amount of a specified benefit over a lifetime or annually for IP, OP, Rx, or EC for MH/SUD or M/S benefits.

Quantitative Treatment Limitations

OHP FFS listed QTLs for MH/SUD benefits within its *2023 MHP Treatment Limitation Review Tool*, such as quantity limits on personal care attendants, drug testing, and IP psychiatric therapy hospital care. However, the QTLs for the services listed were not hard limits on services and benefits since the coverage determination process allowed individuals to exceed numerical limits based on medical necessity. Therefore, the QTLs identified by OHP FFS were evaluated for parity as NQTLs.

Non-Quantitative Treatment Limitations

Table Q-2 presents a summary of the NQTLs implemented by the organization, including compliance with parity requirements.

Table Q-2—Parity Results by Specific Treatment Limitation Type and Benefit and Service Type

NQTL	Applicable Benefit and Service Type								Parity Rating
	MH/SUD				M/S				
	IP	OP	Rx	EC	IP	OP	Rx	EC	
Medical Management	X	X	X		X	X	X		*Not Compliant*
Provider Network	X	X	X		X	X			*Not Compliant*
Pharmacy Management			X				X		*Not Compliant*
Other: Not Applicable									*NA*

NA—OHP FFS reported it has not applied this treatment limitation to any service classification for MH/SUD or M/S benefits; therefore, the parity rating is not applicable.

In general, OHP FFS was unable to provide documented evidence to demonstrate that standardized NQTL processes and procedures were in place to ensure that NQTLs were comparable and not applied more stringently for MH/SUD benefits compared to M/S benefits. As a result, a comprehensive evaluation of parity could not be performed. Specific results within each NQTL category are presented below.

Medical Management

- OHP FFS' documentation and tool responses were limited to listing references to regulatory requirements and coverage guidelines when defining the NQTLs used to manage members' health care services—i.e., OARs and the HERC *Prioritized List of Health Services*. OHP FFS also provided a link to its *Prior Authorization Handbook*; however, this handbook was a provider-facing document that included instructions for providers to submit PA requests. Without supporting documentation (e.g., internal policies, procedures, processes, standard operating procedures, and workflows) to demonstrate how the treatment limitations were implemented and applied to MH/SUD and M/S benefits, OHP FFS was unable to demonstrate that NQTLs were comparable and not applied more stringently for MH/SUD benefits compared to M/S benefits. The lack of standardized processes and procedures resulted in a *Not Compliant* finding.

Provider Network

- OHP FFS identified provider enrollment, credentialing, and recredentialing as provider network NQTLs, along with reimbursement rates, geographic restrictions, and specialty requirements. However, geographic restrictions and specialty requirements were limited to M/S providers and not relevant to the parity evaluation.
- For provider enrollment/credentialing and reimbursement rates, OHP FFS documentation and tool responses were limited to listing references to OARs, fee schedules, and a link to the OHP Provider Enrollment website. Without supporting documentation (e.g., internal policies, procedures, processes, standard operating procedures, and workflows) to demonstrate how these treatment limitations were implemented and applied to MH/SUD and M/S providers, OHP FFS was unable to demonstrate whether these NQTLs were in parity. The lack of documented processes and procedures resulted in a *Not Compliant* finding.

Pharmacy Management

- OHP FFS implemented several pharmacy management NQTLs, including PA for prescriptions; determining usual, customary, and reasonable charges; formulary design; and benefit tiers. However, OHP FFS' documentation and tool responses were limited to listing references to regulatory requirements and a link to the OHP website when defining the NQTLs it used to manage members' MH/SUD and M/S pharmacy benefits. Without supporting documentation (e.g., internal policies, procedures, processes, standard operating procedures, and workflows) to demonstrate how the treatment limitations were implemented and applied to MH/SUD and M/S pharmacy benefits, OHP FFS was unable to demonstrate that the NQTLs were comparable and not applied more stringently for MH/SUD benefits compared to M/S benefits. The lack of documented processes and procedures resulted in a *Not Compliant* finding.

Other NQTLs

- No additional NQTLs were identified by OHP FFS.

Availability of Information

OHP FFS disseminated medical necessity criteria through the member handbook, provider handbook, and the OHP FFS website. OHP FFS' Notice of Adverse Benefit Determination informed members of the ability to request free copies of criteria and standards used in making coverage determinations. The member handbook listed the services requiring PA; however, it did not include information regarding medical necessity criteria or provide instructions on how to obtain the information. This lack of information resulted in a *Partially Compliant* finding.

Administrative Data Profile

Claims

Table Q-3 presents a summary of the results from the analysis of paid claims by service and benefit type. Overall, OHP FFS showed a substantial difference (13.6 percentage points) in the percentage of paid claims between MH/SUD (61.2 percent) and M/S (47.6 percent) services, with a greater percentage of MH/SUD claims being paid compared to M/S claims. However, substantial differences between the percentage of paid MH/SUD claims and paid M/S claims were noted for IP and OP claims (13.6 percentage points and 13.7 percentage points, respectively). Of those, the percentage of paid IP MH/SUD claims (31.8 percent) was substantially lower than the percentage of paid IP M/S claims (45.4 percent). Additionally, when compared to the CCOs, OHP FFS paid a substantially smaller percentage of submitted claims for both IP and OP services (i.e., 30.4 percentage points and 40.9 percentage points, respectively). However, caution should be used when interpreting these results as differences may be due to alternative payors (e.g., Medicare and CCOs) responsible for primary payment. Due to the structure of OHP FFS' provider network, all enrolled providers are considered IN; as a result, claims analyses were not conducted by provider network status.

Table Q-3—Number and Percentage of Claims by Benefit Type

Service Type	Benefit Type	Total Claims	Paid Claims[1]		Out-of-Network Paid Claims[1]		CCO Aggregate Paid Claims
		Number	Number	Percent	Number	Percent	
IP	MH/SUD	3,434	1,091	31.8%	NR	NR	83.4%
	M/S	55,640	25,255	45.4%	NR	NR	83.8%
OP	MH/SUD	776,301	476,011	61.3%	NR	NR	91.9%
	M/S	3,347,223	1,594,265	47.6%	NR	NR	88.7%
Total	**MH/SUD**	**779,735**	**477,102**	**61.2%**	NR	NR	91.6%
	M/S	**3,402,863**	**1,619,520**	**47.6%**	NR	NR	88.5%

NR—indicates appeals data were not reported by OHP FFS.

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

Utilization Management

Table Q-4 presents a summary of the results from the analysis of PAs by service and benefit type. Across all service types, a greater percentage of M/S PAs were denied compared to MH/SUD PAs for IP and OP service types. However, there was a moderate difference (8.5 percentage points) in the percentage of denied Rx PAs between MH/SUD (27.0 percent) and M/S (18.5 percent) benefits. Unlike the CCOs, OHP FFS did not have an appeals level for IP or OP PA denials; rather, all appeals to an adverse benefit determination were treated as a contested State hearing. Among Rx appeals, there was a moderate difference of 9.6 percentage points in the percentage of overturned Rx appeals between MH/SUD (65.8 percent) and M/S (75.4 percent) benefits. Moreover, although a low percentage of PA denials resulted in a hearing, there was a substantial difference (33.5 percentage points) in the percentage of OP denials overturned via hearing between MH/SUD (75.0 percent) and M/S (41.5 percent), suggesting that a higher percentage of MH/SUD PA requests may have been denied inappropriately compared to M/S PA requests. However, caution should be used when interpreting these results due to the small number of denials resulting in a hearing.

Table Q-4—Prior Authorization Results by Service Type and Benefit Type

Service Type	Benefit Type	Prior Authorization			Appeals		Hearings	
			Denied					
		Total	Number	Percent[1]	Total Percent[2]	Overturned Percent	Total Percent	Overturned Percent
IP	MH/SUD	2,005	7	0.3%	NR	NR	0.0%	NA
	M/S	929	194	20.9%	NR	NR	0.0%	NA
OP	MH/SUD	3,937	107	2.7%	NR	NR	0.8%	75.0%
	M/S	4,081	859	21.0%	NR	NR	4.2%	41.5%
Rx	MH/SUD	7,949	2,143	27.0%	52.7%	65.8%	1.7%	20.0%
	M/S	11,177	2,066	18.5%	47.3%	75.4%	4.7%	28.6%

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

NR—indicates appeals data were not reported by OHP FFS.

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

Provider Enrollment

Table Q-5 presents a summary of the results from the analysis of provider enrollment and terminations. OHP FFS had no data for provider applications. OHP FFS exhibited a substantial difference (11.9 percentage points) in the percentage of terminated providers; however, MH/SUD providers were terminated at a lower rate (8.3 percent) than M/S providers (20.2 percent).

Table Q-5—CY 2022 Provider Enrollment and Terminations by Benefit Type

Benefit Type	Enrollment/Credentialing/Recredentialing Applications		Terminations	
	Number Received	Percent Approved	Number	Percent
MH/SUD	NR	NR	1,935	8.3%
M/S	NR	NR	16,467	20.2%

Note: OHP FFS data systems did not track incoming provider applications by MH/SUD and M/S provider types. As such, OHP FFS was excluded from the analysis of application approvals.
NR—indicates provider enrollment data were not reported by OHP FFS.

Adequacy of MH/SUD Provider Networks

Provider Network Capacity

Provider Counts

Table Q-6 presents the total number of MH and SUD providers contracted with OHP FFS. Trend analysis was not possible in 2023 since OHP FFS provider data were not available in 2022. OHP FFS only submitted data for MH/SUD providers; therefore, M/S and MH/SUD provider totals and the percentage of the network represented by MH/SUD providers could not be calculated.

Table Q-6—Number and Percentage of MH/SUD Practitioners by Quarter and Provider Type

Provider Type	Q2 2022			Q1 2023			Difference	
	All Providers (N)	Provider (N)	Providers (%)	All Providers (N)	Provider (N)	Providers (%)	Provider (N)	Percent Change
MH	NR	NR	NR	104,964	6,933	6.6%	NA	NA
SUD	NR	NR	NR	104,694	1,013	1.0%	NA	NA

NA—indicates a denominator of zero; results could not be calculated.
NR—indicates provider data were not reported by OHP FFS.

Provider-to-Member Ratios

Table Q-7 presents the provider-to-member ratios for MH and SUD providers in Q1 2023.

Table Q-7—Provider-to-Member Ratios by Benefit and Provider Type

Provider Type	Providers (N)	Members (N)	Ratio
MH	6,933	127,890	1:19
SUD	1,013	19,226	1:19

Time and Distance

Table Q-8 presents the average time and distance to the nearest three MH and SUD providers by urbanicity (i.e., urban or rural). The state-established time and distance standards are 30 minutes/30 miles in urban settings and 60 minutes/60 miles in rural settings for at least 95.0 percent of members. OHP FFS met the urban and rural time and distance access requirements for average time and distance to the nearest three MH and SUD providers.

Table Q-8—Average Time and Distance to the Nearest Three MH/SUD Providers by Provider Type and Geography

Provider Type	Urban						Rural					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
MH	1.2	1.5	1.8	1.0	1.2	1.4	4.3	5.4	6.9	4.0	4.9	6.4
SUD	2.6	3.3	3.5	2.0	2.6	2.7	8.4	11.3	13.6	7.7	10.4	12.4

Table Q-9 presents the percentages of OHP FFS members with access to MH and SUD services by urbanicity. OHP FFS met the time and distance standards for access to MH and SUD providers in urban and rural settings.

Table Q-9—Time and Distance Results by Geography

MH		SUD	
Urban	Rural	Urban	Rural
100%	>99.9%	>99.9%	99.8%

Appointment Availability

OHP FFS did not monitor appointment availability for any provide types.

Access-Related Grievances

OHP FFS did not maintain a centralized repository of grievances, nor did it track and categorize the types of grievances received. As such, OHP FFS was unable to effectively monitor or extract grievances for reporting and monitoring.

Summary of Overall Strengths, Weakness, and Recommendations

Based on the findings outlined in the 2023 MHP Evaluation, OHP FFS results suggested several opportunities for improvement in the administration and monitoring of parity between MH/SUD and

M/S benefits. Specifically, because of the lack of documented policies and procedures, along with limitations associated with information systems, OHP FFS was unable to fully demonstrate that treatment limitations for MH/SUD services were comparable to and were applied no more stringently than the limitations applied to M/S benefits. Due to the lack of information, a comprehensive assessment of parity could not be performed; however, when available, the results did not identify systemic issues that negatively affected parity between MH/SUD and M/S services. Rather, findings frequently highlighted general regulatory compliance issues affecting both MH/SUD and M/S benefits uniformly. OHP FFS' results were used to identify the following strengths, weaknesses, and recommendations with respect to the quality, timeliness, and accessibility of health care services.

Strength/ Weakness	Description	Domain(s)
+	**Strength:** No strengths were identified for OHP FFS.	
−	**Weakness:** OHP FFS received *Not Compliant* parity findings for medical management, provider network, and pharmacy management NQTLs that were implemented. **Why the weakness exists:** OHP FFS' tool responses and documentation were limited to listing regulatory requirements and links to OHP website pages when defining the NQTLs used to manage members' MH/SUD and M/S benefits. Documentation did not demonstrate that the process and requirements used to apply treatment limitations to MH/SUD benefits were comparable and applied no more stringently than the limitations applied to M/S benefits. **Recommendations:** OHP FFS should develop and maintain internal policies, procedures, processes, standard operating procedures, workflows, etc., that address the selection, implementation, and monitoring of all treatment limitations used by the organization to ensure they are comparable and applied no more stringently to MH/SUD benefits than to M/S benefits.	
−	**Weakness:** OHP FFS was unable to submit all the required provider enrollment data for the 2023 MHP Analysis. **Why the weakness exists:** MH/SUD and M/S provider enrollment practices and outcomes cannot be evaluated if relevant data are not collected, readily tracked, differentiated, and reported. This places inherent limitations on OHP FFS' ability to internally monitor and evaluate the parity of provider credentialing and/or contracting operations. **Recommendations:** OHP FFS must update or modify its administrative systems to capture additional data elements (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, HSAG recommends that OHP FFS work with OHA and its contractor to map available data fields to required MHP evaluation data elements.	

Strength/ Weakness	Description	Domain(s)
	OHP FFS must implement these changes in order to support future MHP reporting requirements.	
–	**Weakness:** OHP FFS was unable to identify and submit all the required grievance data for the 2023 MHP Analysis. **Why the weakness exists:** Grievances cannot be evaluated if relevant data are not collected, readily tracked, differentiated, and reported. This places inherent limitations on OHP FFS' ability to internally monitor and evaluate grievances by benefit type and category (i.e., access-related). OHP FFS does not currently maintain a centralized repository of grievances, nor does it track and categorize the types of grievances received. **Recommendations:** OHP FFS must update or modify its administrative systems to capture and distinguish both MH/SUD and M/S grievances, including the ability to define/categorize the type of grievances received regardless of department and/or vendor.	🔑
–	**Weakness:** OHP FFS does not currently monitor appointment availability of its contracted providers, or their compliance with regulatory requirements. **Why the weakness exists:** OHP FFS has not established the mechanisms or methodology to collect, evaluate, and report on the availability of appointments for MH/SUD and/or M/S services. **Recommendations:** OHP FFS should implement mechanisms to capture and report on the availability of appointments by provider type in alignment with State administrative rules and federal standards.	🔑
–	**Weakness:** OHP FFS showed substantial differences in the percentage of paid MH/SUD IP claims compared to paid M/S IP claims. Although differences in the percentage of paid claims may be legitimate, they may also highlight procedural differences that indicate potential barriers to members' access to MH/SUD services. **Why the weakness exists:** The percentage of paid MH/SUD IP claims was substantially lower than the percentage of paid M/S IP claims. **Recommendations:** OHP FFS should review claim denials to understand factors affecting the lower percentage of paid MH/SUD IP claims compared to paid M/S IP claims. OHP FFS should assess whether any barriers exist for members accessing MH/SUD services.	🔑

= Quality, = Timeliness, = Access

Appendix R. MHP Community Partner Feedback

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

Consumers

- April 12, 2023
  - Reported access barriers to receiving care, including the inability to sign up for or receive OHP coverage.
  - Consumer experience and interactions with providers remained a central concern for consumers, including the availability of culturally responsive care providers. Many consumers expressed the need for more inclusive providers.
- November 8, 2023
  - Requested greater representation of the member's voice within the study metrics and interpretation of findings.
  - Conveyed importance of the follow-up after emergency department visit for MH/SUD diagnosis should be with a provider that is meaningful for the member.

CCOs

- May 23, 2023
  - Increased focus on network adequacy and understanding the availability of network data.
  - Understanding reimbursement rate differences, including greater transparency in provider rates and rate methodologies.
  - Understanding the differences in MH/SUD and M/S benefits.
  - Recommended OHA focus on the intent of the law and to convene joint CP meetings that include all three CP groups instead of three separate sessions.
- October 24, 2023
  - CCOs reiterated interest in having OHA convene a joint CP meeting that includes all parties instead of holding separate sessions.
- CCOs were provided with an opportunity to provide written feedback on individual results between November 17, 2023, and December 5, 2023. [Insert summary of feedback.]

Providers

- April 11, 2023

  - Update billing practices to reflect clinical practice, including:
    - Allowing MH providers to bill for multiple assessment visits prior to billing and finalizing diagnosis.
    - Allowing members to attend more than one group session per day; policies currently limit payments to providers for only one group session.
  - Investigate coverage disparities between CCOs, OHP FFS, and other payers for MH/SUD services—e.g., peer support services. Providers noted that CCOs do not currently pay for these services.
  - Review timeliness of CCO payments for MH and SUD services.
  - Requested clarification on current or future restrictions surrounding telehealth services, including understanding differences in the implementation of telehealth services for MH/SUD and M/S services.
  - Review inpatient discharge, referral, and care management for behavioral health services.
    - M/S care coordination and management services are more established leading to gaps in the quality/appropriateness of MH/SUD care coordination services.
    - Inpatient/residential discharge planning and follow-up for the coordination of downstream services is limited for MH/SUD services.
- November 15, 2023
  - Agreed with targeting coverage and payment differences between CCO and OHP FFS for select MH and SUD services, including, but not limited to, peer support services, MH residential services, crisis respite, and subacute crisis respite.
  - Expressed importance of looking beyond compliance with regulatory standards and understanding impact on members.
  - Examine network adequacy based on participation status of contracted providers—i.e., IN, single use agreement, OON—and its impact on the availability of services.
  - Assess payment patterns across CCOs and OHP FFS associated with billing of services—i.e., multiple services with the same provider on the same day.
  - Evaluate payment patterns for OON providers and the potential for any enhanced payment structures which may increase network adequacy and improve access for MH services.

Appendix S. Statewide Denial Reasons

Table S-1 and Table S-2 show the statewide aggregate percentage of denial reasons for all service types (i.e., IP, OP, and Rx) and by benefit (i.e., MH/SUD and M/S) for all PA requests, including the distribution for total denials (i.e., MH/SUD and M/S combined). Results in the table are sorted in descending order from the most to least frequent denial reason.

Table S-1—Statewide PA Denial Reasons by Benefit

	Total		MH/SUD		M/S	
	N	%	N	%	N	%
Does Not Meet Criteria	52,482	41.5%	5,456	60.1%	47,026	40.0%
Not a Covered Benefit	33,638	26.6%	615	6.8%	33,023	28.1%
Treatment Limitation	15,779	12.5%	1,852	20.4%	13,927	11.9%
Service is *Below the Line*	12,202	9.6%	195	2.1%	12,007	10.2%
Administrative Denial	5,994	4.7%	513	5.7%	5,481	4.7%
Out-of-Network Provider	4,041	3.2%	293	3.2%	3,748	3.2%
Unknown	2,366	1.9%	148	1.6%	2,218	1.9%

Table S-2—Statewide PA Denial Reasons by Service Type and Benefit

Denial Reason	IP						OP						Rx					
	Total		MH/SUD		M/S		Total		MH/SUD		M/S		Total		MH/SUD		M/S	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Does Not Meet Criteria	1,229	53.1%	248	81.6%	981	48.8%	30,268	45.5%	606	41.6%	29,662	45.5%	20,985	36.4%	4,602	62.9%	16,383	32.6%
Not a Covered Benefit	286	12.3%	2	0.7%	284	14.1%	23,379	35.1%	147	10.1%	23,232	35.7%	9,973	17.3%	466	6.4%	9,507	18.9%
Treatment Limitation	480	20.7%	21	6.9%	459	22.8%	2,116	3.2%	180	12.4%	1,936	3.0%	13,183	22.9%	1,651	22.6%	11,532	22.9%
Service is *Below the Line*	18	0.8%	0	0.0%	18	0.9%	3,245	4.9%	17	1.2%	3,228	5.0%	8,939	15.5%	178	2.4%	8,761	17.4%
Administrative Denial	220	9.5%	25	8.2%	195	9.7%	1,965	3.0%	164	11.3%	1,801	2.8%	3,809	6.6%	324	4.4%	3,485	6.9%
Out-of-Network Provider	30	1.3%	1	0.3%	29	1.4%	3,821	5.7%	288	19.8%	3,533	5.4%	190	0.3%	4	0.1%	186	0.4%
Unknown	53	2.3%	7	2.3%	46	2.3%	1,794	2.7%	53	3.6%	1,741	2.7%	519	0.9%	88	1.2%	431	0.9%