Oregon Medicaid Mental Health Parity Analysis
System-Wide Overview

Oregon Health Authority

HEALTH SYSTEMS DIVISION

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Oregon HEALTH PLAN

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Introduction

Mental health parity (MHP) regulations are intended to ensure coverage and access to services treating substance use disorders and mental health conditions. The required analysis of mental health benefits is governed by federal regulations.

The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 governs how mental health (MH) and substance use disorder (SUD) treatments are delivered in group health plans. MHPAEA requires that plans ensure that limitations on mental health or substance use disorder (MH/SUD) benefits are comparable to and applied no more stringently than the limitations applied to medical and surgical (M/S) benefits. Provisions of MHPAEA became applicable to the Oregon Health Plan (OHP) in October 2017 when the Medicaid Parity Final Rule (CMS-2333-F) went into effect.

- The rule requires parity in key areas:
    - Aggregate lifetime and annual dollar limits;
    - Finanical requirements (FR - such as copays);
    - Quantitative treatment limitations (QTL - such as visit limits);
    - Non-quantitative treatment limitations (NQTL - such as prior authorization).

The rule requires that limitations in the areas mentioned above are not more restrictive for MH/SUD than for M/S, for members:

- In a managed care organization (such as a CCO);
- Covered by the Children´s Health Insurance Program (CHIP);
- Covered under the Affordable Care Act (ACA).

To meet the requirements of the law, the Oregon Health Authority (OHA) and Oregon's 15 coordinated care organizations (CCOs) must show that limitations (such as day limits, prior authorization requirements, or network admission standards) for MH and SUD services are comparable to and applied no more stringently than those for M/S services.

Oregon Medicaid overview

The Oregon Health Authority (OHA) acts as Oregon's single state Medicaid agency. It oversees administration of medical assistance in Oregon. Low-income Oregonians receive Oregon Health Plan (OHP) coverage, funded primarily through Medicaid and the Children's Health Insurance Program (CHIP). In 2014, Oregon expanded OHP eligibility by implementing provisions of the Affordable Care Act (ACA).

Benefits

Medicaid, CHIP and ACA populations receive the same benefit package, OHP. OHP is the main benefit package and includes M/S and MH/SUD services such as, but not limited to:

- Addiction treatment;
- Diagnostic services;
- Hospital care;
- Medical care including shots and checkups;
- Maternity, prenatal, and newborn care;
- Medical equipment and supplies;

- Mental health care;
- Office visits (e.g., doctor, nurse, etc.)
- Physical, occupational and speech therapy; and
- Prescription drugs.

These benefits are provided in accordance with the Prioritized List of Health Services, developed by the Health Evidence Review Commission. The list places a priority on prevention in order to avoid disease and future medical conditions altogether to the greatest extent possible.

Delivery systems

OHA contracts with private companies, primary care providers and clinics to provide comprehensive coordination and management for medical, dental and mental health care. To deliver these services, there are two delivery systems:

- Managed care: OHA pays contracted managed care entities a monthly financial allotment for each enrolled member, whether or not the member gets services in that month.
- Fee-for-service (FFS): OHA pays contracted providers a fee for each service they deliver to members.

Coordinated care organizations

In 2012, coordinated care organizations (CCOs) became the primary managed care model. Locally established throughout Oregon, each CCO operates on its own global budget with a methodology that allows for growth at a fixed rate from year to year. CCOs are accountable for the health outcomes of the population they serve. OHA and the federal government monitor these outcomes closely.

As of February 1, 2018, OHA had contracts with 15 CCOs to provide comprehensive physical, oral and behavioral health services to the OHP population:

1. Advanced Health
2. AllCare
3. Cascade Health Alliance
4. Columbia Pacific CCO
5. Eastern Oregon CCO
6. Health Share of Oregon
7. Intercommunity Health Network
8. Jackson County Connect
9. PacificSource – Central
10. PacificSource – Gorge
11. PrimaryHealth of Josephine County
12. Trillium Community Health
13. Umpqua Health Alliance
14. Willamette Valley Community Health
15. Yamhill Community Care

Fee-for-Service

Fee-For-Service means the state directly pays enrolled providers for each service performed. This applies to:

- OHP members who are not enrolled in managed care; and
- Services paid by OHA (not the CCO) for all OHP members, known as carve-outs. Carve-outs include some waivered services such as the 1915(c) benefit; drugs in standard therapeutic classes 7

(ataractics-tranquilizer) and 11 (psychostimulants-antidepressants); and Depakote, Lamictal and their generic equivalents.

Newly eligible OHP members may use the Fee-for-Service delivery system to access care until they complete CCO enrollment. Approximately 10 percent of the OHP population remains FFS, meaning they do not get enrolled in CCOs for various reasons (such as federal law, state policies and CCO availability in certain parts of the state).

Use of multiple delivery systems

M/S and MH/SUD services under the OHP benefit are the same for all members, although they may receive their services through multiple delivery systems. CCO members have specific levels of enrollment that determine whether they access care through a CCO or the FFS system.

- CCOA: MH/SUD, M/S and dental health care are covered by a CCO.
- CCOB: MH/SUD and M/S are covered by a CCO.
- CCOE: MH/SUD is covered by a CCO. M/S and dental care are covered FFS.
- CCOG: MH/SUD is covered by a CCO. M/S is covered FFS.

For the purposes of mental health parity analysis, CCOA and CCOB benefits are grouped together, and CCOE and CCOG are grouped together.

Mental health parity analysis process

Oregon's MHP analysis process evaluates OHP delivery systems to ensure that limitations on MH/SUD benefits are comparable to and applied no more stringently than the limitations applied to M/S benefits. Under the parity rule, MHP requirements apply to all OHP benefits delivered through managed care and FFS delivery systems.

This analysis is based on the guidance outlined in the toolkit provided by the Centers for Medicare & Medicaid Services (CMS): *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*.

Benefit mapping

The first step in the MHP analysis is to determine which services are defined as MH/SUD and which are M/S. MH/SUD services are those that are used to treat a MH/SUD diagnosis, and M/S services are those used to treat a M/S diagnosis. For the purpose of Oregon Medicaid's parity analysis, the current International Classification of Diseases (ICD-10) has been adopted for mapping conditions into M/S and MH/SUD buckets.

For the purpose of Oregon's MHP analysis:

- Mental health benefits means benefits for items or services for mental health conditions listed in ICD-10 Chapter 5 (F), except for subchapter 1 (F01-09, mental disorders due to known physiological conditions), subchapter 2 (F10-F19, Mental and Behavioral disorders due to psychoactive substance use) and subchapter 8 (Intellectual disabilities).
- Substance use disorder benefits means benefits for items or services for substance use disorder conditions listed in ICD-10 Chapter 5 (F) subchapter 2 (F10-F19, Mental and Behavioral disorders due to psychoactive substance use).
- Benefits used to treat all other ICD-10 diagnoses are considered medical/surgical.

Benefits are assigned to M/S or MH/SUD groupings based on the ICD-10-CM diagnosis, not according to who is providing the service or which delivery system is being used. For example, an ER visit to address a MH/SUD diagnosis is considered a MH/SUD benefit and an ER visit to address a M/S diagnosis is considered an M/S benefit.

MH/SUD, and M/S benefits are then mapped into four classifications: inpatient, outpatient, prescription drug and emergency care. OHA developed the Oregon Mapping Guide to define how CCOs and OHA assign services to these classifications for the purpose of MHP analysis.

Analysis of dollar limits and financial requirements

MHP analysis requires a review of dollar limits and financial requirements that apply to MH/SUD benefits. These include aggregate lifetime (AL) and annual dollar limits (ADL), and financial requirements (FR).

Aggregate lifetime and annual dollar limits

Aggregate lifetime (AL) and annual dollar limits (ADL) place a cap on the dollar benefits an individual consumer may receive. ALs and ADLs set a fixed limit to the benefit amount in a year or in the consumer's lifetime. ALs and ADLs cannot be applied to MH/SUD benefits unless they are applied to one third of M/S benefits. These limits cannot be more restrictive for MH/SUD than those applied to M/S benefits.

OHP does not permit the use of ALs or ADLs. OHA reviewed the policies and operations of its FFS system for ALs and ADLs. Each CCO also reviewed its policies and operations for ALs and ADLs. The result of this review yielded no instances of ALs or ADLs in the Oregon Medicaid delivery system.

Financial requirements

Financial requirements (FR) require consumers to pay to access services. FRs include fees such as copays, coinsurance and deductibles. The MHP rule requires a comparison of FRs for MH/SUD and M/S benefits.

OHP does not permit the use of FRs. OHA reviewed the policies and operations of its FFS system for FRs. Each CCO also reviewed its policies and operations for FRs. The result of this review yielded no instances of FRs in the OHP delivery system.

Analysis of treatment limitations

Quantitative treatment limitations (QTLs) and non-quantitative treatment limitations (NQTLs) are also analyzed.

Quantitative treatment limitations

QTLs impose hard numerical limits to the scope or duration of a service. Examples of QTLs include visit, day or unit limits where there is no avenue for increasing the benefit beyond a fixed limit. The rule holds that no QTL can be applied to MH/SUD services that is more restrictive than a QTL applied to M/S services in that classification.

Oregon Medicaid does not permit the use of QTLs. OHA reviewed the policies and operations of its FFS system for QTLs. OHA created and deployed a data collection worksheet to assist CCOs in identifying QTLs. Each CCO also reviewed its policies and operations for QTLs. The result of this review yielded no instances of QTLs in the OHP delivery system.

Non-quantitative treatment limitations

NQTLs are health care management limitations such as prior authorization or certain provider network requirements. The rule holds that no NQTL can be applied to MH/SUD services that is not comparable to or is

more stringent than those applied to M/S services in that classification, in regards to processes, strategies, evidentiary standards, or other factors. This standard is applied to a NQTL's policies and procedures as written, and in operation.

Comparability is assessed by classification (e.g., inpatient, outpatient). The comparison is between services addressing a M/S diagnosis and services addressing a MH/SUD diagnosis. The process evaluates the reason a NQTL is used, the evidence that supports its use, and the process for its implementation. The stringency criterion evaluates the rigor of the review process, the evidence for the level of stringency and the consequences when a limitation is applied.

NQTL parity analysis:

- Evaluates whether M/S and MH/SUD limits are applied using comparable methods and similar levels of evidence in support of applying the limit and specific rationales and evidence for how stringently the limit is applied.
- Requires the collection of detailed information about how CCOs and the FFS systems apply these limitations in policy and in operation.

NQTL types

OHA examined five NQTLs in the OHP delivery system.

- Provider admission to network limits: Provider admission criteria impose limits to providers seeking to join a panel of approved providers. Such limits include: closed networks, credentialing, requirements in addition to state licensing, and exclusion of specific provider types.
- Prior authorization for prescription drug limits: Prior authorization is a means of determining whether dispensing medication will be authorized. Prior authorization of prescription drugs limits the availability of specific medications.
- Out-of-network/out-of-state limits: Out-of-network and out-of-state limits affect how members access out of network and out of state providers and address how CCOs may ensure the orderly access to providers not in a CCO network.
- Utilization management limits applied to inpatient services: Utilization management (UM) is typically implemented through prior authorization, concurrent review, and retrospective review (RR). Utilization management may be used to ensure medical necessity of treatments for MH/SUD and M/S treatments. These limits may be analyzed separately for inpatient and outpatient services.
- Utilization management limits applied to outpatient services: Utilization management limits may be applied to both outpatient and inpatient treatments.

NQTL data collection

In the first phase of the NQTL analysis, OHA developed data collection worksheets based on guidance outlined in the CMS parity toolkit, *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*. OHA assisted CCOs in gathering operational and policy information to support mental health parity assessments. OHA provided technical assistance in the form of webinars, FAQs, and one-to-one technical assistance calls. All CCOs submitted this documentation prior to October 2017.

In the second phase, OHA developed a questionnaire for each NQTL based on a CMS sample NQTL analysis for UM. For each CCO, OHA:

- Populated the applicable NQTL questionnaire with information provided by the CCO in Phase 1 as well as information about FFS benefits

- Identified specific additional information needed from the CCO and included questions and prompts to help the CCO gather the needed information. The questions and prompts were tailored to collect the additional information necessary for the NQTL analysis based on the COO and FFS information already collected
- Reviewed the revised questionnaires and then conducted individual calls via webinar to discuss the updated information and any outstanding questions
- Documented updates to the questionnaires in real-time
- Followed up by email as needed to clarify or collect additional information

NQTL analysis

OHA used the information from the updated questionnaires to compare the processes, strategies, evidentiary standards and other factors for each MH/SUD NQTL as it applies to MH/SUD benefits and M/S benefits, in writing and in operation, in a classification, for each benefit package. The processes, strategies, evidentiary standards and other factors were reviewed for comparability and stringency in writing and in operation.

Mental health parity findings

OHA has completed a systematic review of dollar limits, financial requirements and quantitative and non-quantitative treatment limitations on MH/SUD benefits.

Dollar limits

The State complies with the rule for the AL and ADL limitation type because no ALs or ADLs were found. No compliance steps are required.

Financial requirements

The State complies with the rule for the FR limitation type because no FRs were found. No compliance steps are required.

Quantitative treatment limitations

The State complies with the rule for the QTL limitation type because no QTLs were found. No compliance steps are required.

Non-quantitative treatment limitations

Provider admission to network

OHA collected and reviewed documentation and information regarding the following potential provider admission NQTLs:

- Closed network
- Network credentialing
- Requirements in addition to state licensing
- Provider exclusions

Based upon the documentation and information, there was no evidence of provider admission limitations due to requirements in addition to state licensing or provider exclusions. Accordingly, Oregon's analysis focused on the two remaining NQTLs: Closed Network and Network Credentialing.

For benefit packages A and B, analysis can be conducted for CCO managed MH/SUD benefits and M/S benefits, since both MH/SUD and M/S providers are admitted to the CCO network and the CCO may apply network limits. In contrast, provider network admission limits do not apply to FFS benefits. For that reason, Oregon's analysis for provider admission was completed for the CCO managed benefits in benefit packages CCOA and CCOB (not the carved out MH/SUD services), and the analysis for benefit packages CCOE/CCOG was not conducted.

Closed network

Four CCOs reported that they may close their provider networks to new inpatient MH/SUD and M/S providers, and eight CCOs said they may close their network to new outpatient MH/SUD and M/S providers. No CCOs reported closing their network to only MH/SUD providers. Based on a review of the reasons why CCOs close their provider network, the evidence used by the CCOs to close their network, and the processes used by the CCOs to close their network, OHA determined that the CCOs that close their network do so in compliance with parity.

CCOs close their network when they determine they have an adequate network in order to balance meeting member access to care needs with cost effectiveness and cost control. Four CCOs also use a closed network as a strategy to promote efficiency in provider monitoring and improve provider relations. CCOs apply network closure in accordance with federal regulations and state rules. All CCOs assess network needs and gaps by monitoring network adequacy data and information, such as time and distance standards, provider capacity reports, specialty providers, unmet needs, complaints and grievances, and out-of-network (OON) requests. CCOs all use a committee structure (credentialing, board or network staff) to determine whether to close (or open) the network to new providers. When the CCO closes the network to new providers, providers are denied admission into the CCO network. However, all but two CCOs apply limited exceptions for providers who demonstrate specialized services that fill a particular need. Most CCOs reported that no MH/SUD providers were denied network admission in the last contract year based upon network closure; in comparison, the number of denied MH/SUD providers is significantly fewer than that of denied M/S providers.

Credentialing

All CCOs require inpatient and outpatient MH/SUD and M/S providers to meet credentialing and re-credentialing requirements to participate in network. OHA reviewed the reasons why CCOs credential or re-credential providers, the evidence used by the CCOs for their credentialing/re-credentialing criteria, and the processes used by the CCOs to credential and re-credential providers. Based on this review, OHA determined that the CCOs apply credentialing and re-credentialing in compliance with parity.

The purpose of conducting credentialing and re-credentialing is to meet federal and state requirements, ensure that providers are able to deliver high quality of care, ensure provider meets minimum competency standards, and ensure members receive safe, medically necessary care. All but two CCOs follow credentialing requirements in national accreditation guidelines (NCQA or URAC). CCOs require MH/SUD and M/S providers to meet credentialing and re-credentialing requirements in order to be admitted to and continue to participate in the CCO's network. The information and documentation new providers are required to complete and submit as part of the credentialing process is substantially the same, and both MH/SUD and M/S providers are given several methods of submitting their application and supporting documentation. The CCOs' credentialing process consistently involves the review and verification of the application and supporting documentation by CCO staff, with the final decision making authority resting with the CCO board or credentialing committee. The credentialing process timeframe for both MH/SUD and M/S providers varies across CCOs, ranging from 2 weeks to 65 days for MH/SUD providers and 2 week to 90 days for M/S providers. Differences in the average length of credentialing and re-credentialing processes were between CCOs. Within each CCO, the average length of time for credentialing and re-credentialing MH/SUD providers was comparable to or less than for M/S providers. Re-credentialing for both MH/SUD and M/S providers is conducted at least every three years, with

the exception of one CCO, which conducts re-credentialing for MH/SUD and M/S providers at least every two years. Failure of MH/SUD and M/S providers to meet credentialing and re-credentialing requirements results in exclusion from the CCO's network. All but one CCO have an appeal process in place for MH/SUD and M/S providers to challenge credentialing and re-credentialing decisions. OHA will work with the CCO that does not appear to have an appeal process in place for providers to challenge credentialing and re-credentialing decision to develop a corrective action plan. Within each CCO, MH/SUD providers have been less impacted by credentialing and re-credentialing denials and terminations than their M/S provider counterparts.

Prior authorization for prescription drugs

All CCOs require prior authorization (PA) of certain MH/SUD and M/S prescription drugs, and OHA requires PA of certain MH carve out drugs. OHA reviewed the reasons why CCOs and OHA apply PA criteria to certain MH/SUD and M/S prescription drugs, the evidence used to establish PA criteria, and the processes used by the CCOs and OHA to develop and apply PA criteria. Based on this review OHA determined that, for all CCOs and the state, application of PA criteria to certain MH/SUD and M/S drugs is in compliance with parity requirements.

CCOs apply PA to promote the appropriate and cost-effective use of both MH/SUD and M/S prescription drugs. The state applies PA to certain MH FFS carve out drugs to promote appropriate treatment. While the state does not consider cost in developing PA criteria for MH drugs, this is less stringent than M/S so is not a parity concern. Evidence used by the CCOs and the state to determine which MH/SUD and M/S drugs are subject to PA includes FDA prescribing guidelines, medical evidence, best practices, professional guidelines, and P&T Committee review and recommendations. PA requests for both MH/SUD and M/S drugs may be submitted by fax and at least one other mode (online, phone, and/or mail) and are responded to within 24 hours. For both MH/SUD and M/S drugs, most PA criteria require clinical documentation such as chart notes. Failure to obtain PA for MH/SUD and M/S drugs subject to prior authorization may result in no reimbursement for the drug. Overall, the percent of MH/SUD drugs subject to PA requirements is comparable to M/S drugs. In addition, the percent of PA denials that are overturned on appeal are comparable for MH/SUD and M/S drugs.

Out-of-network/out-of-state limits

All CCOs provide out-of-network (OON) and out-of-state (OOS) benefits, and OHA provides OOS benefits. OHA reviewed the reasons why CCOs and OHA establish standards for non-emergency OON/OOS benefits, the evidence used to establish the standards, and the application of those standards. Based on this review, OHA determined that the state and all but one CCO is in compliance with parity requirements for benefit packages A and B. OHA will work with the one CCO that does not appear to be providing OON/OOS benefits in accordance with parity to develop a corrective action plan as needed.

Four CCOs have an open network for both MH/SUD and M/S. This means that any service delivered by an OON Medicaid provider is treated identically to network providers from a coverage standpoint. In other words, if the benefit is covered and properly delivered, billed and authorized, the provider will be paid for those services at the FFS rate. The purpose of having an open network is to ensure that members have access to appropriate quality care. Two of the CCOs with an open network require prior authorization for OOS for both MH/SUD and M/S benefits. The other two CCOs with an open network require prior authorization for OOS for M/S benefits but not MH/SUD benefits. For these two CCOs, given that the requirement for MH/SUD is less stringent than for M/S, this is not a parity concern. For the CCOs without an open network, the CCO seeks to maximize the use of in-network providers because the CCO's provider network consists of local providers that have been credentialed and contracted with the CCO. While the state has not established a network of MH/SUD providers, the state seeks to maximize the use of in-state providers for similar reasons.

The CCO's purpose for providing OON and/or OOS coverage (as applicable to the CCO) is to provide needed MH/SUD and M/S benefits when they are not available in-network or in-state (as applicable). Similarly, for

MH/SUD FFS benefits, the state provides OOS coverage to provide needed benefits when they are not available in-state. For both MH/SUD and M/S non-emergency OON and/or OOS benefits (as applicable to the CCO), the CCO (and the state for FFS MH/SUD OOS benefits) requires prior authorization to determine medical necessity and to ensure no in-network/in-state providers are available to provide the benefit. OON/OOS coverage requirements are based on federal and state requirements, including OAR (for both the state and the CCO) and the CCO contract (for the CCO).

Requests for non-emergency MH/SUD and M/S OON and/or OOS benefits (as applicable to the CCO/state) are made through the CCO/state prior authorization process and are reviewed for medical necessity and in-network/in-state coverage. The prior authorization timeframes (14 days for standard requests and 72 hours for urgent requests) apply. OOS FFS MH/SUD providers are reimbursed the Medicaid FFS rate. If the OOS FFS MH/SUD provider is not enrolled in Oregon Medicaid, the provider must enroll in Oregon Medicaid. Similarly, all the CCOs require OON/OOS providers to be enrolled with Oregon Medicaid. Several CCOs stated that if the OON/OOS MH/SUD or M/S provider does not agree to the FFS rate, then the CCO will establish a single case agreement (SCA). Two CCOs also establish a SCA at the provider's request.

For both MH/SUD and M/S, if a request for a non-emergency OON and/or OOS benefit (as applicable to the CCO/state) does not meet applicable criteria, it will not be authorized, and/or payment for the service will be denied by the CCO/state. Members and providers may appeal the denial of OON/OOS authorization requests/non-payment of OON/OOS services to the CCO/state as applicable. While the state does not have statistics regarding OOS requests, most of the CCOs provided information on MH/SUD and/or M/S OON/OOS requests, denials, and appeal overturn rates. For those that provided information on both MH/SUD and M/S OON/OOS requests, the information on denial rates and appeal overturn rates is comparable.

Similar to the analysis for benefit packages A and B, OHA reviewed the reasons why CCOs and OHA establish standards for non-emergency OON/OOS benefits, the evidence used to establish the standards, and the application of those standards. Based on this review, OHA determined that, for benefit packages E and G, the state and all but two CCOs apply OON/OOS standards in compliance with parity requirements. OHA will work with the two CCOs that do not appear to be providing OON/OOS benefits in compliance with parity to develop a corrective action plan as needed.

Utilization management limits applied to inpatient services

All MH/SUD and M/S inpatient (IP) benefits require notification (emergency admissions), PA and/or concurrent review (CR) to confirm coverage, assure services are medically necessary and delivered in the least restrictive environment, which also reduces overutilization of these high cost services. Qualified individuals review documentation that supports the medical necessity of an MH/SUD and M/S authorization request relative to OARs, HERC PL and guidelines, and evidence-based medical necessity or level-of-care criteria (e.g., ASAM). The frequency of MH/SUD and M/S IP UM is tied to the individual's condition, the treatment setting, reimbursement approach and the expected rate of improvement or anticipated discharge. The failure to obtain authorization may result in non-coverage. In addition to federally required appeal and fair hearing processes, retrospective review (RR), reconsideration and other exception processes are available when authorization requests are denied. For both MH/SUD and M/S the stringency with which UM is conducted is monitored through appeal overturn rates, supervision, chart review or formal inter-rater reliability testing. Based on the parity review, OHA plans to strengthen the evidence base for certain medical necessity criteria and the frequency of UM, standardize RR and appeal processes, improve the consistency of criteria application and assure only peers make denial determinations for MH/SUD. Inclusive of the OHA action plans, the application of UM to IP MH/SUD benefits in benefit packages A, B, E and G is compliant with parity requirements.

Utilization management limits applied to outpatient services

Utilization management of outpatient MH/SUD and M/S Home and Community-Based Services (HCBS) benefits is required to meet federal requirements that Person-Centered Service Plans (PCSPs) provide benefits in the least restrictive environment. A qualified team that includes the participant develops PCSPs within 90 days for both MH/SUD and M/S. The PCSP is based on an assessment and other relevant supporting documentation and is reviewed no less than annually. The failure to obtain authorization may result in non-coverage. Federally required appeal and fair hearing processes are available to members when authorization requests are denied; and RR or reconsideration processes are also available for certain MH/SUD benefits. For both MH/SUD and M/S the stringency with which outpatient UM is conducted is monitored through quality reviews and appeal overturn rates.

Some non-HCBS MH/SUD and M/S outpatient services are assigned UM because medical necessity review offers an opportunity to confirm coverage, evaluate the safety of certain outpatient services and/or prevent overutilization that has been identified by specific medical necessity criteria or in utilization reports. Qualified individuals review documentation that supports the medical necessity of a MH/SUD and M/S authorization request relative to OARs, the Prioritized List of Health Services and Guideline Notes, and evidence-based medical necessity criteria. The frequency of MH/SUD and M/S UM is tied to the individual's condition and the expected rate of improvement. The failure to obtain authorization may result in non-coverage. In addition to federally required appeal and fair hearing processes, RR, reconsideration and other exception processes are available when authorization requests are denied. For both MH/SUD and M/S, the stringency with which outpatient UM is conducted is monitored through appeal overturn rates, supervision, chart review or formal inter-rater reliability testing. Based on the parity review, OHA plans to strengthen the evidence base for certain medical necessity criteria and the frequency of UM, standardize RR and appeal processes, improve the consistency of criteria application and assure only peers make denial determinations for MH/SUD. Inclusive of the OHA action plans, the application of UM to outpatient MH/SUD HCBS and non-HCBS benefits in benefit packages A, B, E and G is compliant with parity requirements.

Availability of information

The MHP rule has two requirements for the availability of information for MH/SUD benefits:

1. The criteria for medical necessity determinations; and

2. The reason for any denial of a MH/SUD benefit.

Criteria for medical necessity determinations

Under parity, the criteria for medical necessity determinations for MH/SUD benefits must be made available to consumers and contracted providers upon request. Oregon CCOs are already subject to a similar requirement under Medicaid managed care rules (42 CFR §438.236(c)). CMS has indicated that entities operating under the managed care rules will be deemed compliant with the parity rule.

Criterial for medical necessity determinations may be requested as follows:

CCO	Medical Necessity Contact
Advanced Health	Benefitinfo@advancedhealth.com
AllCare Health	behavioralhealth@allcarehealth.com
Cascade Health Alliance	MHSUDBenefits@cascadecomp.com
Columbia Pacific CCO	cswebcolumbia@careoregon.org
Eastern Oregon CCO	memberservices@gobhi.net

CCO	Medical Necessity Contact
Health Share of Oregon	MHParity@healthshareoregon.org
Intercommunity Health Network	carecoordinationteam@samhealth.org
Jackson Care Connect	cswebjackson@careoregon.org
PacificSource - Central Oregon	Communitysolutionscs@pacificsource.com
PacificSource - Columbia Gorge	Communitysolutionscs@pacificsource.com
PrimaryHealth	info@primaryhealthfamily.com
Trillium Health	MMCS@Trilliumchp.com
Umpqua Health	UHAMemberServices@UmpquaHealth.com
Willamette Valley Community Health CCO	info@mvipa.org
Yamhill Community Care Organization	bhauthorizations@co.yamhill.or.us

Criteria for medical necessity determinations for the Fee-for-service system may be requested from bhpocpa.auths@dhsoha.state.or.us.

Reason for any denial of services

The reason for any denial of payment for a MH/SUD benefit must be made available to the consumer. CCOs must provide a notice of adverse benefit determination, including the right of the enrollee to receive the reason for any denial of payment (as in 42 CFR §438.404).

Oregon Medicaid implements this requirement in Oregon Administrative Rule under the Notice of Adverse Benefit Determination Requirements rule (OAR 410-141-3240). This OAR may be viewed at https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=239762.

Ongoing monitoring

Ongoing monitoring of mental health parity is built into OHA processes. The contracts governing CCOs already require that CCOs comply with federal regulation. The 2018 CCO contract includes the requirement that CCOs comply with the provisions of the Medicaid Parity Final Rule (CMS-2333-F). CCO delivery systems will be monitored using the CCO compliance structure. OHA will conduct a review of the OHP delivery system on an annual basis.

Acronyms for Mental Health Parity Reports/Assessments

AL/ADLs	Aggregate Lifetime or Annual Dollar Limits
ASAM	American Society of Addiction Medicine
CCO	Coordinated Care Organization
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CR	Concurrent Review
FDA	Food and Drug Administration
FFS	Fee-for-Service
FR	Financial Requirement
HCBS	Home and Community-Based Services
HSD	Health Systems Division
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
IP	Inpatient
M/S	Medical/Surgical
MCG®	Milliman Care Guidelines®

MH	Mental Health
MHPAEA	Mental Health Parity and Addiction Equity Act
NCQA	National Committee for Quality Assurance
NQTL	Non-Quantitative Treatment Limitation
OHA	Oregon Health Authority
OON	Out of network
OOS	Out of state
OP	Outpatient
P&T	Pharmacy and Therapeutics
PA	Prior Authorization
QTL	Quantitative Treatment Limitation
RR	Retrospective Review
SPA	State Plan Amendment
SUD	Substance Use Disorder
UM	Utilization Management