Summary Analysis of Mental Health Parity in Oregon Medicaid

Update to the Oregon Medicaid
Mental Health Parity Analysis
System-Wide Overview

Oregon Health Authority
HEALTH SYSTEMS DIVISION
Medicaid Programs

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Oregon HEALTH PLAN

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Executive summary

The Oregon Health Authority (OHA) has assessed the Oregon Health Plan (OHP) delivery system's compliance with federal mental health parity (MHP) requirements (CMS 2333-F). The analysis covered each of the coordinated care organization's (CCO) and OHA's fee-for-service (FFS) system.

This compliance activity provides several opportunities to strengthen the system and improve the quality of member care. The parity assessment process:

- Identifies and addresses more restrictive policies and standards for mental health and substance use disorder (MH/SUD) benefits as compared to medical/surgical (M/S) benefits.
- Requires both CCOs and OHA to systematically review their MH/SUD and M/S policies and practices and address any concerns.
- Fosters MH/SUD and M/S collaboration and coordination.
- Reveals specific areas of focus for improving the delivery and administration of MH/SUD benefits.

Action plans for identified parity concerns

As a result of the analysis, CCOs and OHA are addressing several areas for improvement through action plans that list solutions being considered and how the CCOs and OHA plan to ensure parity. OHA's FFS action plan addresses FFS-specific concerns and systemic concerns.

Action plans will be completed by December 31, 2018 to address the following:

- Updating medical necessity criteria (MNC) to reflect evidence-based standards
- Evaluating how often criteria are applied in accordance with evidence-based standards
- Evaluating and testing the consistency with which medical necessity criteria are applied
- Ensuring professional peers make denials
- Standardizing retrospective review timelines and conditions
- Ensuring that all contractors follow appropriate notice of action (NOA) and appeals processes

Action plans will be completed by March 31, 2019 to address the following:

- Testing the consistency of MNC application
- Ensuring the comparability in network admission criteria for out-of-network/out-of-state (OON/OOS) MH/SUD and M/S providers

Improvements in the Oregon Medicaid system

Any differences in how limits are applied to MH/SUD as compared to M/S benefits must be based on evidence, rather than standard practice. In this way, compliance with parity improves access to evidence-based, quality MH/SUD care. Specific improvements resulting from this analysis include:

- Increased quality of utilization management (UM) practices regarding MNC, the frequency of review and how consistently MNC are applied.
- Increased opportunities for collegial consultation regarding potential denials (must be a professional peer that makes a denial determination).
- Increased confidence that prior authorization is not being over-utilized.

- Comparability in the length of time and the conditions under which retrospective review is permitted for MH/SUD and M/S services.
- Increased confidence that Oregon Medicaid is in compliance with notice of action (NOA) and appeals processes for all services.
- Comparability in network admission criteria for out-of-network/out-of-state (OON/OOS) MH/SUD and M/S providers.

Continued parity compliance:

Compliance with the MHP regulations is enforced by the State via new language in the CCO and other contracts, the OHA-led assessment and action plans, and continued monitoring activities. OHA is in the process of developing a monitoring system to include a screening tool that CCOs and FFS will complete on an annual basis to determine the need for an updated parity assessment.

Background

The Oregon Health Authority has recently conducted a review of the Oregon Health Plan (OHP) benefits provided to individuals enrolled in a coordinated care organization (CCO) or in the fee-for-service (FFS) system, to determine compliance with the federal mental health parity (MHP) requirements (CMS 2333-F, also known as parity).

Federal parity requirements (CMS-2333-F)

Parity requires that limits on mental health and substance use disorder (MH/SUD) benefits, such as therapy sessions, are no more restrictive than those applied to medical/surgical (M/S) benefits, such as primary care doctor visits.

This means that limits can be applied to MH/SUD benefits, but they must pass certain tests to show they are similarly applied to M/S benefits.

There are three types of benefit limits that must meet parity requirements.

Dollar limits and financial requirements

Parity analysis requires a review of dollar limits and financial requirements that apply to MH/SUD benefits.

- Dollar limits are aggregate lifetime (AL) and annual dollar limits (ADL). ALs and ADLs set a fixed dollar 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 at least one third of M/S benefits. OHP does not permit the use of dollar limits.
- 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 dollar limits and FRs. Each CCO also reviewed its policies and operations for dollar limits and FRs. The result of this review yielded no instances of dollar limits or FRs in the Oregon Medicaid delivery system.

The State complies with the parity requirements for dollar limits and FRs because no dollar limits or FRs are applied. No action plans are required.

Quantitative treatment limits (QTLs)

QTLs are numerical limits (e.g., 30 visits per year) that impose without exception "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 receiving additional services beyond the limit. The Mental Health Parity Final Rule states that no QTLs can be applied to MH/SUD services that are more restrictive than QTLs applied to M/S services in a classification.

Oregon Medicaid does not permit the use of QTLs for MH/SUD services. OHA created and deployed a QTL data collection worksheet for the Oregon Medicaid system and reviewed the policies and operations

of its FFS system for QTLs. Each CCO also reviewed its policies and operations for QTLs. The result of this review yielded no instances of QTLs being applied to MH/SUD services in the OHP delivery system.

The State complies with the parity requirements for QTLs because no QTLs apply to MH/SUD services. No action plans are required.

Non-quantitative treatment limits (NQTLs)

NQTLs are non-numerical benefit limits such as prior authorization, network admission standards and step therapy for prescription drugs. Parity requires that if an NQTL is applied to MH/SUD benefits, it is applied in a comparable manner for M/S benefits and is not applied more stringently to MH/SUD benefits. Differences in how limits are applied to MH/SUD as compared to M/S benefits must be based on evidence, rather than standard practice. In this way, compliance with parity improves access to evidence-based, quality MH/SUD care.

For example:

- When a CCO or OHA reviews a prior authorization request, the CCO or OHA determines whether the service is "medically necessary." This decision is made by comparing the provider's request to medical necessity criteria.
- MNC pull together information about what services work best for which conditions, how much of a service/item is needed, and whether a person should be admitted to a facility to receive the service.
- Medical necessity review is often conducted as part of a utilization management program, which identifies the most cost-effective approach to medically necessary treatment. UM preserves funds and resources to make sure medically necessary services are available to members that need them.

Parity requires that when a CCO or FFS conducts a medical necessity and utilization review, it applies UM and MNC in a comparable manner; and no more stringently to MH/SUD requests for benefits than to M/S requests for benefits.

Note that this comparison is made within each CCO individually, not across the entire Oregon Medicaid system. So, one CCO can conduct UM differently than another CCO and still comply with parity.

NQTL types

OHA employed a contractor (Mercer) to examine the following 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 coverage of medication will be authorized. Prior authorization of prescription drugs may limit 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 provide access to providers not in a CCO network.

- **Utilization management limits applied to inpatient and outpatient services:** UM is typically implemented through prior authorization, concurrent review, and retrospective review (RR). Utilization management processes are applied to ensure the medical necessity and cost-effectiveness of MH/SUD and M/S benefits. UM may limit the availability and amount of benefits for certain individuals.

OHA's NQTL analysis results

OHA evaluated the NQTLs listed above and identified several parity concerns. The CCOs and OHA FFS were required to submit action plans that specified the solutions they were considering, the steps they would take to implement those solutions and achieve parity compliance and the date the plan would be completed.

CCOs and OHA developed an action plan for each parity concern. For example, the evidence supporting medical necessity determinations was a common concern across CCOs and OHA.

- In an action plan, a CCO might choose to evaluate whether to buy evidence-based MNC or to develop it internally. The CCO would then list the steps for implementing each approach and the expected completion dates.
- Steps in this example might include: assessing the feasibility of developing criteria internally; evaluating vendors offering third party criteria; contracting with a vendor; and implementing the criteria.

Four CCOs (Cascade Health Alliance, Columbia Pacific CCO, Eastern Oregon CCO, and Jackson Care Connect) had no parity findings resulting from this analysis and do not require a parity action plan. InterCommunity Health Network has already completed their action plan.

Following are the action items; the CCOs or FFS that must submit action plans to address the action item; and a brief discussion of the strategies being considered to address the concern. The action plans and associated progress are also summarized in Appendix A.

Action Item: Alignment of the evidence base for medical necessity criteria (MNC)

If UM reviewers use evidence-based criteria for M/S benefits, they must also use evidence-based criteria (not clinical discretion) for MH/SUD benefits.

Review results

Five CCOs (AllCare, Health Share of Oregon, PrimaryHealth of Josephine County, Umpqua Health Alliance and Willamette Valley Community Health) and OHA FFS must:

- Review and update the criteria they use to approve or deny requests for MH/SUD benefits; and
- Ensure that the criteria are evidence-based.

All other CCOs meet parity requirements for MNC.

Strategies to address the action item

CCOs have indicated that they will either purchase third party criteria from a MNC vendor or develop their own evidence-based criteria. The FFS system is also investigating the use of third party criteria or transferring the management of services lacking evidence-based MNC to a contractor that uses them. Four of the five CCOs and FFS will each select one of these options and implement by December 31, 2018. The fifth CCO, Umpqua, will implement third party criteria from a MNC vendor by March 31, 2019.

Action Item: How often MNC are applied (frequency of review)

If medical necessity reviews of inpatient (IP) or outpatient (OP) MH/SUD benefits are conducted more frequently than medical necessity reviews of IP or OP M/S benefits, parity would require evidence that the more frequent review is needed for IP or OP MH/SUD benefits.

Review results

Five CCOs (Advanced Health, AllCare, Health Share of Oregon, PrimaryHealth of Josephine County and Willamette Valley Community Health) and OHA (FFS) must review and strengthen the evidence supporting the frequency of medical necessity review of MH/SUD benefits.

All other CCOs meet parity requirements for this item.

Strategies to address the action item

CCOs will either use their own historical utilization data to establish the best frequency of review (e.g., consistent with expected time to improve) or purchase this information from a third-party vendor. FFS will either purchase this information from a vendor, utilize its own historical data or transfer services without evidence-based frequency of review to qualified contractors that conduct UM frequency consistent with evidence. CCOs and FFS will each select one of these options and implement the selected option by December 31, 2018.

Action item: The consistency of MNC application

If the standard for consistent MNC application is lower for MH/SUD than M/S, this could indicate less consistent application of MNC for MH/SUD. Thus, the standard should be the same for MH/SUD and M/S.

Review results

Four CCOs (AllCare, Health Share of Oregon, PacificSource and Willamette Valley Community Health) and OHA (FFS) must align their MH/SUD and M/S standards for consistent UM criteria application. InterCommunity Health Network and Trillium Community Health completed their action plans for this item.

All other CCOs meet parity requirements in this area.

Strategies to address the action item

CCOs will either purchase internal consistency testing modules or ensure that existing consistency of application standards are aligned between MH/SUD and M/S services.

- The consistency of MNC application was one of the more challenging concerns to address for the smallest CCOs, where a single reviewer often reviewed all MH/SUD prior authorizations. If only

one reviewer applies criteria for a single CCO, it is difficult to assess how consistent his or her application is with other reviewers.

- To address this challenge, smaller CCOs may combine the MH/SUD and M/S consistency of application processes (with at least one reviewer each) or recruit a licensed supervisor to be a second reviewer.

For FFS services without a process for ensuring consistent application of MNC, OHA will create or purchase internal standards and policies, or have a contractor with these standards manage those services.

CCOs and FFS will each select one of these options by December 31, 2018 and complete initial testing by March 31, 2019.

Action item: Whether professional peers make denials

If only M/S providers licensed by the State to provide a service may determine that the service is not medically necessary, then only MH/SUD providers licensed by the State to provide a MH/SUD service can determine that the MH/SUD service is not medically necessary.

Review results

Two CCOs (Advanced Health and PrimaryHealth of Josephine County) and OHA (FFS) must ensure that only a professional peer (someone who is qualified to provide or order the requested service) makes MH/SUD denial determinations. Advanced Health and PrimaryHealth have implemented their changes for this action item and currently meet parity requirements.

All other CCOs meet parity requirements for this item.

Strategies to address the action item

OHA will implement policies that require professional peers to make denial decisions. If internal professionals are not available, external contractors could provide this service as well. OHA will ensure that policies requiring the use of professional peers to make denial decisions are in place and that resources to carry them out are identified by December 31, 2018.

Action item: Comparable retrospective review (RR) timelines and conditions

Retrospective review allows a provider to make a late authorization request without having to go through an appeal process to do so. The conditions or timeframes for RR of M/S benefits cannot be more favorable than for RR of MH/SUD benefits.

Review results

All CCOs meet parity in this area. FFS must align timeframes for RR of M/S and MH/SUD benefits.

Plan to address the action item

OHA must standardize the availability of RR for MH/SUD and M/S benefits. The alignment of MH/SUD and M/S Oregon Administrative Rules (OARs) dealing with RR is in process and will assist in the

standardization of RR conditions and timelines. Amendment of relevant OARs will be completed by December 31, 2018.

Action item: Contractors follow Notice of Action (NOA) and appeal process

The parity assessment process suggested that NOA and appeals are an area that may require further analysis.

Review results

OHA must ensure that all CCOs and OHA FFS contractors provide notices of action/adverse benefit determination, and that appeal/fair hearing processes are available, as required by federal regulations.

Plan to address the action item

OHA will be addressing NOA and appeal process concerns by implementing a monitoring process to ensure that all contractors, including CCOs, are following the federally mandated NOA and appeals processes.

Action item: Prior authorization applies to some, not all, MH/SUD outpatient (OP) services.

Because prior authorization can sometimes act as a barrier to care, it is important that it is only applied when a review of medical necessity is likely to improve the quality or cost-effectiveness of care.

If all MH/SUD OP benefits require prior authorization and only some M/S OP benefits require prior authorization, it is important to evaluate the reasons for assigning prior authorization to make sure it has not been over-applied to MH/SUD benefits.

Review results

One CCO (Advanced Health) must ensure that application of prior authorization meets parity requirements. All other CCOs and OHA meet parity requirements for this item.

Plan to address the action item

Advanced Health will only apply UM to MH/SUD services that are prone to over-utilization or have safety concerns. The frequency of UM will be tied to timelines for expected improvements consistent with the CCO's utilization data. Taking these actions will bring Advanced Health into compliance with MHP for this item. Advanced Health intends to implement this new policy by December 31, 2018.

Action item: Comparable requirements for out-of-network (OON) and/or out-of-state (OOS) providers.

Each CCO establishes standards for access to OON/OOS services consistent with federal and state requirements. If a CCO requires MH/SUD OON/OOS providers to meet requirements in addition to those required for M/S OON/OOS providers, parity would require evidence that the additional information is needed or a reduction in the MH/SUD OON/OOS requirements.

Review results

One CCO (Yamhill Community Care) must ensure that OON/OOS requirements meet parity. All other CCOs and OHA meet parity for this item.

Plan to address the action item

Yamhill will review the information requirements for MH/SUD providers relative to M/S providers and either align them or provide a parity-compliant rationale for any unique MH/SUD requirements for OOS/OON providers. They will implement this strategy by March 31, 2019.

Improvements in care stemming from MHP compliance

Historically, quality research on MH/SUD conditions and services has trailed the quality research for M/S conditions and services leading to fewer evidence-based MNC for MH/SUD services. The MH/SUD quality research that existed was scattered over hundreds of smaller volume journals that were difficult to access and required complex search algorithms to identify. This resulted in MH/SUD UM practices based more on clinical judgment or promising practices, than actual evidence.

In recent years, the quality and quantity of MH/SUD research has increased, but the MNC for Oregon's MH/SUD services has not always kept pace. Parity compliance provides a unique opportunity to increase the quality of MH/SUD services by requiring parity/comparability between M/S and MH/SUD UM practices, such as MNC.

Specific improvements to services stemming from parity compliance:

- Increased evidence-base for MH/SUD MNC.
- Frequency of review of services will now be based on evidence instead of standardized time periods such as 30 days or 60 days.
- Increased consistency in authorization decisions across members.
- Increased qualifications for the professionals making denial determinations. All denial determinations will be made by a professional peer. A professional peer is a licensed clinician who has the ability to order the service being reviewed. This ensures that the person denying a service has the knowledge base to understand when a service is medically necessary and when it is not.
- Increased time for RR of MH/SUD services - alignment of RR timelines and conditions between MH/SUD and M/S services will ensure that MH/SUD services are allotted similar timeframes to request RR, under comparable conditions. Currently, OARs require M/S services have a RR time of at least 90 days whereas MH/SUD services requires at least 30 days.
- Increased confidence that the NOA and appeals processes are followed consistent with federal regulations so that members are informed of adverse decisions and their appeal and hearings rights.
- Increased confidence that UM is only applied to MH/SUD OP benefits prone to overutilization or associated with safety concerns – there was only 1 CCO with this issue.
- Increased confidence that OON/OOS MH/SUD providers are not facing higher barriers to participate in a network than their M/S counterparts – there was only 1 CCO with this issue.

Next steps

OHA, in partnership with the CCOs, will ensure continued parity compliance and resulting quality improvements through multiple approaches including:

CCO contracts

The requirements of CMS 2333-F have been included in the 2019 contract. This means that not only does parity apply directly to each CCO under federal rule, but OHA has also added MHP requirements to the contract it holds with each CCO. The contract and underlying federal regulations may be used to enforce parity requirements.

Parity action plans

The parity assessment process is bringing increased scrutiny on CCOs to ensure that CCOs operations comply with the requirements of CMS 2333-F. This 18-month process has required each CCO to report on their entire OHP delivery system. This assessment of CCO policies and procedures revealed specific areas of concern for remediation under parity. Each CCO has developed individualized action plans with specific steps for addressing their parity concerns and timelines for completing these steps. Completion of these action plans will result in overall system enhancement.

As shown in Appendix A, eight CCOs and FFS must complete action plans in the areas indicated. OHA expects most action plans will be completed by the end of 2018.

Monitoring mental health parity compliance

OHA will continue to monitor for compliance with parity requirements in both the FFS and CCO delivery systems. Beyond the current process, CCOs will be required to assess parity compliance when there are changes that might impact parity (e.g., a change in benefits or management of benefits). For example, when a CCO changes subcontractors, a review of policies and processes will be required to determine whether the new delivery system meets parity standards.

The parity review process should be updated any time there is a change that might impact parity. For example, OHA adds a new CCO.

OHA is creating reporting templates to support ongoing parity analysis by CCOs and OHA. This reporting will help OHA determine when a CCO needs to update its parity assessment.

Appendix A: Progress by action plan category as of December 12, 2018

x	Meets current parity requirements	o	Action item complete	MM/DD/YYYY	Projected date complete

Action plan category	Advanced Health	AllCare	Cascade Health Alliance	Columbia Pacific CCO	EOCCO	Health Share	IHN	Jackson Care Connect	PacificSource	PrimaryHealth	Trillium	Umpqua Health Alliance	Willamette Valley Community Health	Yamhill Coordinated Care	OHA (fee-for-service)
Update UM criteria	x	12/31/2018	x	x	x	12/31/2018	x	x	x	o	x	3/31/2019	12/31/2018	x	12/31/2018
Evaluate how often criteria are applied (frequency of review)	12/31/2018	12/31/2018	x	x	x	12/31/2018	x	x	x	o	x	x	12/31/2018	x	12/31/2018
Monitor consistency of criteria application	x	3/31/2019	x	x	x	12/31/2018	o	x	12/31/2018	X	o	x	12/31/2018	x	12/31/2018
Ensure professional peers make denials	o	x	x	x	x	x	x	x	x	o	x	x	x	x	12/31/2018
Standardize RR timelines and conditions	x	x	x	x	x	x	x	x	x	x	x	x	x	x	12/31/2018
Ensure that all contractors follow the NOA/appeal process	x	x	x	x	x	x	x	x	x	x	x	x	x	x	12/31/2018
Ensure PA applies to some (not all) outpatient services	12/31/2018	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Evaluate requirements for out-of-network and out-of-state providers	x	x	x	x	x	x	x	x	x	x	x	x	x	3/31/2019	x