# 2023 CCO Prior Authorization Report


HEALTH SYSTEMS DIVISION
CCO Quality Assurance and Contract Oversight Unit
HSD.QualityAssurance@odhsoha.oregon.gov

Report Date: March 2024

# Table of Contents

# Executive Summary

## House Bill 2517

Oregon House Bill (HB) 2517, passed during the 2021 Legislative Session, requires the Oregon Health Authority (OHA) to compile and post information reported from coordinated care organizations (CCOs) regarding prior authorizations received during the calendar year. This report contains aggregate CCO data, including the number of requests for prior authorizations (PAs) received by the CCOs, the number of requests initially denied, the reasons for the denials, the total number of PA related appeals, and the number of PA related denials that were reversed on appeal.

# Background

## CCO Contract Exhibit I reporting requirements

CCO Grievance and Appeal System requirements, including PA reporting, are outlined in Exhibit I of the CCO Contract. OHA began collecting PA data from CCOs in Quarter 3 of 2022 via changes to the quarterly Exhibit I Grievance and Appeal System reports. OHA releases an updated CCO Prior Authorization report, annually in March, containing data related to the prior year. This report contains data from Quarters 1-4 of calendar year 2023.

## Expansion of reporting and impact in 2024

OHA's older reporting templates have been redesigned to better capture reasons for PA denials. OHA expanded the reporting capability for PA denial categories in 2023, thus ensuring that more nuanced reasons for denial are captured and reported. Examples include separate categories for "Lack of medical necessity", "Incomplete request," and "Treatment below the funding line." These categories will all be reflected in the 2024 report. OHA also issued clarifying guidance to CCOs in Q1 2023 to include pre-service requests for Non-Emergent Medical Transportation (NEMT) services in the reporting.

## Prior authorization, denial, and appeal process

Although many Oregon Health Plan (OHP) services require CCOs to provide direct access --no referral or prior approval – many other services require approval before the service is administered. This is known as *prior authorization*. Prior authorizations (PAs) are submitted by a provider to the member's CCO. Examples of common services that require PA include: planned surgical procedures, care in a skilled nursing facility, and some radiological services such as magnetic resonance imaging (MRI).

CCOs are required to review PA requests as quickly as the member's health condition requires, per 410-141-3835, and must meet the review timeframes listed below.

### *Timeframes for prior authorizations*

- Standard decisions must be made within 14 days. If more time is needed, CCOs can request an extension of 14 additional days.
- If a member or provider feel that following the standard timeframe puts the member's life, health or ability to function in danger, an expedited prior authorization decision can be requested.
- Expedited decisions are typically made within 72 hours. If a determination is made that an expedited decision is not required (based on the criteria described in the bullet above), the request will revert back to the standard timeframe.

### *Denials and appeals*

If a PA is not approved, members receive notification of the denial, also called a Notice of Adverse Benefit Determination (NOABD). These notices provide information about the member's rights, including how to appeal to the CCO if the member disagrees with the denial and how to ask OHA to review the denial in a contested case hearing.

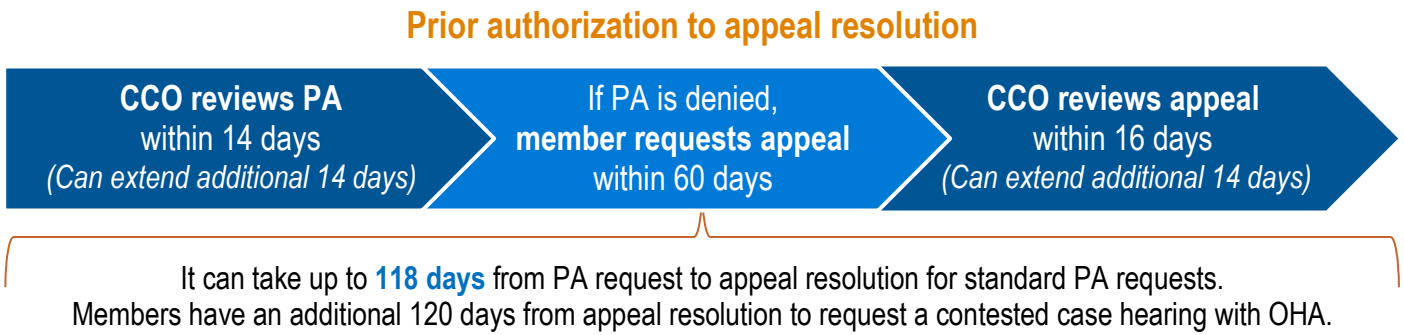
An appeal could lead to an overturned denial. Like PAs, CCOs are also required to review appeal requests as quickly as the member's health condition requires, per 410-141-3890, and must meet the review timeframes listed below.

### *Timeframes for appeals*

- Members must ask for an appeal within 60 days of a denial (the date of the Notice of Adverse Benefit Determination). Authorized representatives and providers, with written consent, can also ask for an appeal on the member's behalf.
- For standard appeals, CCOs have 16 days to review the request and respond. If more time is needed, CCOs can request an extension of 14 additional days.
- If a member or provider feel that following the standard timeframe puts the member's life, health or ability to function in danger, an expedited appeal can be requested.
- CCOs are required to resolve expedited appeals within 72 hours. If a determination is made that an expedited decision is not required (based on the criteria described in the bullet above), the request will revert back to the standard timeframe.

Please see Figure 1. below to better understand prior authorization, denial, and appeal timeframes. These timeframes are important to consider when interpreting the data presented in the remaining Figures below. Approval or denial of a request for PA and/or resolution of an appeal or contested case hearing related to a request for PA may not necessarily occur within the same quarter as the date the PA was submitted to the CCO for consideration.

**Figure 1. Timeframes for PA review, approval or denial, and appeal**

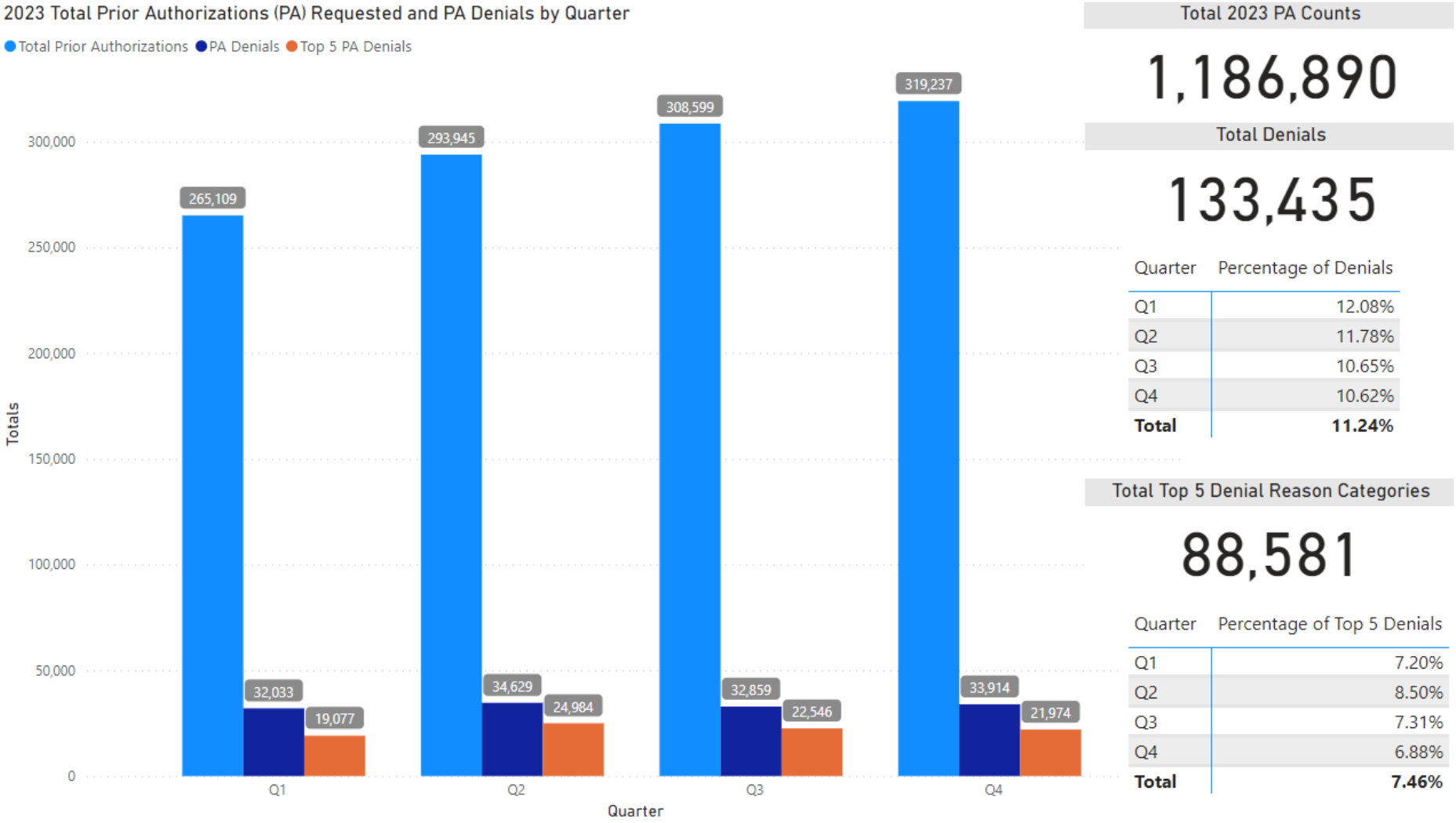



## CCO Prior Authorization Reporting and Review

CCOs are required to submit the Grievance and Appeal Log to OHA quarterly (within 45 days after the end of each quarter). Respective due dates each year are: Feb. 15, May 15, Aug. 15, and Nov.15. On a quarterly basis, OHA cleans the data, performs an analysis and compiles data related specifically to PAs. Results of the analysis for quarters 1-4, 2023 are included below. Note that 2023 total numbers for PAs are higher than those for 2022, in large part due to the inclusion of Non-Emergent Medical Transportation (NEMT) data beginning in Q1 2023.

## *2023 CCO Statewide Aggregate Prior Authorization Data by Quarter*

**Figure 2. Prior Authorizations and Denials by Quarter**




**Total 2023 PA Counts**

**1,186,890**

**Total Denials**

**133,435**

| Quarter | Percentage of Denials |
|---|---|
| Q1 | 12.08% |
| Q2 | 11.78% |
| Q3 | 10.65% |
| Q4 | 10.62% |
| **Total** | **11.24%** |

**Total Top 5 Denial Reason Categories**

**88,581**

| Quarter | Percentage of Top 5 Denials |
|---|---|
| Q1 | 7.20% |
| Q2 | 8.50% |
| Q3 | 7.31% |
| Q4 | 6.88% |
| **Total** | **7.46%** |

**Figure 3. Denials of PAs by Denial Reason and Quarter**

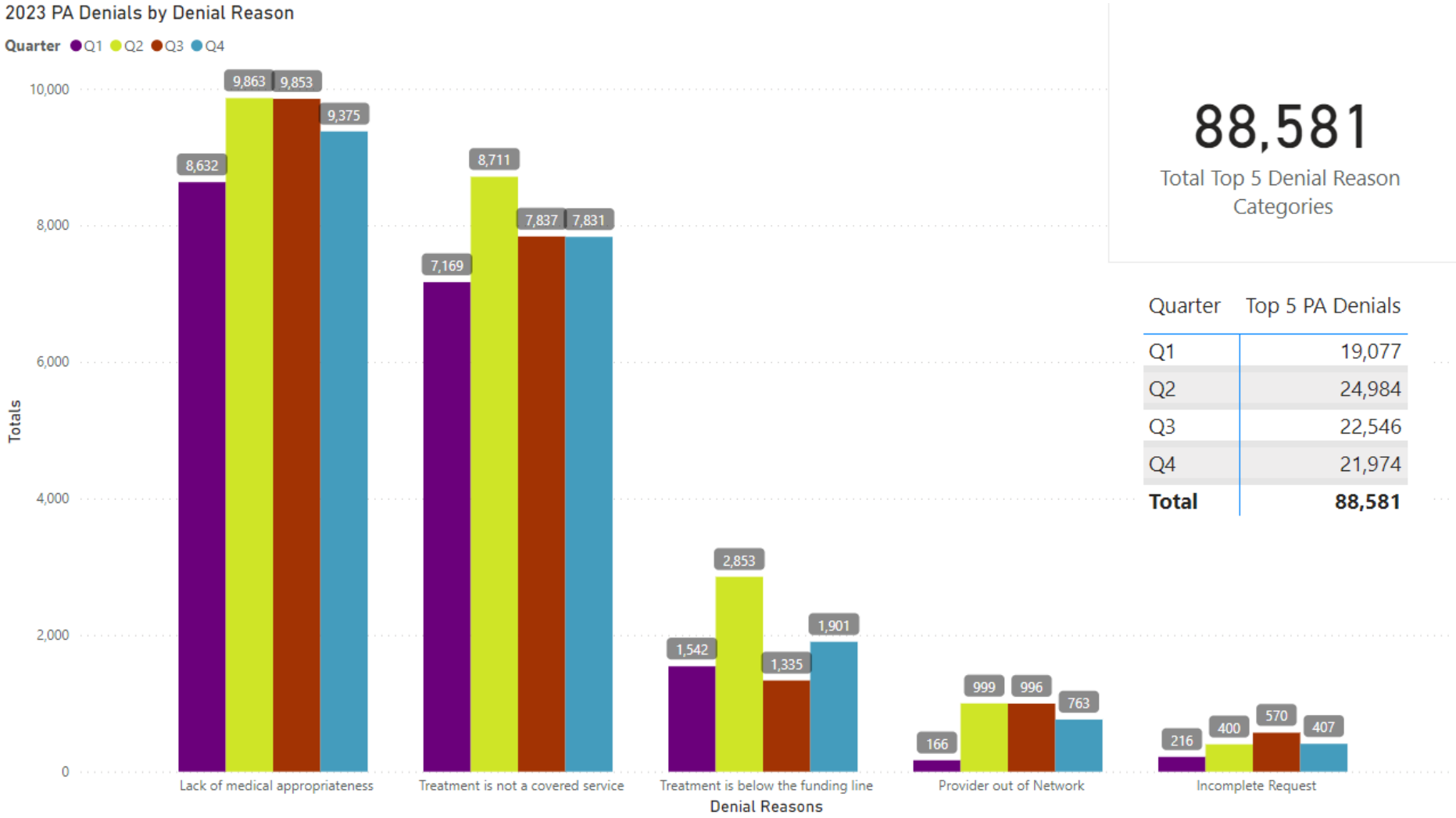
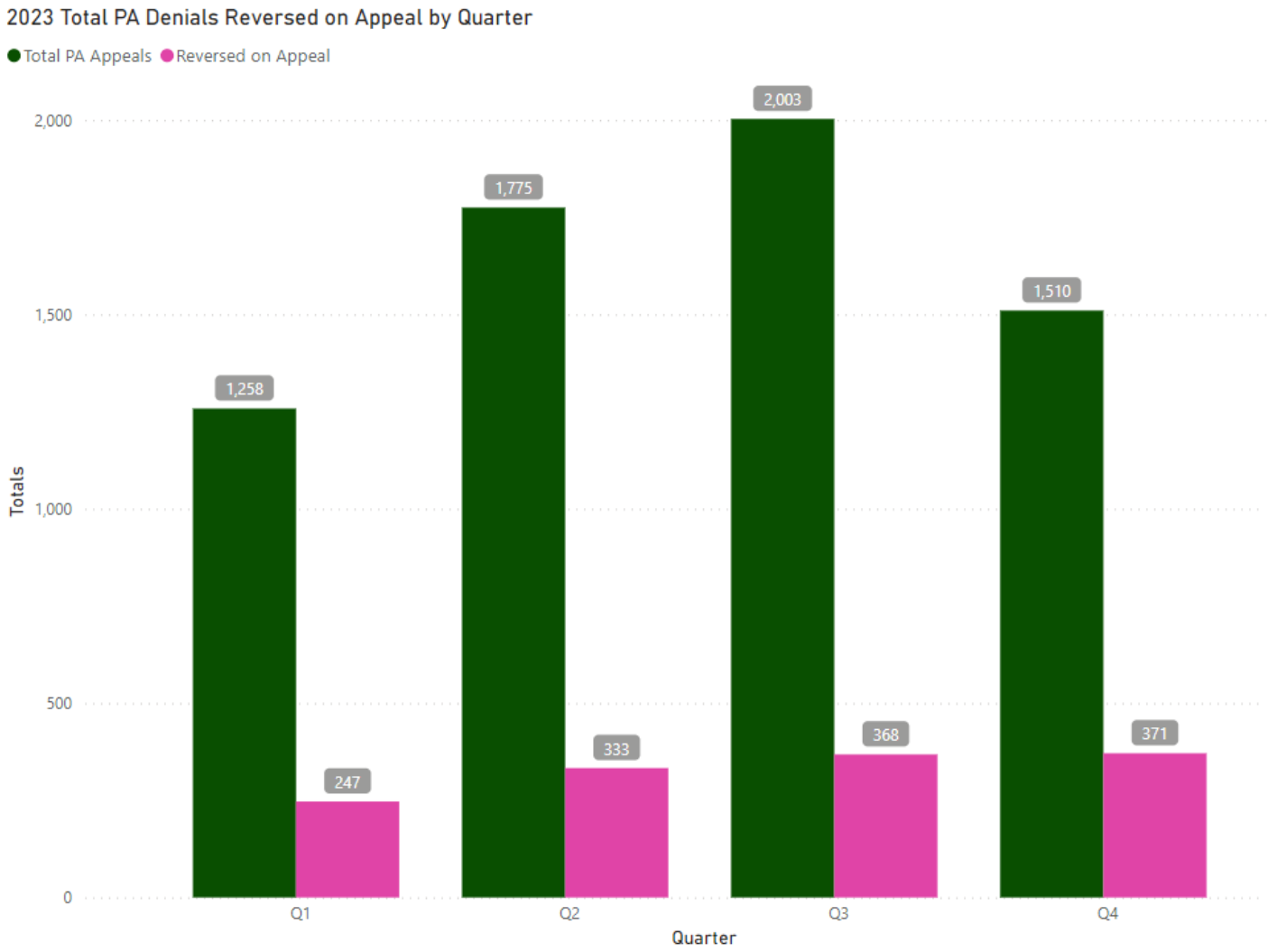


**Figure 4. PA Denials Overturned on Appeal by Quarter in 2023**




6,546

Total Appeals

| Quarter | Total Overturned | Total Appeals |
|---|---|---|
| Q1 | 247 | 1,258 |
| Q2 | 333 | 1,775 |
| Q3 | 368 | 2,003 |
| Q4 | 371 | 1,510 |
| **Total** | **1,319** | **6,546** |

| Quarter | Percentage Appeals Overturned |
|---|---|
| Q1 | 19.63% |
| Q2 | 18.76% |
| Q3 | 18.37% |
| Q4 | 24.57% |
| **Total** | **20.15%** |

## References

- Oregon House Bill 2517
- CCO Contract Exhibit I (10)(b)(1)
  - Contract templates are posted on the Oregon Health Authority CCO Contract Forms webpage
- Oregon Administrative Rules 410-141-3835, 410-141-3890, 410-141-3915

## Language access and accommodation

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact HSD.QualityAssurance@odhsoha.oregon.gov or 503-945-5772. TTY 711. We accept all relay calls.