2022 CCO Prior Authorization Report

HEALTH SYSTEMS DIVISION
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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 inaugural report contains aggregate CCO data, including the number of requests for prior authorization (PA) received by the CCOs, the number of requests initially denied, the reasons for the denials, and the number of 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. As a result, this report contains data from Quarters 1-3 of calendar year 2022. Quarter 4 data will be added to this report in March of 2023. This report will be updated annually in March hereafter to allow for Q4 data to be included and promulgated.

Expansion of reporting categories and impact in 2024

OHA's older reporting templates have been redesigned to better capture reasons for PA denials. Beginning in calendar year 2023, OHA will expand the reporting capability for PA denial categories, thus ensuring that more nuanced reasons for denial are captured and reported in 2024. Examples include separate categories for "Lack of medical necessity" and "Incomplete request," and adding a new category for "Treatment below the funding line."

Prior authorization, denial, and appeal process

Although many Oregon Health Plan (OHP) services require CCOs to provide direct access --no referral or prior approval -- some 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 prior authorization include: many 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 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 determined not to require expedited decision, the request will revert 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. These notices provide information about the member's rights, including how to appeal if the member disagrees with the denial and how to ask OHA to review the denial in a contested case hearing.

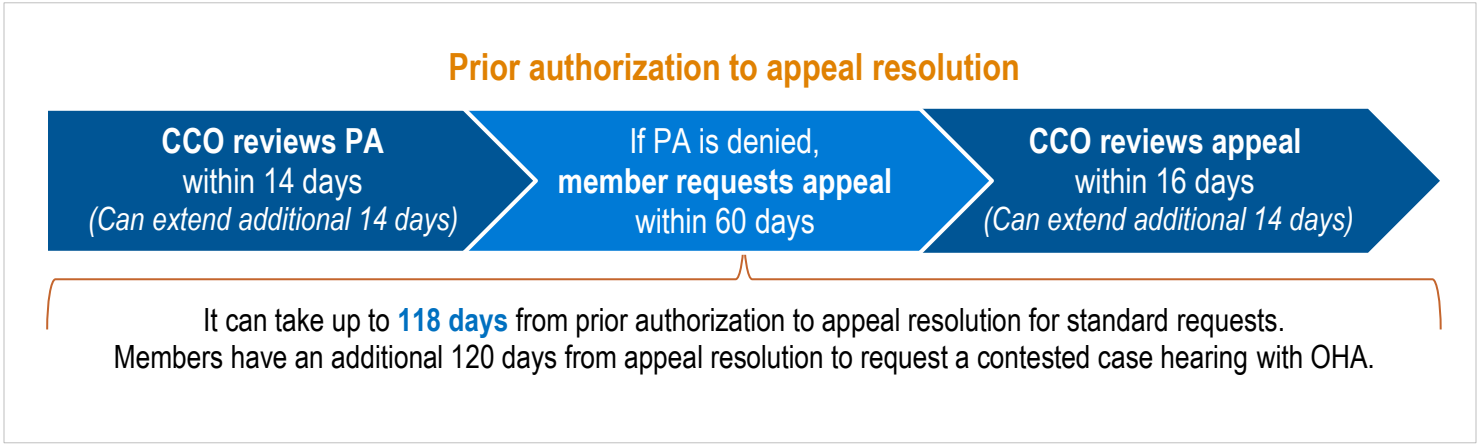
An appeal could lead to an overturned denial. Like PAs, CCOs are also required to review appeal requests as quickly as the member's health condition requires, per 410-141-3890, and must meet the review timeframes listed below.

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 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 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 determined not to require expedited appeal, the request will revert 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 prior authorization and/or resolution of an appeal or contested case hearing related to a request for prior authorization may not occur within the same quarter as the date the PA was submitted to the CCO for consideration.

Figure 1. Timeframes from PA authorization, denial, and appeal



CCO Prior Authorization Denial Review

Methodology

OHA utilized the CCO Contract required Exhibit I Grievance System Reporting tool: Grievance and Appeals Log, collected quarterly, for the analysis.

OHA presented HB 2517 requirements and reporting tool updates to CCOs via the Contracts and Compliance Workgroup meetings on July 26, 2022, and October 25, 2022, as well as the Quality Health Outcomes Committee meeting on November 14, 2022.

OHA sent out revised versions of the Grievance and Appeals Log to CCOs on August 15, 2022, and November 10, 2022, via email notifications to CCO contract administrators, second and third contacts, and also posted the new log and instructions on the CCO Contract Forms webpage.

OHA received questions and insightful feedback from the CCOs regarding changes to the report template which OHA has incorporated into the latest report template design. The newest version is scheduled for release in January 2023.

Reporting schedule

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.

OHA compiled data received from the Nov. 15, 2022 Grievance and Appeal Logs from each CCO, along with data received from a separate email inquiry sent to CCOs on Dec. 5, 2022, requesting their Q1 and Q2 PA data by Dec. 19, 2022. OHA performed an analysis of the data and provided the results in the "2022 Statewide CCO Aggregate Prior Authorization Data", included below. PA information for Q4 2022 will be reported as an addendum to this report after OHA receives that information from CCOs as part of their quarterly Exhibit I reporting in February 2023.

2022 CCO Statewide Aggregate Prior Authorization Data for Quarters One through Three

Figure 2. Prior Authorizations and Denials by Quarter

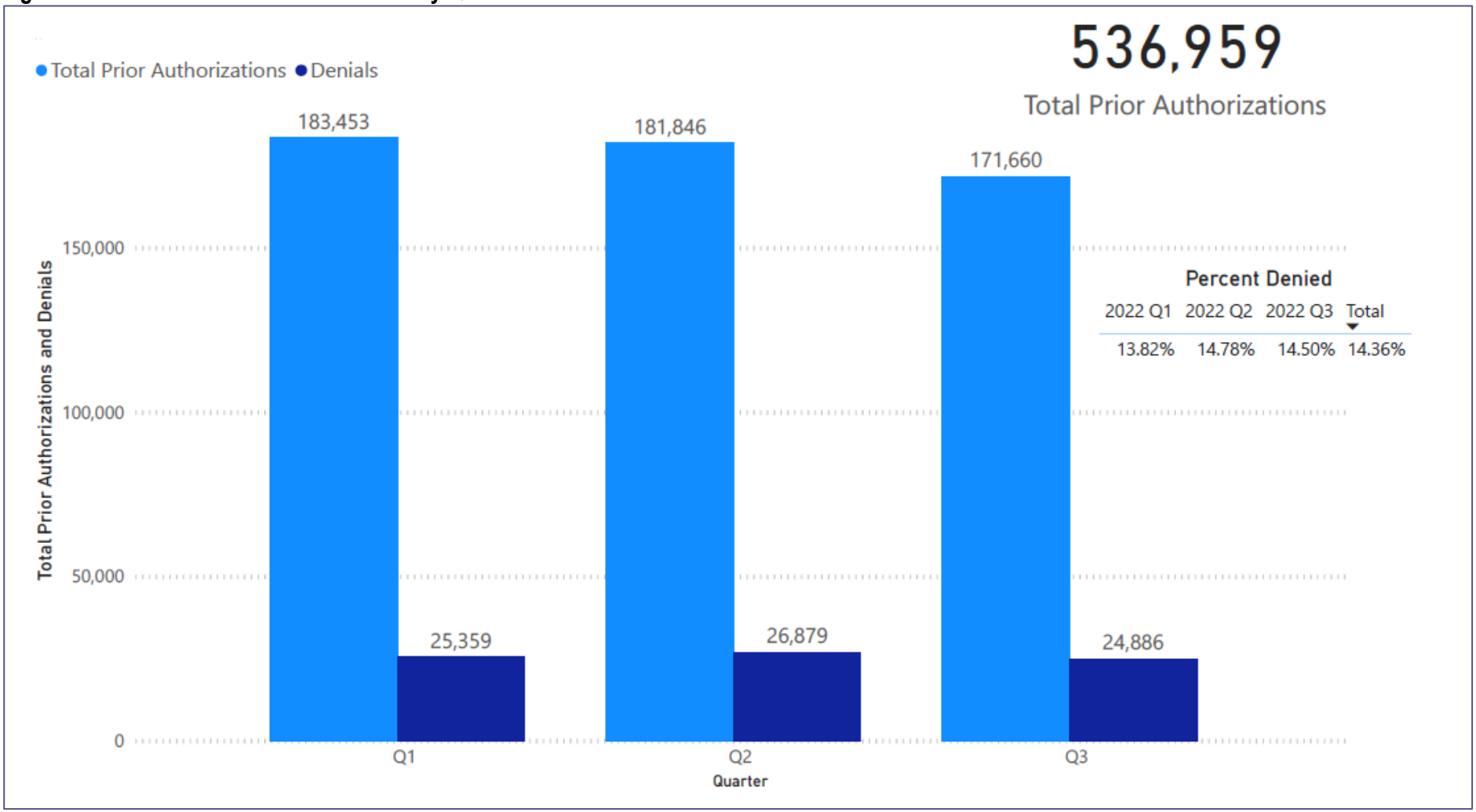


Figure 3. Denials of PAs by Denial Reason and Quarter

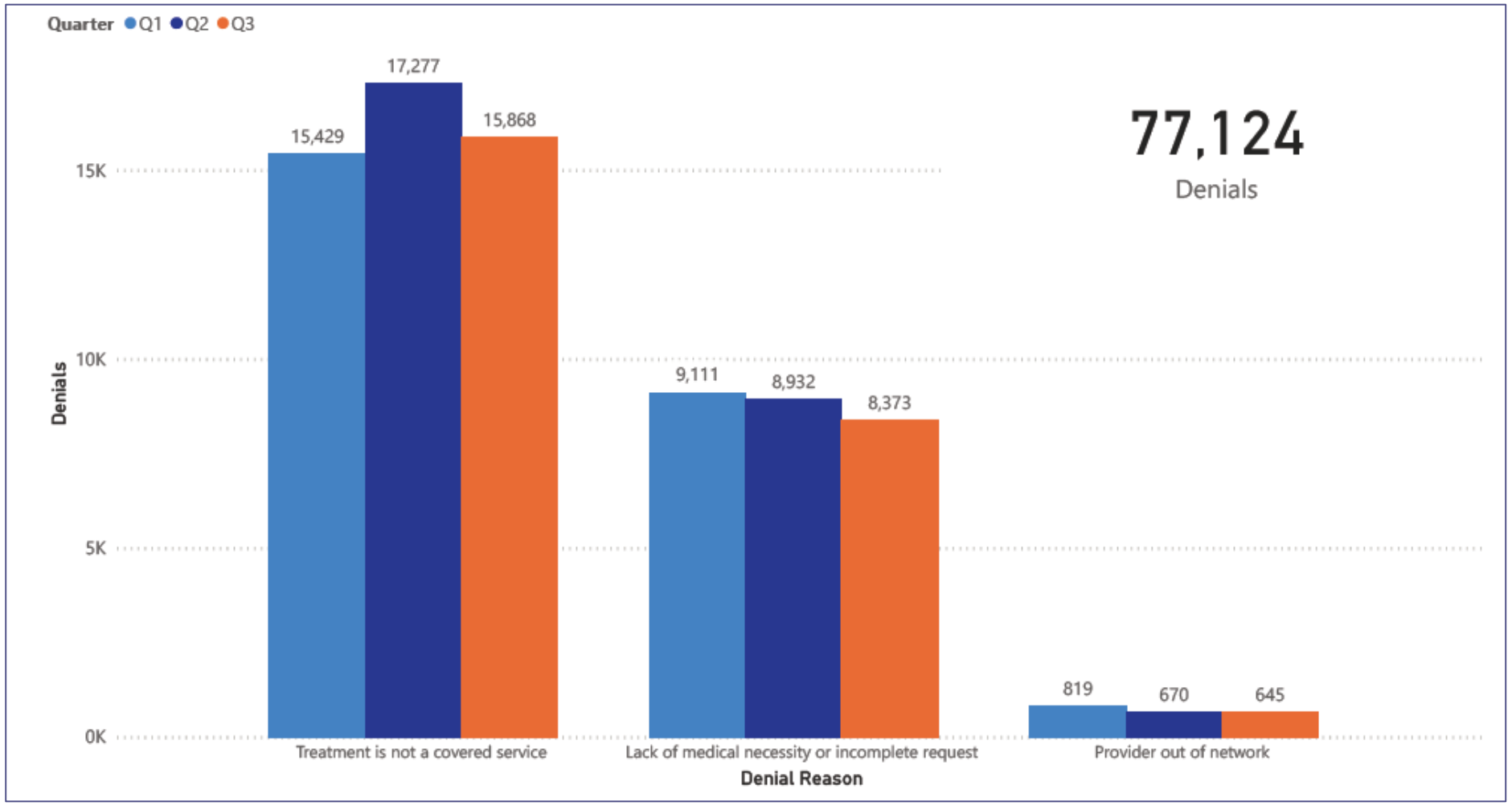
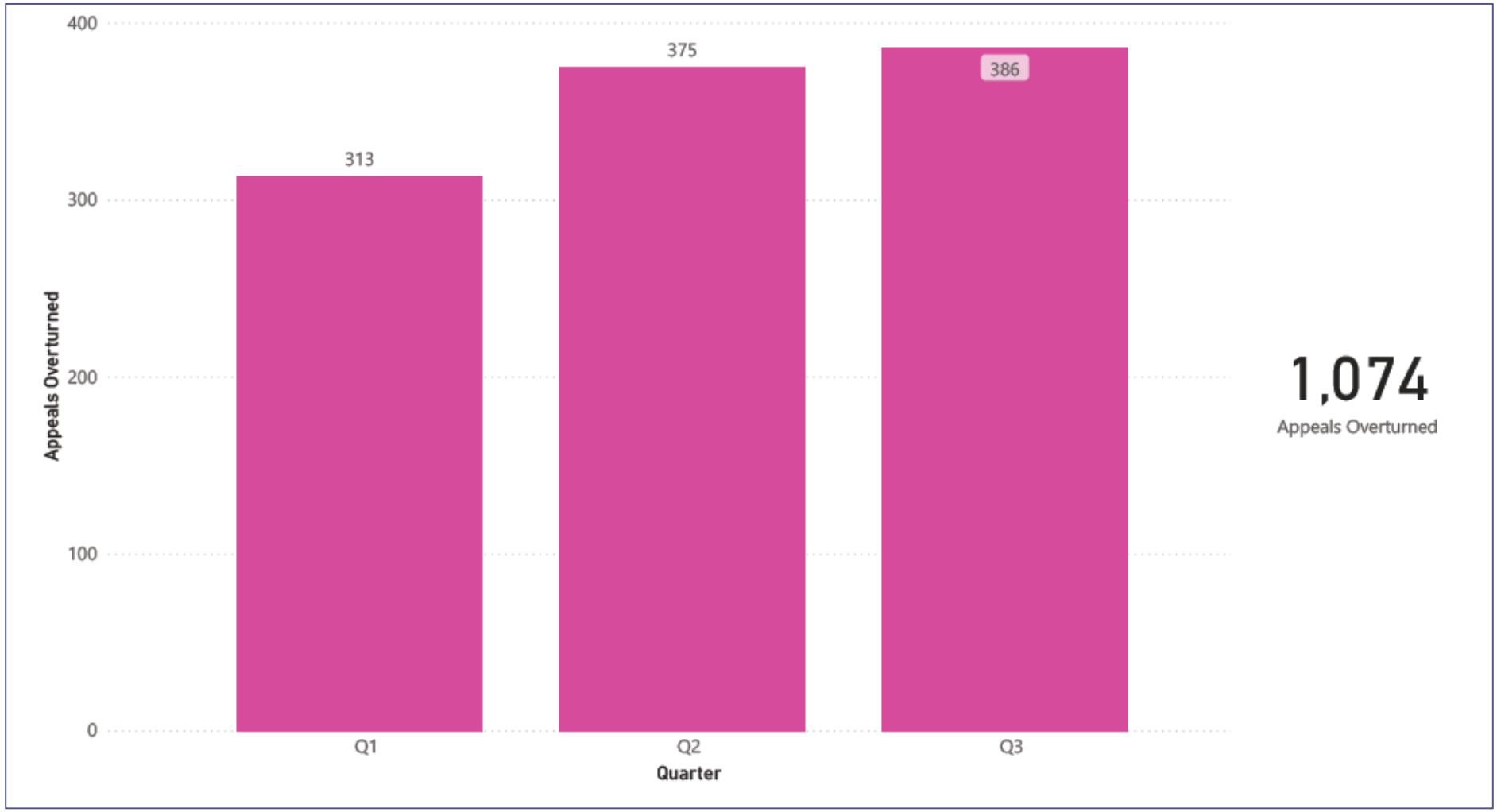


Figure 4. Appeals Overturned by Quarter in 2022



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 (voice/text). We accept all relay calls.