Department of Health and Human Services
Office of Inspector General
Office of Audit Services

August 2026 | A-09-24-02007

Health Share of Oregon Did Not Always Comply With Federal and State Requirements When Denying Prior Authorization Requests

REPORT HIGHLIGHTS

August 2026 | A-09-24-02007

Health Share of Oregon Did Not Always Comply With Federal and State Requirements When Denying Prior Authorization Requests

Why OIG Did This Audit

- OIG has identified longstanding challenges, including insufficient oversight and limited access to specialists, that may reduce the quality of health care services provided to Medicaid enrollees.
- We audited Health Share of Oregon (Health Share), an Oregon coordinated care organization (CCO), because it had the highest number of denied and appealed service requests of any CCO in Oregon.
- This audit is part of a series of OIG audits examining Medicaid managed care organization (MCO) denials. CCOs are similar to traditional MCOs but have some key differences.

What OIG Found

Of the 100 denied service requests we sampled, 21 did not comply with all Federal and State requirements for denying medical services and items, prescription drugs, and dental procedures that required a prior authorization. Of these 21 denied service requests that did not comply, 6 did not comply with more than one requirement. Specifically, Health Share:

- Denial decisions were not made by individuals with appropriate expertise in addressing the enrollees' medical or oral health needs (13 denied service requests)
- Denial notices did not include required contact information or were not provided in the enrollee's non-English language (7 denied service requests)
- Did not provide denial notices timely (6 denied service requests)
- Did not consult with providers before making a denial decision (4 denied service requests)
- Did not notify the provider of the denial decision (1 denied service request)

21%
of denied service requests covered by our audit did not comply with requirements

Based on our sample results, we estimated that 5,677 denied service requests that required a prior authorization (21 percent of the denied service requests covered by our audit) did not comply with all Federal and State requirements during calendar year 2023.

What OIG Recommends

We made four recommendations to Health Share, including that it assess and improve its quarterly reviews of denial notices and related prior authorization documentation. The full recommendations are in the report.

Health Share concurred with three of our recommendations, partially concurred with the remaining recommendation, and provided information on actions that it has taken and planned to take to address our recommendations.

TABLE OF CONTENTS

APPENDICES

INTRODUCTION

WHY WE DID THIS AUDIT

The Office of Inspector General (OIG) has identified longstanding challenges, including insufficient oversight and limited access to specialists, that may reduce the quality of health care services provided to individuals enrolled in Medicaid. Medicaid managed care organizations (MCOs) provide Medicaid enrollees with health care services through a network of health care providers.

Oregon was one of the first States to adopt a type of Medicaid accountable care organization when it established coordinated care organizations (CCOs) in 2012.[1] CCOs are similar to traditional MCOs but have some key differences, such as being locally governed with representation from Medicaid enrollees, health care providers, and other local stakeholders. CCOs offer a wide range of health-related benefits including physical, dental, prescription drugs, and mental health care services.

This audit is part of a series of OIG audits examining Medicaid MCO denials, including work examining the use of prior authorizations that may result in delays for enrollees seeking to access physical health services. Previous OIG reports have highlighted concerns related to the Medicaid managed care program and its oversight, such as high prior authorization denial rates and limited State oversight.[2, 3] We selected Health Share of Oregon (Health Share), an Oregon CCO, for audit because Health Share had the highest number of denied and appealed service requests of any CCO in Oregon during calendar year (CY) 2023 (audit period).

OBJECTIVE

Our objective was to determine whether Health Share complied with Federal and State requirements when it denied requested medical services and items, prescription drugs, and dental procedures that required a prior authorization.

[1] A CCO is a network of different types of participating providers that have agreed to work together in their local communities to provide coordinated care to Medicaid enrollees.

[2] OIG, *High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care* (OEI-09-19-00350), July 17, 2023.

[3] OIG, *CMS Did Not Ensure That Selected States Complied With Medicaid Managed Care Mental Health and Substance Use Disorder Parity Requirements* (A-02-22-01016), Mar. 25, 2024.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to eligible low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the Act)). The Federal and State Governments jointly fund the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its own Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

To enhance access to and the quality of health care for Medicaid enrollees, many States implemented managed care delivery systems. Under these systems, States contract with MCOs to deliver covered services. In risk-based managed care arrangements, State Medicaid agencies pay MCOs a fixed capitation payment for each enrollee. The State Medicaid agency makes the capitation payment regardless of whether the enrollee receives services during the period covered by the payment.

The contractual risk-based arrangements between State Medicaid agencies and MCOs shift financial risk for the costs of Medicaid services from the State Medicaid agency and the Federal Government to the MCO. If an MCO spends more on covered services than it receives in capitation payments, the MCO absorbs the loss; if it spends less, it keeps the gain. This financial risk gives MCOs a potential incentive to limit what they pay their network providers either by improperly denying enrollees' access to covered services, constraining their payments to providers, or both.

Federal regulations require each State Medicaid agency to monitor its Medicaid managed care program comprehensively. The State's monitoring system must address all aspects of the managed care program, including the performance of each MCO's administration and management, appeal and grievance systems, and claims management (42 CFR §§ 438.66(a) and (b)). Each contract between a State and an MCO must provide that the MCO may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee (42 CFR § 438.210(a)(3)(ii)).

Oregon's Medicaid Managed Care Program

The Oregon Health Authority (State agency) administers Oregon's Medicaid program, known as the Oregon Health Plan (OHP). Initially, various types of MCOs, such as those providing physical, mental, and dental health care, contracted directly with the State agency. However, effective as of 2012, the State agency contracted with CCOs to provide these services.

A CCO is a network of different types of participating providers (e.g., physical, mental, and dental health care providers and those that provide addiction treatment) that have agreed to

work together in their local communities to serve enrollees who receive health care coverage through Medicaid. CCOs are similar to traditional MCOs but have some key differences, such as having more active roles for providers and community members. CCOs are accountable for the health outcomes of the population they serve and bear financial responsibility for providing all covered health care services.

The provisions of the contract between a CCO and the State agency allow the CCO to subcontract the majority of the work performed under the contract. Although a CCO may subcontract certain activities to outside entities (i.e., subcontractors), the CCO is responsible for all duties included in the contract and must monitor subcontractors' performance.

Health Share of Oregon

Health Share, located in Portland, Oregon, has been serving Medicaid enrollees as a CCO since September 2012 by delivering covered benefits such as medical health services, behavioral (mental health plus substance use) health services, prescription drugs, and dental services. It also coordinates care and resources for enrollees and works with community partners in providing health care, education, housing, transportation, and social services to broaden health access and opportunity. It subcontracts management of Medicaid benefits with five primary care networks and five dental care organizations.[4]

During our audit period, Health Share received approximately $3.1 billion in Medicaid capitation payments from the State agency to provide covered benefits to more than 400,000 Medicaid enrollees, making it the largest CCO in Oregon. Health Share reported spending nearly $2.3 billion on covered benefits during the same period.

Health Share's Prior Authorization Process

Health Share's OHP Health Plan Services Contract, Coordinated Care Organization (the Contract) defines prior authorization as payment authorization for specified medical services or items given by State agency staff or its contracted agencies before providing the service.[5] The Contract states that at a minimum, Health Share will provide covered services that are medically appropriate and for a covered condition (i.e., diagnosis) and related treatment

[4] For reporting purposes, we refer to these networks and organizations as subcontractors.

[5] The term of the contract was 5 years from its coverage effective date of Jan. 1, 2020. In September 2023, the contract term was extended by 2 years.

(referred to as condition-treatment pairs) on the Prioritized List of Health Services (Prioritized List).[6, 7]

The Contract also states that Health Share will provide treatment, including ancillary services, which is included in or supports the condition-treatment pairs on the Prioritized List. In addition, the Contract states that Health Share will provide diagnostic services that are medically necessary and reasonable to diagnose the presenting condition, regardless of whether the final diagnosis is covered.[8]

Health Share's Member Handbook provides a list of covered services that may require prior authorization. Health care services requiring prior authorization must be approved by Health Share before the services are provided.

Health Share fully delegates prior authorization decisions to its subcontractors, which follow their own internal prior authorization processes. Health Share in turn monitors its subcontractors' performance to ensure that the subcontractors comply with Federal and State requirements. While all of the subcontractors have slight technical variations in their processes, their overall processes are almost identical. The prior authorization process begins when an enrollee's health care provider submits a request for health care services electronically through a secure provider portal system or fax. The request generally includes the enrollee's diagnosis, the requested service, and if necessary, medical information related to the request.

[6] Developed by the State agency's Health Evidence Review Commission, the Prioritized List ranks health conditions and treatment pairs by priority. Oregon policymakers use the Prioritized List to determine which benefits will be covered by Medicaid.

[7] As stated in Oregon Administrative Rules Compilation (OAR) 410-120-0000, "medically appropriate" means health services, items, or medical supplies that are: (1) recommended by a licensed health provider practicing within the scope of their license; (2) safe, effective, and appropriate for the patient based on standards of good health practice and generally recognized by the relevant scientific or professional community based on the best available evidence; (3) not solely for the convenience or preference of an OHP client, member, or a provider of the service item or medical supply; and (4) the most cost effective of the alternative levels or types of health services, items, or medical supplies that are covered services that can be safely and effectively provided to an OHP client or member in the State Agency's Health Systems Division or MCO's judgment. All covered services must be medically appropriate for the member, but not all medically appropriate services are covered services.

[8] According to OAR 410-120-0000, medically necessary means "health services and items that are required by a client or member to address one or more of the following: (a) the prevention, diagnosis, or treatment of a client or member's disease, condition, or disorder that results in health impairments or a disability; (b) the ability for a client or member to achieve age-appropriate growth and development; (c) the ability for a client or member to attain, maintain, or regain independence in self-care, ability to perform activities of daily living or improve health status; or (d) the opportunity for a client or member receiving Long Term Services & Supports as defined in these rules to have access to the benefits of non-institutionalized community living, to achieve person centered care goals, and to live and work in the setting of their choice; (e) a medically necessary service must also be medically appropriate. All covered services must be medically necessary, but not all medically necessary services are covered services."

The subcontractors' initial reviewers, such as registered nurses (RNs), use Oregon Administrative Rules Compilation (OAR), the Prioritized List, contract language, and medical necessity criteria based on relevant standards of practice to review prior authorization requests and make administrative decisions on the request. If the initial reviewer believes there are additional factors to consider, the prior authorization request is sent to a medical director for review. The medical director will determine whether to approve, deny, or partially deny the request and provide a rationale for the decision. If a request is approved, the subcontractor notifies the provider. If a request is denied, the subcontractor issues a letter to the provider and to the enrollee, detailing the reason for the denial.[9] Subcontractors maintain prior authorization requests, denials, and appeals information and data, which they report to Health Share, which then reports quarterly denial data to the State agency.

If enrollees or providers disagree with the denial decision, they may file an appeal with Health Share within 60 days of the date of the denial letter.[10] After exhausting Health Share's appeals process, the enrollee or provider may request a State contested case hearing from the State agency if they disagree with Health Share's decision.

HOW WE CONDUCTED THIS AUDIT

Our audit covered 27,032 service requests for Medicaid medical services and items, prescription drugs, and dental procedures, that required a prior authorization and were denied during calendar year 2023 (audit period), including prior authorization requests denied by Health Share during the appeal process.[11] We selected and reviewed a random sample of 100 denied service requests that required a prior authorization to determine whether Health Share denied the requests in accordance with Federal and State requirements.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions

[9] According to the Contract in effect during our audit period, Exhibit I – Grievance and Appeal System, section 3, when Health Share has made, or intends to make, an adverse benefit determination, Health Share must notify the requesting provider and mail to the enrollee a written Notice of Adverse Benefit Determination. An adverse benefit determination includes: (1) the denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; and (2) the reduction, suspension, or termination of a previously authorized service (OAR 410-141-3875(1)(b)).

[10] State regulations and the Contract in effect during our audit period state that adjudication of appeals in a member appeals process may not be delegated to a subcontractor (OAR 410-141-3875(14), the Contract, Exhibit B – SOW – Part 4, 11(a)(9)(b)), and Exhibit I – Grievance and Appeal System, section 1(e)(11)). Health Share stated that it retains responsibility for appeals but enlists the assistance of the applicable subcontractor to process the appeal by gathering information, performing a new clinical review (using different staff than used for the original review and denial) and providing a recommendation on action. Health Share reviews the case and recommendation, and if Health Share agrees with the recommendation, it becomes the appeal decision.

[11] Our audit excluded denied service requests for behavioral health services.

based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, Appendix B contains a list of related OIG reports, Appendix C contains service requests denials by category, Appendix D contains the details of our statistical sampling methodology, Appendix E contains our sample results and estimates, and Appendix F contains Federal and State requirements for Medicaid MCO services that require a prior authorization.

FINDINGS

Health Share did not always comply with Federal and State requirements when it denied requested medical services and items, prescription drugs, and dental procedures that required a prior authorization. Of the 100 sampled denied service requests, 79 complied with Federal and State requirements; however, the remaining 21 denied service requests did not comply with at least 1 requirement.[12] Specifically, Health Share:

- Denial decisions were not made by individuals with appropriate expertise in addressing the enrollees' medical or oral health needs (13 denied service requests)

- Denial notices did not include required contact information or were not provided in the enrollee's non-English language (7 denied service requests)

- Did not provide denial notices timely (6 denied service requests)

- Did not consult with providers before making a denial decision (4 denied service requests)

- Did not provide notice to the provider of the denial decision (1 denied service request)

These denied service requests did not comply with the requirements, in part because Health Share did not provide clear guidance to its subcontractors about which credentials are required for reviewers to have the required expertise to make decisions regarding prior authorizations. In addition, Health Share's subcontractors did not have processes for sending certain prior authorization requests to medical directors for review and experienced a high staff turnover during our audit period. Although Health Share performed quarterly reviews of a sample of its subcontractors' denial notices and related prior authorization documentation, these reviews were not effective in detecting certain issues with prior authorization denials made by its subcontractors.

[12] Of the 100 sampled denied service requests, 6 did not comply with more than 1 requirement.

Based on our sample results, we estimated that, for our audit period, 5,677 denied service requests that required a prior authorization (21 percent of the denied service requests covered by our audit) did not comply with all Federal and State requirements.

DENIAL DECISIONS WERE NOT MADE BY INDIVIDUALS WITH APPROPRIATE EXPERTISE

Federal regulations state that each contract must require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs (42 CFR § 438.210(b)(3)).

State regulations and the Contract in effect during our audit period state that decisions to deny a service authorization request; reduce a previously authorized service request; or authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has clinical expertise in treating the enrollee's medical, behavioral, or oral health needs or in consultation with a health care professional with clinical expertise in treating the enrollee's condition or disease (OAR 410-141-3835(10)(f)(B), the Contract, Exhibit B – Statement of Work (SOW) – Part 2, 3(b)(2)).

Health Share clarified that RNs are not allowed to make clinical denial decisions. They are allowed to make administrative denials in situations in which a prior authorization was requested for an enrollee who was not enrolled with Health Share or not enrolled in the OHP. In such cases, the denial would be based on lack of eligibility, and not on clinical factors or the OHP coverage rules.

For 13 of the 100 sampled denied service requests, denial decisions were not made by individuals who had appropriate expertise in addressing the enrollees' medical or oral health needs.

Example of a Denial Not Made by an Individual Who Had Appropriate Expertise in Addressing the Enrollee's Medical Needs

A provider submitted a prior authorization request for ultrasound-guided neck injections with the goal of determining whether an enrollee was an appropriate candidate for surgery to help treat neck and arm pain. The provider submitted medical records and a letter explaining that two other doctors had evaluated the enrollee and determined medical necessity for the injections. The subcontractor denied this service request because its RN who reviewed the request determined that the injections were not a covered service.

Subcontractors' denial decisions were administratively made by RNs, benefit specialists, or prior authorization and referral analysts based on standing orders developed by medical directors or dentists. One subcontractor stated that there was a lack of clarity from the State agency as to

what credentials were considered to have the required expertise. Another subcontractor stated that before May 2025, its process did not include sending all denied prior authorization requests to a medical director for review.

Denial decisions that are made by individuals who do not have appropriate expertise in addressing an enrollee's medical and oral health needs could place the health and safety of the enrollee at risk because the enrollee may not receive medically necessary services. In addition, it may lead to additional delays in obtaining necessary services if an enrollee appeals a denial decision that was erroneously made by an individual who did not have the appropriate expertise in making the denial decision.

DENIAL NOTICES DID NOT INCLUDE REQUIRED CONTACT INFORMATION OR WERE NOT PROVIDED IN ENROLLEES' NON-ENGLISH LANGUAGE

Federal regulations require that the State must require each MCO to make its written materials that are critical to obtaining services, including denial notices, available in the prevalent non-English languages in the MCO's particular service area and available in alternative formats upon request of the enrollee or potential enrollee at no cost, and include the telephone number of the MCO's customer service unit (42 CFR § 438.10(d)(3)).

State regulations and the Contract in effect during our audit period state that denial notices are required to include the MCO's contact information, including name, address, and telephone number, if applicable (OAR 410-141-3885(2)(a)(A) and the Contract, Exhibit I – Grievance and Appeal System, section 3(a)(2)(b)).

State regulations require written materials, including appeal notices and all denial and termination notices, to be made available in the prevalent non-English languages in the MCO's particular service area (OAR 410-141-3585(3)). Further, the Contract in effect during our audit period states that Health Share's denial notice must be consistent with the requirements of 42 CFR section 438.10, including, without limitation, translating a denial notice for those enrollees who speak prevalent non-English languages (the Contract, Exhibit I – Grievance and Appeal System, section 3(a)(1)).

For 7 of the 100 sampled denied service requests, denial notices provided to enrollees did not include Health Share's contact information or were not provided in the enrollee's non-English language.

For six of the seven denied service requests, denial notices sent to enrollees included the subcontractors' contact information, but did not include Health Share's contact information. Health Share stated that it required subcontractors to include its contact information in the notice. Health Share also stated that it allowed subcontractors to include on denial notices either Health Share's contact information only or both the subcontractors' own contact information and Health Share's contact information. The associated subcontractor explained

that, during our audit period, it used a template that Health Share had previously approved that did not include Health Share's contact information.

For the remaining denied service request, the provider submitted the prior authorization request and medical records that stated that the enrollee was "Spanish-speaking only." However, the denial notice was in English, and the subcontractor did not send the enrollee a version in Spanish. The subcontractor explained that, during our audit period, it did not have a process to provide denial notices in languages other than English.

Excluding Health Share's contact information in the denial notice may prevent enrollees from contacting Health Share if they encounter problems with the subcontractor. Also, providing denial notices in a language that is not the enrollee's prevalent non-English language could place the health and safety of the enrollee at risk since the enrollee may not understand that the requested service has been denied or the reason for the denial. The enrollee therefore may not be able to request alternative services or appeal the denial decision, which may lead to delays in obtaining necessary services.

DENIAL NOTICES WERE NOT PROVIDED TIMELY

Federal regulations require that MCOs must provide notice of authorization decisions as expeditiously as the enrollee's condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service (42 CFR § 438.210(d)(1)). Federal regulations also require that MCOs must provide notice for all covered outpatient drug authorization decisions by telephone or other telecommunication device within 24 hours of a request for prior authorization (42 CFR § 438.210(d)(3)). In addition, Federal regulations require that the State must require each MCO to make its written materials that are critical to obtaining services, including appeal notices and all denial and termination notices, available in the prevalent non-English languages in its particular service area (42 CFR § 438.10(d)(3)).

State regulations and the Contract in effect during our audit period state that, for standard authorization requests for services not previously authorized, each MCO must provide notice as expeditiously as the enrollee's condition requires and no later than 14 days following receipt of the request for service (OAR 410-141-3835(10)(a)(A), the Contract, Exhibit B – SOW – Part 2, 3(b)(11), and Exhibit I – Grievance and Appeal System, section 3(b)(3)(a)). Further, State regulations require that a response for outpatient drugs should be provided within 24 hours (OAR 410-141-3835(10)(b)(A)).[13] In addition, State regulations require that written materials, including appeal notices and all denial and termination notices be made available in the prevalent non-English languages in the MCO's particular service area (OAR 410-141-3585(3)). The Contract in effect during our audit period states that the notice must meet language and format requirements including, without limitation, translating a Notice of Adverse Benefit

[13] The Contract, Exhibit B – SOW – Part 2, 3(b)(13), and Exhibit I, Grievance and Appeal System, section 3(b)(4).

Determination (NOABD) for those enrollees who speak prevalent non-English languages (the Contract Exhibit I – Grievance and Appeal System, section 3(a)(1)).

For 6 of the 100 sampled denied service requests, denial notices were not provided to enrollees timely as required.

- The denial notices for three denied service requests were not provided to the enrollee and provider within 14 calendar days following receipt of the requests for service. (See the example below.)

- The denial notices for two denied service requests were not provided to the enrollees in their prevalent non-English language (i.e., Spanish) within 14 calendar days following receipt of the requests for service.[14]

- The denial notice for one request for prior authorization of a drug was not provided within 24 hours after the request.

Example of a Denial for Which Health Share's Subcontractor Did Not Follow Established Timeframes for Denial Notices

A provider submitted a prior authorization request for wound supplies on behalf of an enrollee who had surgery. The subcontractor received the prior authorization request on August 22, 2023, and denied the request because the enrollee's diagnosis was not a covered diagnosis.

Although the subcontractor was required to provide the denial notice within 14 calendar days following receipt of the request for service, it mailed the denial notice to the enrollee and provider on October 9, 2023, 48 calendar days after the subcontractor received the request.

The subcontractor that incorrectly processed five of the six denied service requests stated that the denial notices were not provided timely because, during our audit period, its utilization management department experienced relatively high staff turnover, resulting in a lower number of experienced staff to manage an increased volume of service requests. The subcontractor that incorrectly processed one of the six denied service requests stated that the pharmacist who reviewed the original prior authorization request incorrectly assessed it as a duplicate and canceled it. The request was reopened to make an appropriate decision, resulting in the denial not being provided to the enrollee timely.

Providing late denial notices could place the health and safety of enrollees at risk since enrollees may not receive medically necessary services timely in situations in which alternate

[14] The two denial notices in the English language were provided timely to the enrollees.

services may be requested by providers. In addition, it may lead to additional delays in obtaining necessary services if an enrollee wants to appeal the denial decision.

PROVIDERS WERE NOT CONSULTED WHEN NECESSARY

Federal regulations state that each contract must require that the MCO consult with the requesting provider for medical services when appropriate (42 CFR § 438.210(b)(2)(ii)).

State regulations and the Contract in effect during our audit period state that the MCO and its subcontractors shall consult with the requesting provider for medical services when necessary (OAR 410-141-3835(10)(f)(A) and the Contract Exhibit B – SOW – Part 2, 3(b)(1)).

For 4 of the 100 sampled denied service requests, the providers were not consulted when necessary.

Example of a Denial for Which Health Share's Subcontractor Did Not Consult With the Requesting Provider

A provider submitted a prior authorization request for a drug to treat an enrollee who had a condition that affected her skin and joints. The medical record that was submitted with the prior authorization request stated that the enrollee had allergies to non-steroidal anti-inflammatory (NSAID) drugs.

The subcontractor's pharmacist who made the denial determination stated the following in the determination notes: "Not accepting NSAID allergy without more information." However, instead of requesting additional information from the provider, the subcontractor's pharmacist denied the prior authorization request.

The subcontractors that incorrectly processed the four denied service requests did not follow their policies and procedures that required requesting additional information from the provider when insufficient information is provided or there are discrepancies in the provided information.

Making denial decisions without consulting with the provider when necessary could place the health and safety of the enrollee at risk because the enrollee may not receive medically necessary services. Such denials may also lead to additional delays in obtaining necessary services while an enrollee appeals a denial decision that should have been approved.

A DENIAL NOTICE WAS NOT PROVIDED TO THE PROVIDER

Federal regulations require that each contract must provide for the MCO to notify the requesting provider of any decision by the MCO to deny a service authorization request, or to

authorize a service in an amount, duration, or scope that is less than requested (42 CFR § 438.210(c)).

State regulations require that when a Managed Care Entity (MCE) has made an adverse benefit determination, the MCE must give the requesting provider, the enrollee, and the enrollee's representative a written NOABD (OAR 410-141-3885(1)).[15]

The Contract in effect during our audit period requires Health Share to provide written notification to the requesting provider when Health Share denies a service authorization request of a covered service or approves a service authorization request for an amount, duration, or scope that is less than requested (the Contract, Exhibit B – SOW – Part 2, 3(b)(17)). In addition, when Health Share has made or intends to make an adverse benefit determination, Health Share must notify the requesting provider (the Contract, Exhibit I – Grievance and Appeal System, section 3 "Notice of Adverse Benefit Determination – Requirements").

For 1 of the 100 sampled denied service requests, a denial notice was not provided to the requesting provider.[16] For this denied service request, the subcontractor documented in its activity log that no verbal notification was provided to the provider, and that the provider notification was faxed. However, the fax failed. The following day, the subcontractor documented that the notification to the provider was sent a second time from the failed fax queue. However, the fax failed again and, on the third day, the subcontractor deleted the failed fax. The subcontractor stated that its process was that failed faxes go to a "failed fax" queue, and a technician would call the provider to verify the fax number and would then resend the notice. However, there was no evidence of a successful fax delivery, and the subcontractor confirmed the denial notice was not mailed to the provider.

The subcontractor's policy stated that in the event of an adverse determination, the provider will be informed in writing through fax if not notified orally when applicable. The policy did not include alternative methods (e.g., mail) for notifying the provider in writing of a denied service request.

Not notifying providers of the denial decision may cause delays in enrollees receiving necessary services. In addition, providers will not know the reason for the denial and will not be able to request alternative services for the enrollees or appeal the denial decision.

[15] According to OAR 410-141-3500(49), MCE "is a general term that means an entity that enters into one or more contracts with the [State agency] to provide services in a managed care delivery system, including but not limited to the following types of entities defined in and subject to 42 CFR Part 438: managed care organizations (MCOs) . . . . A CCO is an MCE for its managed care contract(s) with the [State agency], without regard to whether the contract(s) involves federal funds or state funds or both."

[16] The enrollee received a written notice of the denial decision.

HEALTH SHARE DID NOT ALWAYS IDENTIFY PRIOR AUTHORIZATIONS FOR SERVICES THAT WERE INCORRECTLY DENIED BY ITS SUBCONTRACTORS

Based on our sample results, we estimated that for our audit period of calendar year 2023, 5,677 denied service requests that required a prior authorization (21 percent of the denied service requests covered by our audit) did not comply with all Federal and State requirements.

Although Health Share fully delegated prior authorization decisions to its subcontractors during our audit period, it performed quarterly reviews of a sample of subcontractors' denial notices and related prior authorization documentation.[17] These reviews were not effective in detecting certain issues with prior authorization denials made by its subcontractors. Health Share stated that, after our audit period, it has expanded the scope of its quarterly reviews, including verifying whether final clinical denial determinations are made by individuals with appropriate expertise. Health Share also stated that it provides feedback to its subcontractors regarding clinical qualification requirements for reviewers at all decision-making levels based on the results of its quarterly reviews.

RECOMMENDATIONS

- We recommend that Health Share continue to assess and improve its quarterly reviews of denial notices and related prior authorization documentation by verifying that: (1) denials are made by individuals with the appropriate expertise in addressing the enrollees' medical and oral health needs; (2) denial notices include Health Share's contact information and translated denial notices are provided in non-English languages when appropriate; and (3) denial notices are provided to enrollees and to providers within Federal and State established timeframes.

- We recommend that Health Share require its subcontractors to update their policies to include alternate methods of notifying providers of the denial decision when the providers are not notified verbally or in writing through fax.

- We recommend that Health Share clarify to its subcontractors when to consult with providers to ensure that provider outreach is conducted when insufficient information is provided with the prior authorization request or there are discrepancies in the provided information.

- We recommend that Health Share request its subcontractors to report in the quarterly denial data: (1) the credentials of the individual who made the denial decision to identify whether denials were made by individuals who had appropriate expertise in addressing the enrollees medical and oral needs and (2) the enrollees' non-English language to identify whether denial notices were sent in the enrollees' non-English language.

[17] According to Health Share, these quarterly reviews began during the first quarter of CY 2021.

HEALTH SHARE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Health Share concurred with our first three recommendations and did not concur with the first part of our fourth recommendation.[18] Health Share also provided information on actions that it has taken and planned to take to address our recommendations. After reviewing Health Share's comments, we revised our fourth recommendation to indicate that Health Share's subcontractors report the *credentials* of the individual who made the denial decision—not the *title* of the individual. We maintain that the recommendation, as revised, is valid.

Health Share's comments are included in their entirety as Appendix G.

HEALTH SHARE COMMENTS

Regarding our first recommendation, Health Share stated that, since the first quarter of 2024, it has conducted enhanced quarterly reviews of denial notices and supporting documentation to verify that individuals making denial decisions have the appropriate expertise to address enrollees' health needs. According to Health Share, the reviews are also conducted to confirm that denial notices sent to members and providers include Health Share's logo, address, and phone numbers, and to confirm that denial notices are provided to enrollees and providers within Federal and State established timeframes. Health Share also stated that, as part of its appeal review process, its staff reviews documentation, including noting when an enrollee has a documented language preference other than English and verifying that all written communication were sent in that language.

Regarding our second recommendation, Health Share stated that it performed subcontractor policy and procedure reviews during a 2025 compliance audit to ensure that subcontractors' policies included alternate methods of notifying members and providers of denial decisions. In addition, Health Share stated that, with the enhanced quarterly review of denial files, it updated the review tool to specifically track the timeliness of prior authorization notifications.

Regarding our third recommendation, Health Share stated that it provided education to subcontractors regarding consulting with providers when insufficient information is provided with the prior authorization request or there are discrepancies in the information provided. In addition, Health Share stated that it instructed subcontractors to use a 14-day extension period allowable under State regulations to obtain sufficient information for decision making and reminded them to make three attempts using two different methods when requesting information needed to process a prior authorization request.

[18] Health Share also requested that the title of this report be changed for consistency with the title of a report cited in Appendix B. We updated the report title to align with some of the issued reports listed in Appendix B.

Regarding our fourth recommendation, Health Share did not concur with the first part of the recommendation in our draft report, and stated that Federal and State regulations do not require that decisions to deny a service authorization request be made by individuals based on their job titles. Rather, Health Share stated that credentials are a more appropriate indicator of clinical expertise, and since 2024, it has reviewed appeals of denial notices daily to ensure that the denial decisions were issued by individuals with appropriate credentials. Health Share noted that the quarterly denial data and the reporting tool are prescribed by the State agency and do not currently have a field related to the title or credentials of the individual making the decision. Therefore, any changes to this data set must be made by the State agency. Health Share also stated that it verifies credentials during its enhanced quarterly reviews.

Health Share concurred with the second part of our fourth recommendation: to require its subcontractors to include enrollees' non-English language in their quarterly denial data reports. Health Share also stated that it is participating in a workgroup convened by the State agency for the purpose of improving its denial data-reporting tool. Health Share stated that discussions are still ongoing on how to add a data element related to whether denial notices were issued in an enrollee's preferred language. In addition, Health Share stated that it requires its subcontractors to report whether denial notices were sent in a non-English language in the quarterly denial data and, beginning in the first quarter of 2024, it reviewed whether denial notices were sent in a non-English language as part of its enhanced quarterly subcontractor denial notice file reviews.

OIG RESPONSE

After reviewing Health Share's comments, we revised the first part of our fourth recommendation to indicate that Health Share's subcontractors report the credentials of the individual who made the denial decision. We maintain that the entirety of our fourth recommendation, as revised, is valid. While there are no Federal or State regulations requiring denial decisions to be tied to a job title, Health Share can request its subcontractors to report the credentials of the individuals making denial decisions in the quarterly denial data submitted to Health Share. Health Share can then use its enhanced quarterly reviews to ensure denial decisions are made by individuals who have appropriate expertise in addressing the enrollees' medical and oral health needs. Health Share can then exclude the specific data from the data set it reports to the State agency.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

During our audit period (CY 2023), Health Share denied 27,032 service requests for Medicaid medical services and items, prescription drugs, and dental procedures that required a prior authorization and had a denial date in CY 2023, including prior authorization requests denied by Health Share during the appeal process in CY 2023.[19] We selected and reviewed a random sample of 100 denied service requests that required a prior authorization to determine whether Health Share denied the requests in accordance with Federal and State requirements.

We reviewed the design, implementation, and operating effectiveness of Health Share's internal controls related to our objective. We obtained an understanding of the Federal and State requirements, and contractual requirements that were relevant to Health Share's monitoring process to ensure that Health Share complied with requirements when denying services that required a prior authorization. We reviewed actions taken by Health Share in CY 2023 to ensure its subcontractors complied with Federal and State requirements.
Our audit enabled us to establish reasonable assurance of the authenticity and accuracy of the prior authorization denials and appeals data obtained from Health Share, but we did not assess the completeness of the data.

We conducted our audit work from August 2024 through May 2026.

METHODOLOGY

We took the following steps to accomplish our objective:

- Reviewed applicable Federal and State requirements, and the Contract between Health Share and the State agency for our audit period

- Interviewed Health Share representatives to obtain an understanding of Health Share's policies and procedures for processing service requests that require a prior authorization as well as Health Share's appeal and monitoring activities

- Obtained and reviewed Health Share's and its subcontractors' policies and procedures covering its approval and denial, and appeal processes for service requests that required a prior authorization

- Obtained and analyzed prior authorization denials and appeals data maintained by Health Share

[19] Our audit excluded denied service requests for behavioral health services.

- Selected a random sample of 100 prior authorization denials and appeals and reviewed the following supporting documentation for each to determine whether Health Share complied with Federal and State requirements when denying these services:

    - Denial and appeal letters to determine whether they were sent to the enrollee and provider within the required timeframe and included the correct content and details in the enrollee's prevalent non-English language, if applicable

    - The OAR, Prioritized List, Health Share's Medicaid Member Handbook, and Contract to determine whether the sampled denied service requests and related appeals were for covered services

    - Whether the denial decision was made by an individual who had the appropriate expertise in addressing the services requested

    - The prior authorization requests submitted by the provider and other supporting documentation for those services that were denied and appealed

- Estimated the total number and percentage of denied service requests in the sampling frame that did not comply with Federal and State requirements

- Discussed the results of our audit with Health Share representatives

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Community Behavioral Health Did Not Comply With Requirements When Denying Prior Authorization Requests	A-03-24-00204	06/08/2026
Louisiana Healthcare Connections Generally Complied With Federal and State Process Requirements When Denying Prior Authorization Requests	A-06-24-02000	03/30/2026
Availability of Surveyed Behavioral Health Providers to Treat New Patients Enrolled in Medicare and Medicaid	OEI-09-21-00410	06/23/2025
CMS Did Not Ensure That Selected States Complied with Medicaid Managed Care Mental Health and Substance Use Disorder Parity Requirements	A-02-22-01016	03/25/2024
New York Did Not Ensure That a Managed Care Organization Complied With Requirements For Denying Prior Authorization Requests	A-02-21-01016	09/18/2023
Amerigroup Iowa's Prior Authorization and Appeal Processes Were Effective, but Improvements Can Be Made	A-07-22-07007	09/13/2023
High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care	OEI-09-19-00350	07/17/2023
Keystone First Should Improve Its Procedures for Reviewing Service Requests That Require Prior Authorization	A-03-20-00201	12/20/2022
Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care	OEI-09-18-00260	04/27/2022

APPENDIX C: SERVICE REQUEST DENIALS BY CATEGORY

Type of Service Requested	What Was Denied (Service Category Examples)	Number of Denied Requests	Percentage of All Denied Requests	Number of Denied Requests Sampled
Dental	➢ Dentures ➢ Root canal	2,394	9%	4
Medical	➢ Durable medical equipment ➢ Inpatient ➢ Outpatient ➢ Physical therapy	6,395	24%	20
Pharmacy	➢ Non-Formulary ➢ Not FDA approved	16,815	62%	71
Radiology	➢ Imaging ➢ Diagnostic testing	1,428	5%	5
Totals		**27,032**	**100%**	**100**

APPENDIX D: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of 27,032 service requests that required a prior authorization and were denied between January 1, 2023, and December 31, 2023, including prior authorization requests denied by Health Share during the appeal process in CY 2023.

SAMPLE UNIT

The sample unit was a denied service request that required a prior authorization.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 denied service requests.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services (OAS) statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We sorted the sample units in the sampling frame by Notice of Adverse Benefit Determination Identification Number. We then consecutively numbered the sample units in the sampling frame. After generating the random numbers according to our sample design, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OIG-OAS statistical software to estimate the total number and percentage of service requests improperly denied by Health Share in the sampling frame. We used the software to calculate the point estimate and the corresponding lower and upper limits of the two-sided 90-percent confidence interval.

APPENDIX E: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Details and Results[20]

Requests in Sampling Frame	Sample Size	Number of Improperly Denied Service Requests in Sample
27,032	100	21

Table 2: Estimated Number and Percentage of Improperly Denied Service Requests in the Sampling Frame *(Limits Calculated at the 90-Percent Confidence Level)*

	Percentage	Number
Point estimate	21.00%	5,677
Lower limit	14.54%	3,930
Upper limit	28.80%	7,785

[20] Of the 100 sampled denied service requests, 6 did not comply with more than 1 requirement.

APPENDIX F: FEDERAL AND STATE REQUIREMENTS

FEDERAL REQUIREMENTS

Requirements of Prior Authorization Programs, Section 1927(d)(5)(A) of the Act

> A State plan under this title may require, as a condition of coverage or payment for a covered outpatient drug . . . the approval of the drug before its dispensing . . . only if the system providing for such approval . . . provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization.

Language and Format, 42 CFR § 438.10(d)(3)

> The State must require each MCO . . . to make its written materials that are critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices available in the prevalent non-English languages in its particular service area. Written materials that are critical to obtaining services must also be made available in alternative formats upon request of the potential enrollee or enrollee at no cost, include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, and include the toll-free and TTY/TDY telephone number of the MCO . . . member/customer service unit. Auxiliary aids and services must also be made available upon request of the potential enrollee or enrollee at no cost.

Authorization of Services, 42 CFR § 438.210(b)

> For the processing of requests for initial and continuing authorizations of services, each contract must require . . .
>
> (2) That the MCO, . . .
>
> (ii) Consult with the requesting provider for medical services when appropriate. . . .
>
> (3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.

Notice of Adverse Benefit Determination, 42 CFR § 438.210(c)

> Each contract [between the State and an MCO] must provide for the MCO . . . to notify the requesting provider, and give the enrollee written notice of any decision by the MCO . . . to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

Timeframe for Decisions, 42 CFR § 438.210(d)

> Each MCO . . . contract must provide . . .
>
> (1) For standard authorization decisions, [the MCO must] provide notice as expeditiously as the enrollee's condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if -
>
> (i) The enrollee, or the provider requests the extension; or
>
> (ii) The MCO . . . justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest. . . .
>
> (3) For all covered outpatient drug authorization decisions, [the MCO must] provide notice as described in section 1927(d)(5)(A) of the Act.

STATE REQUIREMENTS

MCE Member Relations: Education and Information, OAR 410-141-3585(3)

> MCEs shall have a mechanism to help members understand the requirements and benefits of the MCE's coordinated care model. The mechanisms developed shall be culturally and linguistically appropriate. Written materials, including provider directories, member handbooks, appeal and grievance notices, and all denial and termination notices are made available in the prevalent non-English languages as defined in OAR 410-141-3575 in its particular service area and be available in formats noted in section (5) of this rule for members with disabilities. MCEs shall accommodate requests made by other sources such as members, family members, or caregivers for language accommodation, translating to the member's language needs as requested.

MCE Service Authorization, OAR 410-141-3835(10)

> (a)(A) For standard authorization requests for services not previously authorized, [the MCE must] provide notice as expeditiously as the enrollee's condition requires and no later than 14 days following receipt of the request for

service with a possible extension of up to 14 additional days, if the following applies:

(i) The member, the member's representative, or provider requests an extension; or

(ii) The MCE justifies (to the [State agency] upon request) a need for additional information and how the extension is in the member's interest. . . .

(b)(A) Respond to requests for prior authorizations for outpatient drugs within 24 hours as described in 42 CFR 438.210(d)(3) and section 1927(d)(5)(A) of the Social Security Act. An initial response shall include: . . .

(ii) A written notice of adverse benefit determination of the drug to the member, and telephonic or electronic notice to the prescribing practitioner, and when known to the MCE, the pharmacy if the drug is denied or partially approved; or

(iii) A written, telephonic, or electronic request for additional documentation to the prescribing practitioner when the prior authorization request lacks the MCE's standard information collection tools such as prior authorization forms or other documentation necessary to render a decision . . .

(f)(A) MCEs shall consult with the requesting provider for medical services when necessary . . .

(f)(B) Decisions shall be made by an individual who has clinical expertise in addressing the member's medical, behavioral, or oral health needs or in consultation with a health care professional with clinical expertise in treating the member's condition or disease. This applies to decisions to:

(i) Deny a service authorization request;

(ii) Reduce a previously authorized service request; or

(iii) Authorize a service in an amount, duration, or scope that is less than requested.

Grievances & Appeals: Notice of Action/Adverse Benefit Determination, OAR 410-141-3885

(1) When an MCE has made an adverse benefit determination, the MCE shall give the requesting provider, the member and the member's

representative a written notice of adverse benefit determination (NOABD). The notice shall:

(a) Comply with the Authority's formatting and readability standards in OAR 410-141-3585 and 42 CFR § 438.10 and be written in plain language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing and following the process for requesting an appeal . . .

(2) (a) [Notices for pre-service denials are required to include]:

(A) MCE contact information and subcontractor contact information including name, address, and telephone number, if applicable, included in the [adverse benefit determination] notice excluding any cover pages. . . .

Authorization or Denial of Covered Services, the Contract, Exhibit B – SOW – Part 2, Section 3(b)

. . . Contractor's Service Authorization Request policies and procedures must comply with all of the following and provide that:

(1) Contractor shall implement mechanisms to ensure consistent application of review criteria for Service Authorization and Prior Authorization decisions, taking into account applicable clinical practice guidelines, and consults with the requesting Provider when appropriate.

(2) Any and all decisions to deny a Service Authorization Request, or to authorize a service in an amount, duration, or scope that is less than requested, be made by a Health Care Professional who has appropriate clinical expertise in treating the Member's physical, mental, Oral Health condition or disease, as applicable.[21]

(11) In accordance with 42 CFR § 438.210(d)(1), Contractor shall provide notice to, in response to all standard Service Authorization Requests, the requesting provider as expeditiously as the member's physical health, Oral Health . . . condition requires, not to exceed fourteen (14) calendar days following receipt of the request for service, with a possible extension of fourteen (14) additional calendar days if the Member or Provider requests an extension, or

[21] OAR 410-120-0000 defines "Health Care Professionals" as individuals with current and appropriate licensure, certification, or accreditation in a medical, mental health, or dental profession who provide health services, assessments, and screenings for clients within their scope of practice, licensure, or certification.

if Contractor justifies a need for additional information and can demonstrate that the extension is in the Member's interest. . . .

(13) For all covered Outpatient drug authorization decisions, Contractor shall provide a response as described in section 1927(d)(5)(A) of the Act and 42 USC 1396r–8(d)(5)(A) and OAR 410-141-3835.

(17) Contractor shall provide written notification to the requesting Provider when Contractor denies a request for authorization of a Covered Service or when Contractor approves a Service Authorization Request but such approval is for an amount, duration, or scope that is less than requested . . .

Notice of Adverse Benefit Determination - Requirements, the Contract, Exhibit I – Grievance and Appeal System, Section 3

When Contractor has made, or intends to make, an Adverse Benefit Determination Contractor shall notify the requesting Provider and mail to the Member a written Notice of Adverse Benefit Determination.

a. Contractor's NOABD must comply with all of the following requirements:

(1) Meet the language and format requirements in Secs. 4 and 5 of Exhibit B, Part 3 of this Contract and be consistent with the requirements of OAR 410-141-3580, 410-141-3585, and 42 CFR § 438.10, including without limitation, translating a NOABD for those Members who speak Prevalent Non-English Languages.

(2) Include all of the following for *pre-service* denials: . . .

(b) Contractor's contact information including name, address, and telephone number.

b. Contractor shall, for every NOABD, meet the following timeframes: . . .

(3) For Prior Authorizations that deny a requested service or that authorize a service in an amount, duration, or scope that is less than requested and are standard authorization decisions:

(a) The NOABD shall be mailed as expeditiously as the Member's health condition requires and in all cases not later than fourteen (14) calendar days following receipt of the request for service, except that:

i. Contractor may have an extension of up to fourteen (14) additional days if the Member or the Provider

requests the extension or when Contractor can justify that a need for additional information and how the extension is in the Member's interest; Contractor shall provide its justification to OHA . . .

(4) For all covered Outpatient Drug authorization decisions, Contractor shall provide a response as described in OAR 410-141-3835.

APPENDIX G: HEALTH SHARE COMMENTS

Jessica Yun Kim
Regional Inspector General for Audit Services
U.S. Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region IX
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

June 18, 2026
VIA EMAIL

Subject: Response to Draft Audit Report Number A-09-24-02007

Dear Jessica Yun Kim,

Please accept this as Health Share of Oregon's response to draft audit report number A-09-24-02007, titled *Health Share of Oregon Did Not Comply With Federal and State Requirements for 21 Percent of Denied Prior Authorization Requests,* prepared by the U.S. Department of Health and Human Services' Office of Inspector General (HHS-OIG).

Health Share of Oregon has administered Medicaid benefits to Oregon's most vulnerable population in Clackamas, Multnomah, and Washington counties since 2012 and is committed to ensuring that this population has access to the healthcare services they need. Health Share is also committed to maintaining the highest standards of compliance with state and federal regulations, including by maintaining an effective regulatory compliance program including oversight monitoring of our subcontractors.

As detailed below, Health Share made improvements to our compliance program in 2024 and 2025 that include structured routine monitoring and auditing of subcontractors with corrective action for any identified deficiencies; improved compliance program infrastructure such as clear guidance through strengthened policies and procedures; and the development of a distinct board level Regulatory and Corporate Compliance Committee (RCC) for oversight.

Health Share appreciates the opportunity to respond to HHS-OIG's recommendations. Health Share concurs with all but one of the four recommendations and has implemented numerous improvement activities to address the issues identified by HHS-OIG and demonstrate compliance.

Customer Service:
503-416-1460 or
888-519-3845 (TTY/TDD: 711)

Website:
healthshareoforegon.org

Administrative Office:
2121 SW Broadway, #200
Portland, OR 97201

As a preliminary matter, Health Share respectfully requests that the title of this report be changed for consistency with the title of a report issued by your office and cited in Appendix B: Related Office of Inspector General Reports. In that report, titled *Amerigroup Iowa's Prior Authorization and Appeal Processes Were Effective, but Improvements Can Be Made* (A-07-22-07007), your office found that 20 percent of the sampled prior authorization denials did not comply with federal and state requirements. This error rate is nearly identical to the error rate found in the current audit sample, which Health Share does not dispute.

1. Continue to assess and improve its quarterly reviews of denial notices and related prior authorization documentation by verifying that: (1) denials are made by individuals with the appropriate expertise in addressing the enrollees' medical and oral health needs; (2) denial notices include Health Share's contact information and translated denial notices are provided in non-English languages when appropriate; and (3) denial notices are provided to enrollees and to providers within Federal and State established timeframes.

Health Share concurs with this recommendation and has already implemented improvements to its quarterly reviews of denial notices and related authorization documents to ensure denials are made by individuals with the appropriate expertise in addressing the enrollees' health needs; denial notices include Health Share's contact information and translated denial notices are provided in non-English languages when appropriate; and denial notices are provided to enrollees and to providers timely.

(1). Since Q1 2024, Health Share has conducted enhanced quarterly reviews of denial notices (Notices of Adverse Benefit Determination, or NOABDs) and supporting documentation. These reviews verify that individuals making denial decisions have the appropriate expertise to address enrollees' health needs.

Health Share requires that subcontractors remediate any deficiencies discovered during the enhanced quarterly review process in alignment with Health Share's Delegated Entity Corrective Action and Sanctions policy. In that scenario, Health Share ensures that formal corrective action processes are followed by issuing Notices of Inadequate Performance or Notices of Non-Compliance requesting a plan for improvement from subcontractors to prevent noncompliance going forward. The issuance of these notices is formally reported to the board-level Health Share RCC for oversight.

In addition, Health Share has reviewed its internal policies to confirm those policies require subcontractors to use individuals with the appropriate clinical expertise to make prior authorization decisions.

Health Share also conducted a 2025 Compliance Audit of subcontractor policies and procedures, which found that all subcontractors complied with the requirement that denial decisions be made by individuals with the appropriate expertise to address enrollees' health needs.

Health Share previously had compliance spot checks as part of its appeal process. These spot checks allow Health Share to more quickly identify and address the expertise of the decision-maker than the enhanced quarterly review process alone. In August 2025, Health Share enhanced those spot checks. Under the revised process, Health Share more thoroughly reviews the elements of the initial prior authorization request and denial that had led to the member's appeal. While the appeal compliance spot checks are a less formal procedure than the quarterly file reviews, they provide feedback to our subcontractors that is closer to real-time. This revised process has allowed Health Share to review a much larger number of cases than the formal quarterly reviews alone.

As part of the enhanced compliance spot checks that take place during the appeal review process, Health Share staff review the documentation of the initial prior authorization request and denial, examining these files for compliance with federal and state requirements, including verification of the name and credentials of the individuals who made the initial decision to deny the prior authorization. If Health Share finds that the initial decision maker did not have the appropriate clinical expertise to make the decision, Health Share notifies the subcontractor that they can take appropriate action to prevent a similar issue going forward. Health Share also considers whether more formal corrective action is needed. To date, since beginning these revised appeal compliance reviews, Health Share has not had to escalate any issues related to improper qualifications of reviewers.

(2). Since Q1 2024, Health Share has implemented enhanced quarterly reviews to confirm that Health Share's logo, address, and phone number are included on NOABDs sent to members and providers. Health Share has also implemented an annual review of NOABD templates used by subcontractors. All subcontractor templates met compliance with this requirement for 2026. These requirements are enforced through the corrective action processes, such as issuance of a Notice of Inadequate Performance or Notice of Non-Compliance, as outlined in Health Share's Delegated Entity Corrective Action and Sanctions policy requesting a plan for improvement from subcontractors to prevent noncompliance going forward. The issuance of these notices is formally reported to the board-level Health Share RCC for oversight.

Health Share's enhanced quarterly NOABD file reviews have also been effective to identify instances of noncompliance related to non-English language notices. These findings of missing or undocumented language taglines, failure to meet Section 1557 requirements for required languages

and formatting, and inconsistent or incomplete translations within letters have been successfully remediated.

Further, under the enhanced spot checks Health Share conducts as part of its appeal review process, Health Share staff review the documentation of the initial prior authorization request and denial, examining these files for compliance with required elements, including noting when a member has a documented language preference other than English, and verifying that all written communications, not just the denial notices, were sent in that language. If Health Share finds that a letter was not sent in the preferred language, Health Share notifies the subcontractor so that they can take appropriate action to prevent a similar issue going forward. Health Share also considers whether more formal corrective action is needed. To date since beginning these revised appeal compliance reviews, Health Share has not had to escalate any issues related to written communications with members not being in the member's preferred language.

(3). Health Share conducts quarterly review to confirm that denial notices are provided to enrollees and providers within federal and state established timeframes. These reviews are effective in identifying any instances of noncompliance with timeliness requirements, including cases in which prior authorization decisions were not made within required timeframes and cases in which no evidence of required extension notices was present. Review criteria also require that NOABDs be issued immediately when timeframes are exceeded and that notice and effective dates be clearly documented. These requirements are enforced through the corrective action processes, such as issuance of a Notice of Inadequate Performance or Notice of Non-Compliance, as outlined in Health Share's Delegated Entity Corrective Action and Sanctions policy requesting a plan for improvement from subcontractors to prevent noncompliance going forward. The issuance of these notices is formally reported to the board-level Health Share RCC for oversight.

Health Share's 2025 Compliance Audit of subcontractor policies and procedures found that all policies comply with federal and state requirements related to timely notification of prior authorization decisions to both members and providers.

Further, under the enhanced spot checks Health Share conducts as part of its appeal review process, Health Share staff review the documentation of the initial prior authorization request and denial, examining these files for compliance with required elements, including the timeliness of the initial decision and notice to the member and provider. This includes verification of whether the decision timeline was extended, in cases where this is allowed, whether the justification for the extension was documented, and whether the member and provider were given proper notification of the extension. If Health Share finds that the timeliness requirements were not met, Health Share notifies the

subcontractor that they can take appropriate action to prevent a similar issue going forward. Health Share also considers whether more formal corrective action is needed. To date, since beginning these revised appeal compliance reviews, Health Share has not had to escalate any issues related to untimely decisions or notices.

2. We recommend that Health Share require its subcontractors to update their policies to include alternate methods of notifying providers of the denial decision when the providers are not notified verbally or in writing through fax.

Health Share concurs with this recommendation and has already implemented improvements such as subcontractor policy reviews to ensure that policies include alternate methods of notifying providers of the denial decision. Health Share conducted subcontractor policy and procedure reviews in Q4 2025 as part of a 2025 Compliance Audit. This audit included a review of subcontractor policies for notifying members and providers of denial decisions.

Through the enhanced quarterly NOABD reviews, Health Share evaluates the timeliness of these notifications by reviewing the notification date and effective date of the denial decision. Beginning with the Q4 2025 enhanced quarterly review of NOABD files, Health Share updated the review tool to specifically track the timeliness of prior authorization notifications.

Health Share's 2025 Compliance Audit of subcontractor policies and procedures found that all subcontractors met compliance with the following Oregon Health Authority (OHA) contract requirements:

> *"The CCO (or Subcontractor) has and follows written policies and procedures that include processes for notifying the requesting provider and giving the member written notice of any decision to a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (notice to the provider need not be in writing).*
>
> *a. If the CCO (or Subcontractor) denies a request for a service authorization or authorizes a service in an amount, duration or scope less than requested, the Subcontractor mails the notice of adverse benefit determination (NOABD) within the following time frames:*
>
> *i. For standard service authorization decisions that deny or limit services, within 14 calendar days of the request for authorization.*
>
> *ii. For expedited service authorization decisions, within 72 hours of the request for authorization.*

iii. For service authorization decisions not reached within the required time frames specified in §438.210(d), on the date these time frames expire."

3. We recommend that Health Share clarify to its subcontractors when to consult with providers to ensure that provider outreach is conducted when insufficient information is provided with the prior authorization request or there are discrepancies in the provided information.

Health Share concurs with this recommendation and has already implemented improvements, such as subcontractor education when to provide clarification and instruction to subcontractors regarding consultation with providers when insufficient information is provided with the prior authorization request or there are discrepancies in the information provided.

Health Share's 2025 Compliance Audit of subcontractor policies and procedures found that all subcontractors met compliance with the following OHA contract requirements: "*The Subcontractor has and follows written policies and procedures to consult with the requesting provider for medical services when appropriate.*" In addition, Health Share provided education to subcontractors on using permissible extensions of time when needed to obtain missing information.

Health Share has instructed subcontractors to use the allowable 14-day extension period permitted under OAR 410-141-3835(10)(a)(A) when insufficient information is provided before issuing a denial for lack of information. This extension period provides additional time for provider outreach to obtain sufficient information for decision making. Health Share communicated this information to subcontractors April 2025 via email, as well as via trainings and workgroups in June, July, October, and November 2025. Subcontractors were also reminded to make three outreach attempts to providers using two different methods when requesting information needed to process a prior authorization request and to document those efforts to support compliance with these communication requirements.

4. We recommend that Health Share request its subcontractors to report in the quarterly denial data: (1) the title of the individual who made the denial decision to identify whether denials were made by individuals who had appropriate expertise in addressing the enrollees medical and oral needs and (2) the enrollees' non-English language to identify whether denial notices were sent in the enrollees' non-English language.

Health Share does not concur with the recommendation to request that its subcontractors include in their quarterly denial data the title of the individuals who made denial decisions. Federal and state regulations do not require that decisions to deny a service authorization request be made by

individuals based on their job titles. In addition, an individual's job title does not, by itself, demonstrate that the individual has appropriate clinical expertise to evaluate a prior authorization request. Credentials are a more appropriate indicator of clinical expertise, and since 2024, Health Share has reviewed appeals of denial notices on a daily basis to ensure that the denial decisions were issued by individuals with appropriate credentials. Health Share additionally verifies credentials during the quarterly enhanced review process noted above. Q3 2025 review and follow-up of NOABDs indicate all of Health Share's subcontractors' denial decisions documented the credentials of individuals who had the appropriate expertise to make the denial decision.

Health Share also notes that quarterly denial data is driven by our CCO contract with OHA. The data and the reporting tool are prescribed by OHA and do not currently have a field related to the title or credentials of the individual making the decision. Any changes to this data set must be made by OHA.

Health Share does concur with the recommendation to require its subcontractors to include enrollees' non-English language in their quarterly denial data reporting and has implemented processes for improvement. All CCOs are currently participating in a Workgroup convened by OHA throughout CY 2026 for the purpose of improving the tool used to report quarterly denial data. One of the improvements under discussion is the reporting of whether notices were issued in a member's preferred language. Discussions are still ongoing on how to add this data element in a way that ensures the results will be meaningful and actionable.

Health Share requires its subcontractors to report quarterly denial data to track whether denial notices were sent in a non-English language, and OHA began requiring CCOs to report those data in Q1 2025. Beginning Q1 2024, Heath Share has also reviewed if denial notices were sent in a non-English language as part of its enhanced quarterly subcontractor NOABD file reviews. To date, Health Share has not identified any instances in which members did not receive notices in their preferred language.

Health Share appreciates the opportunity to respond to the HHS-OIG draft 2023 audit recommendations and share improvements that have been made.

Sincerely,

Mindy Stadtlander, MPH
Health Share of Oregon
Chief Executive Officer

Report Fraud, Waste, and Abuse

OIG Hotline Operations accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs. Hotline tips are incredibly valuable, and we appreciate your efforts to help us stamp out fraud, waste, and abuse.

TIPS.HHS.GOV

Phone: 1-800-447-8477

TTY: 1-800-377-4950

Who Can Report?

Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. Learn more about complaints OIG investigates.

How Does It Help?

Every complaint helps OIG carry out its mission of overseeing HHS programs and protecting the individuals they serve. By reporting your concerns to the OIG Hotline, you help us safeguard taxpayer dollars and ensure the success of our oversight efforts.

Who Is Protected?

Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of whistleblowing or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.

Stay In Touch

Follow HHS-OIG for up to date news and publications.

 OIGatHHS

 HHS Office of Inspector General

Subscribe To Our Newsletter

OIG.HHS.GOV

Contact Us

For specific contact information, please visit us online.

U.S. Department of Health and Human Services
Office of Inspector General
Public Affairs
330 Independence Ave., SW
Washington, DC 20201

Email: Public.Affairs@oig.hhs.gov