HEALTH WEALTH CAREER

ADVANCED HEALTH (AH)

NQTL ANALYSIS

CONTENTS

INTRODUCTION

The Oregon Health Authority (OHA) contracted with Mercer Government Human Services Consulting, part of Mercer Health & Benefits LLC, to provide technical assistance with assessing compliance with the Medicaid and Children's Health Insurance Program (CHIP) regulations implementing the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA, herein referenced as "parity").

The parity rule requires that financial requirements and treatment limitations on MH/SUD benefits not be more restrictive than financial requirements or limitations on M/S benefits. This includes: (a) aggregate lifetime and annual dollar limits; (b) Financial requirements (FRs) such as copays; (c) quantitative treatment limitations (QTLs) such as visit limits; and non-quantitative treatment limitations (NQTLs), such as prior authorization. Summaries of OHA's parity analysis are available on the OHA website at: https://www.oregon.gov/OHA/HSD/OHP/Pages/MH-Parity.aspx

OHA analyzed the following four NQTLs for each CCO:

- **Utilization management (UM) applied to inpatient and outpatient benefits:** UM is typically implemented through prior authorization, concurrent review, and retrospective review (RR). Utilization management processes are applied to ensure the medical necessity and cost-effectiveness of MH/SUD and M/S benefits.
- **Prior authorization for prescription drugs:** Prior authorization is a process used to determine if coverage of a particular drug will be authorized.
- **Provider admission requirements:** Provider admission criteria may impose limits on providers seeking to participate in a CCO's network. Such limits include: closed networks, credentialing, requirements in addition to state licensing, and exclusion of specific provider types.
- **Out-of-network/out-of-state standards:** Out-of-network and out-of-state standards affect how members access out-of-network and out-of-state providers.

In the first phase of the NQTL analysis, OHA developed data collection worksheets based on guidance from the Centers for Medicare & Medicaid Services (CMS). In the second phase, OHA and Mercer developed a questionnaire for each NQTL. For each CCO, OHA and Mercer:

- Populated the applicable NQTL questionnaire with information provided by the CCO in Phase 1 as well as information about FFS benefits provided to CCO members.
- Identified specific additional information needed from the CCO and included questions and prompts to help the CCO gather the needed information. The questions and prompts were tailored to collect the additional information necessary for the NQTL analysis based on the COO and FFS information already collected.
- Reviewed the revised questionnaires and then conducted individual calls via webinar to discuss the updated information and any outstanding questions.
- Documented updates to the questionnaires in real-time.
- Followed up by email as needed to clarify or collect additional information.
- Finalized the information in the questionnaires.

Based on the information in the updated questionnaires (see sections 1-6 for each NQTL below) Mercer drafted preliminary compliance determinations regarding whether each NQTL met parity requirements and recommended action plans to address potential parity concerns. Mercer reviewed the updated

questionnaires, preliminary compliance determinations, and draft action plans with OHA, and OHA made the final compliance determination, including any applicable action plans (see sections 7 and 8, as applicable, for each NQTL below).

The following documents OHA's analysis of NQTLs applied by Advanced Health to MH/SUD benefits. This includes the updated questionnaires (see sections 1-6 for each NQTL below) and the final compliance determinations, including any applicable action plans (see sections 7 and 8, as applicable, for each NQTL below). Note that, as applicable, the CCO completed an action plan template with additional information on its own action plan, including timeframes, and will update that on an ongoing basis until the action plan has been completed.

INPATIENT UTILIZATION MANAGEMENT

NQTL: Utilization Management (Prior Authorization (PA), Concurrent Review (CR), Retrospective Review (RR))
Benefit Packages: A, B, E, and G for Adults and Children
Classification: Inpatient (IP)
CCO: Advanced Health (AH)

Benefit package A and B: MH/SUD benefits in columns 1 (CCO MH/SUD) and 2 (FFS MH/SUD) compared using strategies 1-7 to M/S benefits in column 3 (CCO M/S). These benefit packages include MH/SUD IP benefits managed by the CCO (Advanced Health sub-capitates two CMHPs, Curry Community Health and Coos Health and Wellness for MH services and sub-capitates ADAPT for SUD benefits), OHA, HIA and KEPRO, compared to M/S IP benefits in column 3 managed by the CCO.

Benefit package E and G: MH/SUD benefits in columns 1 (CCO MH/SUD) and 2 (FFS MH/SUD) compared using strategies 1, 2, 4 to M/S benefits in column 4 (FFS M/S). These benefit packages include MH/SUD IP benefits managed by the CCO, OHA, HIA and KEPRO, compared to M/S IP benefits in column 4 managed by OHA.

1. To which benefits is the NQTL assigned?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• (1, 2, 3, 4, 6, 7) PA and CR are required for planned non-emergency admissions to acute IP (in and out-of-network (OON)), PRTS, subacute and 10 days after an IP SUD detoxification admission. • (1, 2, 3, 4, 6, 7) Emergency admissions require notification within one business day of admission and subsequent CR. In practice, the CCO does not penalize providers.	• (1, 4) PA (only) for MH/SUD procedures performed in a medical facility (e.g., gender reassignment surgery authorizations for benefit packages E and G), experimental/investigational, and extra-contractual benefits are conducted by OHA consistent with the information in column 4 for benefit packages E and G. • (2, 4, 5) A level-of-care review is required for SCIP, SAIP and subacute care that	• (1, 2, 3, 4, 6, 7) PA and CR are required for planned non-emergency admissions to IP hospital, (in and OON) and IP hospice/palliative care (excludes routine maternity, which are 7% of admissions). • (1, 2, 3, 4, 6, 7) Emergency admissions require notification within one business day of admission and subsequent CR. • (1, 2, 3, 4) Skilled nursing facility benefits (first 20 days) require PA.	• (1, 2, 4) PA and CR are required for in-state and OOS planned surgical procedures (including transplants) and associated imaging, rehabilitation and professional surgical services delivered in an IP setting and listed in OAR 410-130-0200, Table 130-0200-1; rehabilitation, and long term acute care (LTAC). (Notification is required for all IP admissions.)

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• (1, 4) Extra-contractual and experimental/investigational/ unproven benefit requests (i.e., exceptions) are submitted through a PA-like process.	is conducted by an OHA designee. (CCO notification is required for emergency admissions to subacute.) • (1, 4, 5) PA for SCIP, SAIP and subacute admission is obtained through a peer-to-peer review between an HIA psychiatrist and the referring psychiatrist. • (1, 2, 4, 5) CR and RR for SCIP and SAIP are performed by HIA. • (1, 2, 4) CR and RR for subacute care are conducted by the CCO. (See column 1.) • (1, 2, 4) PA, inclusive of a Certificate of Need (CONS) process, is conducted by HIA for PRTS. PRTS CR is conducted by the CCO. (See column 1.) • (1, 2, 4, 5) PA and CR for AFH, SRTF, SRTH, YAP, RTF, and RTH are performed by KEPRO.	• (1, 4) Extra-contractual and experimental/investigational/unproven benefit requests (i.e., exceptions) are submitted through a PA-like process.	• (1, 2, 4) PA, CR and RR for Behavior Rehabilitation Services (BRS) are performed by OHA, DHS or OYA designee. • (1, 2, 4) CR of SNF services beginning on the 21st day. (CCO requires PA and manages the first 20 days – see column 3) • (1, 4) Requests for extra-contractual and experimental/investigational /unproven benefit requests (i.e., exceptions) are submitted through a PA-like process.

2. Comparability of Strategy: Why is the NQTL assigned to these benefits?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• (1) To ensure coverage, medical necessity and prevent unnecessary utilization (e.g., in violation of relevant OARs and associated Health Evidence Review Commission (HERC) Priority List (PL) and guideline notes[1]). • (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. • (3) Maximize use of INN providers to promote cost-effectiveness when appropriate. • (4) To comply with federal and State requirements. • (6) Preserve limited IP resources. • (7) Opportunity to provide care coordination for safe transitions as well as to ensure provision of additional supports and services to	• (1) UM is assigned to ensure medical necessity of services/prevent overutilization of these high cost services. • (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual (e.g., matching the level of need to the least restrictive setting using the LOCUS – Level-of-Care Utilization System and LSI – Level of Service Inventory). • (4) To comply with federal and State requirements. • (5) Most MH residential services were excluded from the capitated arrangements with the CCOs due to the high cost and unpredictability of services and associated risk.	• (1) To ensure coverage, medical necessity and prevent unnecessary utilization (e.g., in violation of relevant OARs and associated HERC PA and guideline notes). • (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. • (3) Maximize use of INN providers to promote cost-effectiveness when appropriate. • (4) To comply with federal and State requirements • (6) Preserve limited IP resources. • (7) Opportunity to provide care coordination for safe transitions as well as to ensure provision of additional	• (1) PA and CR are assigned to prevent overutilization (e.g., requests for care that are not medically necessary in violation of relevant OARs, the Health Evidence Review Commission (HERC) PL and guidelines). • (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. • (4) To comply with federal and State requirements.

[1] References to HERC PL and/or guidelines include the Prioritized List of Health Services, guideline notes, and the body of literature behind the guideline notes.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
address high risk period immediately following discharge.		supports and services to address high risk period immediately following discharge.	

3. Comparability of Evidentiary Standard: What evidence supports the rationale for the assignment?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• (1, 2 and 4) HERC PL and guidelines. • (1) UM and claims reports are reviewed for trends in overutilization on a quarterly basis. Have determined average length of stay for adults and youth, by diagnosis and presenting problem. Evaluates outliers. • (1) Annual cost and utilization reports that confirm IP as a cost driver based on percentage of spend.	• (1, 2 and 4) HERC PL and guidelines. (HERC provides outcome evidence and clinical indications for certain diagnoses that may be translated into UM requirements.)	• (1, 2 and 4) HERC PL and guidelines. • (1) UM and claims reports are reviewed for trends in overutilization on a quarterly basis • (1) Annual cost and utilization reports that confirm IP as a cost driver based on percentage of spend.	• (1, 2 and 4) The HERC PL and guidelines. • (1) PA staff reports. If the UM team identifies any services for which utilization appears to be increasing (e.g., number of requests) or it appears that the State is paying for medically unnecessary care, the UM team consults with the health analytics team to analyze and evaluate adjustments to PA or CR.
• (1) Medical literature demonstrates high cost of unnecessary medical care (i.e. 30% of medical costs). (Institute of Medicine Report, (2012). Also see Fisher, Elliott S., MD, MPH, Wennberg, David E., MD, MPH, Stukel, Therese A., PhD et al., The Implications of Regional Variations in	• (1) Medical literature demonstrates high cost of unnecessary medical care (i.e., 30% of medical costs). (Institute of Medicine Report, (2012). Also see Fisher, Elliott S., MD, MPH, Wennberg, David E., MD, MPH, Stukel, Therese A., PhD et al., The Implications	• (1) Medical literature demonstrates high cost of unnecessary medical care (i.e. 30% of medical costs). (Institute of Medicine Report, (2012)). Also see Fisher, Elliott S., MD, MPH, Wennberg, David E., MD, MPH, Stukel, Therese A., PhD et al., The Implications	• (1) Health analytics reports. The health analytics team and policy analysts refer services that have been identified to have increasing utilization to the UM team for evaluation.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Medicare Spending: Part 2. Health Outcomes and Satisfaction with Care, Center for the Evaluative Clinical Sciences, Dartmouth Medical School, VA Outcomes Group, White River Junction VT, Center for Outcomes Research and Evaluation, Maine Medical Center, & Institute for the Evaluative Clinical Sciences, Toronto, Canada, Financial support was provided by grants from the Robert, Wood Johnson Foundation, the National Institutes of Health (Grant Number CA52192) and the National Institute of Aging (Grant Number 1PO1AG19783-01), 2002, pp 1-32. • (2) Oregon Performance Plan (OPP) requires that BH services be provided in least restrictive setting possible. The OPP is a DOJ-negotiated Olmsted settlement. Also see Roberts, E., Cumming, J & Nelson, K., A Review of Economic Evaluations of Community Mental Health	of Regional Variations in Medicare Spending: Part 2. Health Outcomes and Satisfaction with Care, Center for the Evaluative Clinical Sciences, Dartmouth Medical School, VA Outcomes Group, White River Junction VT, Center for Outcomes Research and Evaluation, Maine Medical Center, & Institute for the Evaluative Clinical Sciences, Toronto, Canada, Financial support was provided by grants from the Robert, Wood Johnson Foundation, the National Institutes of Health (Grant Number CA52192) and the National Institute of Aging (Grant Number 1PO1AG19783-01), 2002, pp 1-32. • (2) The Oregon Performance Plan (OPP) requires that BH services be provided in the least restrictive setting possible. The OPP is a DOJ-negotiated Olmsted settlement.	of Regional Variations in Medicare Spending: Part 2. Health Outcomes and Satisfaction with Care, Center for the Evaluative Clinical Sciences, Dartmouth Medical School, VA Outcomes Group, White River Junction VT, Center for Outcomes Research and Evaluation, Maine Medical Center, & Institute for the Evaluative Clinical Sciences, Toronto, Canada, Financial support was provided by grants from the Robert, Wood Johnson Foundation, the National Institutes of Health (Grant Number CA52192) and the National Institute of Aging (Grant Number 1PO1AG19783-01), 2002, pp 1-32. • (2) Medical errors in the hospital is the third leading cause of death in the US. Makary, M. & Daniel, M. Medical Error - The Third Leading Cause of Death in the US, BMJ, 2016;353:i2139.	

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Care, Sage Journals, Oct. 1, 2005, 1-13. Accessed May 25, 2018. http://journals.sagepub.com/doi/10.1177/1077558705279307 • (2) Inherent restrictiveness of residential settings and dangers associated with seclusion and restraint. Also see Cusack, K.J., Frueh, C., Hiers, T., et. al., *Trauma within the Psychiatric Setting: A Preliminary Empirical Report,* Human Services Press, Inc., 2003. 453-460. • (3) Network providers' credentials have been verified and they have contracted to accept the network rate. • (4) Applicable federal and State requirements.	• (4) PRTS CONS: OAR 410-172-0690 and 42 CFR 441.156. • (4) OARs and other applicable federal and State requirements. • (5) Cost and utilization reports	• (3) Network providers' credentials have been verified and they have contracted to accept the network rate. • (4) Applicable federal and State requirements. • (6) Michael Morris, Emergency Department Boarding of Psychiatric Patients in Oregon: Report Briefing, OHA Public Health	• (4) Applicable federal and State requirements.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• (6) Michael Morris, Emergency Department Boarding of Psychiatric Patients in Oregon: Report Briefing, OHA Public Health Division, OHA 0730 (12/16), February 1, 2017 pp 1-16. • (7) Watts, V. Psychiatric Patients at Highest Suicide Risk Following Hospital Discharge, Psychiatric News, Psychiatry online, 18 Oct. 2016. https://doi.org/10.1176/appi.pn.2016.10b8		Division, OHA 0730 (12/16), February 1, 2017 pp 1-16. • (7) Dharmarajan, K., Hsieh, A. Kulkarni, V et al., Trajectories of risk after hospitalization for heart failure, acute myocardial infraction or pneumonia: retrospective cohort study, BMJ 2015;350:h411.	

4. Comparability and Stringency of Processes: Describe the NQTL procedures (e.g., steps, timelines and requirements from the CCO, member, and provider perspectives).

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Timelines for authorizations: • Emergency requests are processed within 24 hours. Urgent requests are processed within 72 hours. Standard requests are to be processed within 14 days.	**Timelines for gender reassignment surgery authorizations (for benefit packages E and G):** **(OHA)** • Standard requests are to be processed within 14 days. **Timelines for child residential authorizations**: **(OHA)**	**Timelines for authorizations:** • Emergency requests are processed within 24 hours. Urgent requests are processed within 72 hours. Standard requests are to be processed within 14 days, although a backlog may develop. Can be up to 28 days if additional information is needed.	**Timelines for authorizations**: • All in-state and out-of-state (OOS) emergency admissions, LTAC, and IP rehabilitation require notification. Notification is preferred within 24 hours of admission, but there is no timeline requirement. Notification allows the State to conduct case management and discharge planning, but

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Documentation requirements: • Records supporting medical necessity such as the admission summary and progress notes.	• OHA provides the initial authorization (level-of-care review) within 3 days of requests for SCIP, SAIP or subacute. **(HIA)** • Authorization requests for PRTS are submitted prior to admission or within 14 days of an emergency admission. An emergency admission is acceptable only under unusual and extreme circumstances, subject to RR by HIA. **Timelines for adult residential and YAP authorizations**: **(KEPRO)** • OARs require emergency requests be processed within 24 hours, urgent within 72 hours, and standard requests within 14 days. **Documentation requirements (OHA):** • PA documentation requirements for non-residential MH/SUD benefits	**Documentation requirements:** • Records supporting medical necessity such as the admission summary and progress notes.	does not limit the scope or duration of the benefit. • PA is required before admission. • OARs require emergency requests be processed within 24 hours, urgent requests within 72 hours and standard requests within 14 days; although a backlog may develop. **Documentation requirements**: • PA documentation requirements include a form that consists of a cover page. Diagnostic and CPT code information and a rationale for

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Some providers may be reviewed through the EHR.	in benefit packages E and G include a form that consists of a cover page. Diagnostic and CPT code information and a rationale for medical necessity must be provided, plus any additional supporting documentation. • The documentation requirement for level-of-care assessment for SCIP, SAIP and subacute is a psychiatric evaluation. Other information may be reviewed when available. **Documentation requirements for PRTS CONS and CR for SCIP and SAIP (HIA)**: • PRTS CONS requires documentation that supports the justification for child residential services including: (a) A cover sheet detailing relevant provider and recipient Medicaid numbers; (b) Requested dates of service; (c) HCPCS or CPT Procedure code requested; and	• Some providers may be reviewed through the EHR.	medical necessity must be provided, plus any additional supporting documentation.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	(d) Amount of service or units requested; (e) A behavioral health assessment and service plan meeting the requirements described in OAR 309-019-0135 through 0140; or (f) Any additional supporting clinical information supporting medical justification for the services requested; (g) For substance use disorder services (SUD), the Division uses the American Society of Addiction Medicine (ASAM) Patient Placement Criteria second edition-revised (PPC-2R) to determine the appropriate level of SUD treatment of care. • There were no reported specific documentation requirements for CR of SCIP or SAIP. **Documentation requirements (KEPRO)**: • Documentation may include assessment, service plan, plan-of-care, Level-of-Care		

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Method of document submission: • Clinical information is provided telephonically, electronically or by fax for review. • CR can also be done by a nurse in the hospital with access to the EHR. • The reviewer may attend an individual's treatment review every 3 months, but goes to the hospital daily.	Utilization System (LOCUS), Level of Service Inventory (LSI) or other relevant documentation. **Method of document submission (OHA):** • For non-residential MH/SUD services in benefit packages E and G, paper (fax) or online PA requests are submitted prior to the delivery of services for which PA is required. • For SCIP, SAIP and subacute level-of-care review, the OHA designee may accept information via fax, mail or email and has also picked up information. Supplemental information may be obtained by phone. **Method of document submission (HIA):** • Packets are submitted to HIA by mail, fax, email or web portal for review for child residential services.	**Method of document submission:** • Notification via fax or phone, followed by medical records either by fax or by electronic interface with EHR.	**Method of document submission**: • Paper (fax) or online PA requests are submitted prior to the delivery of services for which PA is required.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Qualifications of reviewers: • Licensed mental health professionals gather relevant clinical information from the provider and conduct medical necessity review. • Only a physician makes denial decisions	Telephonic clarification may be obtained. • Psychiatrist to psychiatrist review is telephonic. **Method of document submission (KEPRO):** • Providers submit authorization requests for adult MH residential to KEPRO by mail, fax, e-mail or via portal, but documentation must still be faxed if the request is through the portal. Telephonic clarification may be obtained. **Qualifications of reviewers (OHA)**: • OHA M/S staff conduct PA and CR (if applicable) for gender reassignment surgery (for benefit packages E and G). (See processes, strategies and evidentiary standards in column 4.) • The OHA designee is a licensed, masters'-prepared therapist that reviews psychiatric evaluations to	**Qualifications of reviewers:** • Reviewers may be trained, unlicensed staff working via protocol and guidelines or licensed staff including RNs. • Denials must be reviewed by a physician.	**Qualifications of reviewers**: • Nurses may authorize and deny authorization requests relative to OAR, HERC PL guidelines and associated notes, and other industry guidelines (e.g., AIM for radiology).

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	approve or deny the level-of-care requested. Psychiatric consultation is available if needed. **Qualifications of reviewers (HIA)**: • Two LCSWs with QMHP designation make residential authorization decisions. • Two psychiatrists make CONS determinations. **Qualifications of reviewers (KEPRO)**: • KEPRO QMHPs must meet minimum qualifications (see below) and demonstrate the ability to conduct and review an assessment, including identifying precipitating events, gathering histories of mental and physical health, substance use, past mental health services and criminal justice contacts, assessing family, cultural, social and work relationships, and conducting/reviewing a mental status examination, complete a DSM diagnosis,		

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	and write and supervise the implementation of a PCSP. • A QMHP must meet one of the follow conditions: – Bachelor's degree in nursing and licensed by the State or Oregon; – Bachelor's degree in occupational therapy and licensed by the State of Oregon; – Graduate degree in psychology; – Graduate degree in social work; – Graduate degree in recreational, art, or music therapy; – Graduate degree in a behavioral science field; or – A qualified Mental Health Intern, as defined in 309-019-0105(61).		

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Criteria: • Authorization decisions are based on the State's definition of medical necessity and OARs, ORS, HERC PL and guidelines, ASAM, or clinical policy/guidelines.	**Criteria (OHA)**: • Authorizations for non-residential MH/SUD services in benefit packages E and G are based on the HERC PL and guidelines, Oregon Statute, OAR, federal regulations, and evidence-based guidelines from private and professional associations. • The OHA designee reviews requests relative to the least restrictive environment requirement. **Criteria (HIA)**: • HERC PL and HIA policy are used for residential CR. **Criteria (KEPRO)**: • QMHPs review information submitted by providers relative to State plan and OAR requirements and develop a PCSP. • The PCSP components are entered into MMIS as an authorization.	**Criteria:** • OARs, HERC PL and guidelines, federal guidelines.	**Criteria**: Authorizations are based on the HERC PL and applicable guidelines, Oregon Statute, OAR, federal regulations, evidence-based guidelines from private and professional associations such as the Society of American Gastrointestinal and Endoscopic Surgeons and InterQual, where no State or federal guidelines exist.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Reconsideration/RR: • Prior to a denial for IP services, a provider-to-provider review is offered. • If MNC are not met for the LOC requested, a denial is issued and an alternative LOC is offered and authorized, for which the reviewer may consult a physician. • If providers fail to obtain authorization in advance, they may submit a post-service claim for review.	**Reconsideration/RR (OHA)**: • A provider may request review of an OHA denial decision. The review occurs in weekly Medical Management Committee (MMC) meetings. (Applies to non-residential MH/SUD services in benefit packages E and G.) • Exception requests for experimental and other non-covered benefits (for benefit packages E and G) may be granted at the discretion of the MMC, which is led by the HSD medical director. • If a provider requests review of an OHA designee level-of-care determination, HIA may conduct the second review. **Reconsideration/RR (HIA)**: • If the facility requests a reconsideration of a CONS denial, a second psychiatrist (who did not make the initial decision) will review the documentation and discuss	**Reconsideration/RR:** • RR is available in limited circumstances (see below)	**Reconsideration/RR**: • A provider may request review of a denial decision. The review occurs in weekly MMC meetings. • Exception requests for experimental and other non-covered benefits may be granted at the discretion of the MMC, which is led by the HSD medical director.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Appeals: • Standard appeal processes apply.	with the facility in a formal meeting. • No policy for CR denials. **Reconsideration/RR (KEPRO)**: • Within 10 days of a denial, the provider may send additional documentation to KEPRO for reconsideration. • A provider may request review of a denial decision, which occurs in weekly MMC meetings or KEPRO's comparable MM meeting. **Appeals (OHA)**: • Members may request a hearing on any denial decision. **Appeals (HIA)**: • Documentation has not included the fair hearing process. **Appeals (KEPRO)**: • Members may request a hearing on any denial decision.	**Appeals:** • Standard appeal processes apply.	**Appeals**: • Members may request a hearing on any denial decision.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Consequences for failure to authorize: • Failure to obtain authorization can result in non-payment for benefits for which it is required. • Failure to provide notification does not result in a financial penalty.	**Consequences for failure to authorize (OHA)**: • Failure to obtain authorization for non-residential MH/SUD services in benefit packages E and G can result in non-payment for benefits for which it is required. • Failure to obtain notification for non-residential MH/SUD services in benefit packages E and G does not result in a financial penalty. • For SCIP, SAIP and subacute, if coverage is retroactively denied, general funds may be used to cover the cost of care. **Consequences for failure to authorize (HIA)**: • Non-coverage. **Consequences for failure to authorize (KEPRO)**: Failure to obtain authorization can result in non-payment for benefits for which it is required.	**Consequences for failure to authorize:** • Services without prior authorization/approved LOS are denied payment.	**Consequences for failure to authorize**: • Failure to obtain authorization can result in non-payment for benefits for which it is required. • Failure to provide notification does not result in a financial penalty.

5. Stringency of Strategy: How frequently or strictly is the NQTL applied?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Frequency of review (and method of payment): • MH: IP care is paid on a per diem basis. SUD IP is capitated. • Planned inpatient (non-emergent) admissions are very infrequent and thus use of PA is very infrequent. • CR is conducted every 3-5 days for MH hospital. CR is incorporated into daily treatment reviews for SUD (employee model). CR occurs every 4-5 days for detox. • Sub-acute is reviewed every 3 days due to an average length of stay of 7-10 days and the intensity of the service • SUD residential is reviewed every 7-10 days due to an average ALOS of 30 days. • PRTS is reviewed every 14 days to 30 days due to ALOS of 60 days.	**Frequency of review (and method of payment) (OHA)**: • Gender reassignment surgery (for benefit packages E and G) is authorized as a procedure. • The initial authorization for SCIP, SAIP and subacute is 30 days. **Frequency of review (and method of payment) (HIA)**: • Child residential services are paid by per diem. • Child residential services authorizations are conducted every 30-90 days. **Frequency of review (and method of payment) (KEPRO)**: • Adult residential and YAP authorizations are conducted at least once per year. In practice reviews average every 6 months.	**Frequency of review (and method of payment):** • IP care is sub-capitated at the hospital where most IP admissions occur. Other hospitals may be paid by DRG. CAHs are paid a percentage of billed charges. • Daily reviews are conducted with the sub-capitated provider, DRGs and CAH hospitals. • SNF: Fax documentation approximately weekly; more frequently if clinical condition requires. • LTAC is reviewed weekly with an ALOS of 20-28 days. • M/S IP rehabilitation is reviewed weekly due to estimated ALOS of 2-6 weeks.	**Frequency of review (and method of payment)**: • Most IP claims are paid DRG; as a result, CR is infrequently used. • CR is conducted monthly for LTAC and rehabilitation. • The State conducts CR for SNF after the first 20 days (which are managed by the CCO) at a frequency that is determined by the care manager, but not less than one time a year. • Authorization lengths are individualized by condition and are valid for up to a year. • Procedural authorizations are valid for 3 months.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
RR conditions and timelines: • Exceptions come in the form of retroactive requests that can be obtained in special circumstances. • RR is considered when the member has had a recent change in eligibility or a retroactive change in eligibility or another extenuating circumstance (member and facility not aware of coverage). • Retro requests are generally limited to 30 days after the date of service.	**RR conditions and timelines (OHA)**: • RR for non-residential MH/SUD services in benefit packages E and G is only available for retro eligibility situations (e.g., the person became eligible during the stay). **RR conditions and timelines (HIA):** • No policy **RR conditions and timelines (KEPRO)**: • The request for authorization is received within 30 days of the date of service. • Any requests for authorization after 30 days from date of service require documentation from the provider that authorization could not have been obtained within 30 days of the date of service.	**RR conditions and timelines:** • Exceptions come in the form of retroactive requests that can be obtained in special circumstances. • RR is considered when the member has had a recent change in eligibility or a retroactive change in eligibility or another extenuating circumstance (member and facility not aware of coverage). • Retro requests are generally limited to 30 days after the date of service	**RR conditions and timelines**: • RR is only available for retro eligibility situations (e.g., the person became eligible during the stay).

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Methods to promote consistent application of criteria: • MNC application is overseen via case conference and supervision.	**Methods to promote consistent application of criteria (OHA)**: • Nurses are trained on the application of the HERC PL and guidelines, which is spot-checked through ongoing supervision. Whenever possible, practice guidelines from clinical professional organizations such as the American Medical Association or the American Psychiatric Association, are used to establish PA frequency for services in the FFS system. (Applicable to non-residential MH/SUD services in benefit packages E and G.) • There is only one OHA designee reviewer for level-of-care review for SCIP, SAIP, and subacute and no specific criteria, so N/A. **Methods to promote consistent application of criteria (HIA):** • Parallel chart reviews for the two reviewers. (No criteria.) **Methods to promote consistent application of criteria (KEPRO)**:	**Methods to promote consistent application of criteria:** • MNC application is overseen via case conference and supervision.	**Methods to promote consistent application of criteria**: • Nurses are trained on the application of the HERC PL and guidelines, which is spot-checked through ongoing supervision. Whenever possible, practice guidelines from clinical professional organizations such as the American Medical Association or the American Psychiatric Association, are used to establish PA frequency for services in the FFS system.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	• Monthly clinical team meetings in which randomly audited charts are reviewed/discussed by peers using the KEPRO compliance department-approved audit tool. • Results of the audit are compared, shared and discussed by the team and submitted to the Compliance Department monthly for review and documentation. • Individual feedback is provided to each clinician during supervision on their authorization as well as plan-of-care reviews.		

6. Stringency of Evidentiary Standard: What standard supports the frequency or rigor with which the NQTL is applied?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Evidence for UM frequency: • Frequency of review is based on diagnosis, presenting condition, average length of stay, intensity of service and availability of resources. (See specifics above.) • HERC PL and guidelines.	**Evidence for UM frequency (OHA (and designee for level-of-care review), HIA and KEPRO)**: • PA length and CR frequency are tied to HERC PL and guidelines, OAR, CFRs, reviewer expertise and timelines for expectations of improvement.	**Evidence for UM frequency:** • Frequency of review is based on experience and expectations for improvement. • HERC PL and guidelines and medical appropriateness are reviewed once; CR beyond	**Evidence for UM frequency**: • PA length and CR frequency are tied to HERC PL and guidelines, DRGs, OAR, CFRs, reviewer expertise and timelines for expectations of improvement. • The Commission that develops HERC consists of

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	• The Commission that develops HERC consists of 13 appointed members, which include five physicians, a dentist, a public health nurse, a pharmacist and an insurance industry representative, a provider of complementary and alternative medicine, a behavioral health representative and two consumer representatives. The Commission is charged with maintaining a priority list of services, developing or identifying evidence-based health care guidelines and conducting comparative effectiveness research. • HERC guidelines of which there are fewer for MH/SUD than M/S. This is because 1) there are fewer technological procedures for MH/SUD (e.g., cognitive behavioral therapy and psychodynamic therapy are billed using the same codes, no surgeries, few devices); 2) the MH/SUD literature is not as robust (e.g., fewer randomized trials, more subjective diagnoses (or the ICD-10-CM diagnoses represent a spectrum) and	expected stay. (See specifics above.)	13 appointed members, which include five physicians, a dentist, a public health nurse, a pharmacist and an insurance industry representative, a provider of complementary and alternative medicine, a behavioral health representative and two consumer representatives. The Commission is charged with maintaining a priority list of services, developing or identifying evidence-based health care guidelines and conducting comparative effectiveness research. • HERC guidelines of which there are more M/S than MH/SUD because 1) there are more technological procedures (e.g., surgery, devices, procedures and diagnostic tests); and 2) the literature is more robust.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Data reviewed to determine UM application: • PA & CR: Denial and appeal rates are monitored.	less standardization in interventions). **Data reviewed to determine UM application (OHA)**: • Denial/appeal overturn rates; number of PA requests; stabilization of cost trends; and number of hearings requested. These data are reviewed in contractor reports, on a quarterly basis by the State. (Applicable to non-residential MH/SUD services in benefit packages E and G.) **Data reviewed to determine UM application (HIA)**: N/A **Data reviewed to determine UM application (KEPRO):** N/A	**Data reviewed to determine UM application:** • PA & CR: Denial and appeal rates are monitored.	**Data reviewed to determine UM application**: • A physician led group of clinical professionals conducts an annual review to determine which services receive or retain PA. Items reviewed include: – Utilization – Approval/denial rates – Documentation/ justification of services – Cost data
IRR standard: • N/A	**IRR standard:** • OHA: N/A • HIA: N/A • KEPRO: N/A	**IRR standard:** • N/A	**IRR Standard**: • N/A
Results of criteria application: • Appeal overturn rate was 0	**Results of criteria application**: • OHA: 0 appeal overturns • HIA: 0 appeal overturns • KEPRO: 0 appeal overturns	**Results of criteria application:** • Appeal overturn rate was 0	**Results of criteria application**: • 0 appeal overturns

7. Compliance Determination for Benefit Packages CCO A and B

IP Benefits: All non-emergent CCO MH/SUD and M/S IP admissions require PA or level-of-care approval. Emergency CCO MH/SUD and M/S IP admissions require notification within one business day and most ongoing IP services require subsequent CR. SUD detoxification is reviewed after the tenth day. Emergency child residential admissions require notification within 14 days. The CCO conducts PA and CR for MH/SUD and M/S IP hospital benefits. An OHA designee conducts level-of-care review for SCIP, SAIP and subacute. CR for SCIP and SAIP child residential benefits is conducted by HIA. HIA conducts the CONS procedure and PA for PRTS. KEPRO conducts PA and CR for adult residential and YAP. The CCO conducts CR for subacute and PRTS. SNF CR is conducted by the CCO for the first 20 days (after which the State conducts CR).

Comparability of Strategy and Evidence: UM is assigned to MH/SUD and M/S IP benefits primarily using five strategies: 1) To ensure coverage, medical necessity and prevent unnecessary overutilization (e.g., in violation of relevant OARs, the HERC PL and guideline notes). Evidence of MH/SUD overutilization includes HERC and research demonstrating 30% of IP costs are unnecessary. 2) To ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. Although strategy (2) primarily applies to MH/SUD benefits, it is permissible because it is a requirement resulting from a DOJ-negotiated Olmstead settlement agreement. Safety issues for M/S are supported by HERC. 3) To maximize use of INN providers to promote cost-effectiveness. Maximizing network utilization only applies to MH/SUD and M/S benefits administered by the CCO.[2] Evidence for the cost-effectiveness of network utilization for both MH/SUD and M/S includes the contracted fees and credentials verification process associated with network participation. 4) To comply with federal and State requirements. In addition, the CCO conducts UM for MH/SUD and M/S to preserve limited resources and facilitate safe transitions as supported by recent studies. 5) To preserve scarce resources as evidenced by documented bed shortages. As a result, the strategies and evidence are comparable.

Comparability and Stringency of Processes: OARs require authorization decisions within 24 hours for emergencies, 72 hours for urgent requests and 14 days for standard requests. Providers are encouraged to submit requests for authorization sufficiently in advance to be consistent with OAR time frames. Most documentation requirements for MH/SUD and M/S IP admissions include information that supports medical necessity such as the admission summary and progress notes. Both MH/SUD and M/S may conduct reviews through the EHR, and MH/SUD UM staff also attend treatment review meetings every three months and make daily hospital visits. Documentation may be submitted by phone, email, fax or electronically. Documentation requirements for child residential PA/level-of-care review include a psychiatric evaluation or a psychiatrist-to-psychiatrist telephonic review. HIA accepts information for child residential CR via mail, email, fax and web portal. Adult residential and YAP require an assessment (i.e., completion of a relevant level-of-care tool (e.g., ASAM, LSI, LOCUS)) and plan-of-care consistent with State plan requirements. KEPRO documentation submission is via mail, email, fax, and web portal. Consistent with OARs,

[2] Residential benefits were not assigned to CCO administration because of the unpredictable costs associated with these services and the CCO's associated financial risk. As a result, the State administers most residential benefits through other subcontractors on a FFS basis.

federal CONS procedures, and due to the potential absence of a psychiatric referral, the PRTS documentation requirements include a cover sheet, a behavioral health assessment and service plan meeting the requirements described in OAR 309-019-0135 through 0140. These documentation requirements are comparable.

Qualified individuals conduct UM applying OARs, HERC, ASAM, and practice guidelines. The OHA designee reviews authorization requests to determine if the level-of-care is the least restrictive environment. HIA reviews care relative to policy. KEPRO develops PCSPs based on State plan and OAR requirements. *OHA plans to enhance the evidence base for child residential authorization decisions through additional research, resulting in admission and CR criteria development.* A physician makes all CCO MH/SUD and M/S denials and a peer-to-peer review is offered prior to a MH/SUD denial. The OHA designee, who is a licensed MH professional, makes denial determinations for level-of-care review for certain child residential services. HIA denials are made by psychiatrists. KEPRO QMHPs develop PCSPs. *OHA plans to ensure that all denial decisions are made by professional peers*. The CCO makes RR available for MH/SUD and M/S. Upon provider request, the OHA designee obtains RR by HIA. HIA allows reconsideration of CONS determinations, but reported they do not have an RR policy for HIA's CR denials for child residential services. For adult residential and YAP services, KEPRO allows reconsideration of denials with the submission of additional documentation within 10 days of the denial. For OHA and KEPRO, the review of a denial decision occurs in a weekly MMC meeting. *OHA intends to standardize RR processes when feasible*. Providers may appeal a MH/SUD and M/S denial decision by the CCO. OHA FFS reviews denials through the fair hearing process, but HIA and the OHA designee have not encouraged use of this process. *OHA plans to confirm all notices of action, appeal and fair hearing processes are consistent with federal requirements.* Failure to obtain authorization may result in non-coverage, although SCIP, SAIP and subacute services may be covered by general fund dollars. Inclusive of OHA's action plans, the MH/SUD and M/S processes are comparable and no more stringently applied to MH/SUD benefits.

Stringency of Strategy and Evidence: Concurrent review is conducted every 3-5 days for MH IP hospital, while SUD and M/S acute IP hospital services are reviewed daily. CCO subacute are reviewed every 7-10 days and PRTS every 14-30 days. (SUD residential review is incorporated into treatment planning reviews conducted by the provider. FFS child residential is reviewed every 30-90 days while FFS adult residential and YAP are reviewed no less than annually, but in practice averages 6 months. The CCO reviews SNF weekly for the first 20 days. Evidence for the frequency of CCO review includes ASAM and other practice guidelines. *OHA plans to task the FFS residential subcontractors with review of CR frequencies relative to the most recent research to confirm MH/SUD review frequency is directly tied to evidence rather than historical standard practice.* In special circumstances, for example, when coverage is not able to be determined at the time of hospitalization, CCO MH/SUD and M/S offer RR within 30 days of admission. KEPRO makes RR available for 30 days post-admission. The OHA designee and HIA do not have standard policies describing when RR is available. In addition, it was discovered that there are conflicting State rules regarding RR timelines. *OHA plans to standardize the availability of RR, including the conditions under which it is permissible and the timeframes. OHA will align OAR requirements and RR offerings by contractors.* The CCO and State review utilization data to determine if PA or CR should be added or adjusted for MH/SUD and M/S IP benefits. For both MH/SUD and M/S the CCO conducts case conferences and supervision to

promote consistency of criteria application. HIA conducts parallel chart reviews for its two reviewers and KEPRO team meetings include random chart audits using a compliance tool followed by team discussion. There is no formal oversight of criteria application for the OHA designee level-of-care review process for certain child residential services. *OHA plans to institute a more formalized measurement of criteria application when feasible.* The CCO reported 0 appeal overturns for M/S and MH/SUD in 2017. Inclusive of OHA action plans, the strategy and evidence are no more stringently applied to MH/SUD than to M/S in writing or in operation.

Compliance Determination: Inclusive of OHA action plans, the UM processes, strategies and evidentiary standards are comparable and no more stringently applied to MH/SUD IP benefits than to M/S IP benefits, in writing or in operation, in the child or adult benefit packages. There were no CCO-specific actions indicated.

Below are the OHA action plans:

1. *OHA is evaluating the purchase of third party MNC, especially as it relates to MNC for child residential authorization decisions. Criteria will be selected that include information upon which CR frequency may be established. In addition, formal measurement (e.g., IRR) of consistency of criteria application will be initiated once criteria are selected and implemented.*
2. *OHA will ensure that all FFS denial decisions are made by professional peers.*
3. *OHA will standardize RR processes, which will include a rule change extending the time RR must be available for MH/SUD from 30 to 90 days to match M/S.*
4. *OHA will confirm all FFS and CCO notices of action and appeal and fair hearing processes are consistent with federal requirements.*

8. Compliance Determination for Benefit Packages CCO E and G

IP Benefits: All IP FFS M/S admissions and all IP CCO MH/SUD emergency admissions require notification. All planned CCO MH/SUD IP admissions, all FFS MH/SUD residential admissions and all M/S nursing facility services, extra-contractual coverage requests (including experimental services), planned surgical procedures (including transplants) and associated, imaging, rehabilitation and professional surgical services delivered in an IP setting and listed in OAR 410-130-0200, Table 130-0200-1 require PA. OHA also conducts PA and CR for in-state and OOS M/S IP rehabilitation and long term acute care. OHA conducts PA for gender transition surgery. An OHA designee conducts level-of-care review for SCIP, SAIP and subacute. HIA conducts the CONS procedure and PA for PRTS. CR for subacute and PRTS is conducted by the CCO. CR for SCIP and SAIP is conducted by HIA. KEPRO conducts PA and CR for adult residential and YAP.

Comparability of Strategy and Evidence: UM is assigned to MH/SUD and M/S IP benefits primarily using three strategies: 1) To ensure coverage, medical necessity and prevent unnecessary overutilization (e.g., in violation of relevant OARs, HERC PL or guidelines). Evidence of MH/SUD overutilization includes HERC, research demonstrating 30% of IP costs are unnecessary; and for MH/SUD benefits administered by the CCO. 2) To ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. Although strategy (2)

primarily applies to MH/SUD benefits, it is permissible because it is a requirement resulting from a DOJ-negotiated Olmstead settlement agreement. M/S safety issues are supported by HERC. 3) To comply with federal and State requirements. As a result, the strategy and evidence are comparable.

Comparability and Stringency of Processes: OARs require authorization decisions within 24 hours for emergencies, 72 hours for urgent requests and 14 days for standard requests. For MH/SUD the CCO requires notification within one business day of admission. Emergency child residential authorization requests must be submitted within 14 days of the admission. Providers are encouraged to submit requests for authorization sufficiently in advance to be consistent with OAR time frames. Most documentation requirements for MH/SUD and M/S IP admissions include information that supports medical necessity such as an admission summary and progress notes. MH/SUD CCO documentation may be submitted by phone, email, fax or electronically. The CCO may conduct MH/SUD reviews via the EHR. CCO MH/SUD staff also attend treatment review meetings every three months and make daily hospital visits. Documentation requirements for child residential PA/level-of-care review include a psychiatric evaluation or a psychiatrist-to-psychiatrist telephonic review. HIA accepts information for child residential CR via mail, email, fax and web portal. Adult residential and YAP require an assessment (i.e., completion of a relevant level-of-care tool (e.g., ASAM, LSI, LOCUS)) and plan-of-care consistent with State plan requirements. KEPRO documentation submission is via mail, email, fax, and web portal. Consistent with OARs, federal CONS procedures, and due to the potential absence of a psychiatric referral, the PRTS documentation requirements include a cover sheet, a behavioral health assessment and service plan meeting the requirements described in OAR 309-019-0135 through 0140. These documentation requirements are comparable.

Qualified individuals conduct MH/SUD CCO UM applying OARs, HERC, ASAM and other practice guidelines. OHA reviews authorization requests relative to HERC PL and guidelines and applicable practice guidelines from national organizations. The OHA designee reviews authorization requests to determine if the proposed level-of-care is the least restrictive environment. HIA reviews care relative to policy. KEPRO develops PCSPs relative to State plan and OAR requirements. *OHA plans to enhance the evidence base for child residential authorization decisions through additional research, resulting in admission and CR criteria development.* Physicians make all CCO MH/SUD denial determinations following an offer of peer-to-peer review. FFS MH/SUD and M/S allow MA licensed therapists and nurses to make a denial determination. *Although not a parity concern in these benefit packages, OHA plans to ensure that all denial decisions are made by professional peers.* CCO MH/SUD makes RR available. Upon provider request, the OHA designee obtains RR by HIA. HIA allows reconsideration of CONS determinations, but reported they do not have an RR policy for HIA's CR denials for child residential services. For adult residential and YAP services, KEPRO allows reconsideration of denials with the submission of additional documentation within 10 days of the denial. For OHA and KEPRO, the review of a denial decision occurs in a weekly MMC meeting. FFS M/S limits RR to retro eligibility circumstances. *Although not a parity issue in these benefit packages, OHA intends to standardize RR processes when feasible* Providers may appeal a MH/SUD denial decision by the CCO to the CCO. OHA FFS reviews denials through the fair hearing process, but HIA and the OHA designee have not encouraged use of this process. *OHA plans to confirm all notices of action, appeal and fair hearing processes are consistent with federal requirements*. Failure to obtain authorization may

result in non-coverage. Inclusive of OHA's action plans, the MH/SUD and M/S processes are comparable and no more stringently applied to MH/SUD benefits.

Stringency of Strategy and Evidence: Concurrent review is conducted every 3-5 days for MH and is incorporated by the provider into service plan reviews for SUD, which is sub-capitated to the CCO. FFS M/S rarely conducts CR because most IP services are paid by DRG. CCO MH/SUD residential frequency of review ranges from every 7 to 30 days. FFS child residential is reviewed every 1-3 months while FFS adult residential and YAP are reviewed no less than annually but in practice average 6 month reviews. SNF is also reviewed no less than annually after the first 20 days. LTAC and rehab hospital (M/S IP) are reviewed monthly. Evidence for the frequency of review for CCO MH/SUD is ASAM and practice guidelines. *OHA plans to task the FFS residential subcontractors with review of CR frequencies relative to the most recent research to confirm MH/SUD review frequency is directly tied to evidence rather than historical standard practice*. In special circumstances, CCO MH/SUD offers RR within 30 days of admission. KEPRO makes RR available for 30 days post-admission. FFS MH/SUD only allows RR for retro-eligibility circumstances. The OHA designee and HIA do not have standard policies describing when RR is available. In addition, it was discovered that there are conflicting State rules regarding RR timelines. *OHA plans to standardize the availability of RR, which will require MH/SUD to offer RR for at least 90 days post admission, consistent with M/S.* The CCO and State review utilization data to determine if PA or CR should be added or adjusted for MH/SUD and M/S IP benefits. For MH/SUD the CCO conducts case review and supervision to promote consistency of MNC application. HIA conducts IRR and parallel chart reviews for its two reviewers and KEPRO team meetings include random chart audits using a compliance tool followed by team discussion. HIA and the OHA designee do not have specific criteria against which decisions are made. FFS M/S conducts spot-checks through supervision to assess criteria application. *OHA plans to institute a more formalized measurement of criteria application when feasible even though this is not a parity issue in these benefit packages.* The CCO reported 0 appeal overturns for MH/SUD in 2017. FFS M/S's appeal overturn rate was also 0. Inclusive of OHA action plans, the strategy and evidence are no more stringently applied to MH/SUD than to M/S in writing or in operation.

Compliance Determination: Inclusive of OHA action plans for benefit packages A and B, the UM processes, strategies and evidentiary standards are comparable and no more stringently applied to MH/SUD IP benefits than to M/S IP benefits, in writing or in operation, in the child or adult benefit packages.

OUTPATIENT UTILIZATION MANAGEMENT

NQTL: Utilization Management (PA, CR, Retrospective Review)
Benefit Package: A, B, E, and G for Adults and Children
Classification: Outpatient (OP)
CCO: Advanced Health (AH)

Benefit package A and B: MH/SUD benefits in column 1 (FFS/HCBS 1915(c)(i) MH/SUD) and column 3 (CCO MH/SUD) as compared by strategy to M/S benefits in columns 2 (FFS/HCBS (c)(k)(j) M/S) and 4 (CCO M/S) respectively. These benefit packages include MH/SUD OP benefits managed by DHS, KEPRO, the CCO, and OHA.

Benefit package E and G: MH/SUD benefits in column 1 (FFS/HCBS 1915(c)(i) MH/SUD) and column 3 (CCO MH/SUD) as compared by strategy to M/S benefits in columns 2 (FFS/HCBS (c)(k)(j) M/S) and 5 (FFS M/S) respectively. These benefit packages include MH/SUD OP benefits managed by DHS, KEPRO, the CCO, and OHA.

1. To which benefits is the NQTL assigned?

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
• (1) 1915(c) Comprehensive DD waiver (operated/managed by DHS) • (1) 1915(c) Support Services DD waiver (operated/managed by DHS) • (1) 1915(c) Behavioral DD Model waiver (operated/managed by DHS)	The following services are managed by DHS: • (1) 1915(c) Comprehensive DD waiver • (1) 1915(c) Support Services DD waiver • (1) 1915(c) Behavioral DD Model waiver • (1) 1915(c) Aged & Physically Disabled waiver • (1) 1915(c) Hospital Model waiver	• (2) All OP MH services provided outside of Community Mental Health Programs require PA after 3 sessions. The CCO plans to streamline processes such that only those OP services subject to overutilization or safety issues will require PA. • (2) All SUD services provided outside of	• (2) PA: All OP services provided by non-contracted providers • (2) Follow-up visits by contracted specialists • (2, 3), OP surgery and office procedures • (2) Sleep studies • (2) Genetic testing • (2) Capsule endoscopy • (2, 3) MRI/MRA, PET	The following services are managed by OHA: • (2, 3) Out of hospital births • (2) Home health services • (2) OT, PT, ST, and audiology for M/S conditions (and autistic disorder, which is also managed according to the processes, strategies and

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
• (1)1915(i)(HK) services for adults (home-based habilitation, behavioral habilitation and psychosocial rehab for persons with CMI) (managed by KEPRO under contract with OHA)	• (1) 1915(c) Medically Involved Children's NF waiver • (1) 1915(k) Community First Choice State Plan option • (1) 1915(j): Self-directed personal assistance	contracted Substance Use Disorder (SUD) OP treatment programs require PA after 3 sessions. The CCO plans to streamline processes such that only those OP services subject to overutilization or safety issues will require PA. • (2) Out-of-network (OON) MH/SUD benefits require PA • CR: – (2,3) Youth day treatment – (2) OT/PT/ST – (2) ABA – (2) MAT	• (2) DME • (2) Outpatient observation over 48 hr • (2, 3) Wound care • (2, 3) Hospice/ Palliative care • (2) OT/PT/ST • (2) Chiropractic • (2) Osteopathic Manipulation • (2) Acupuncture • (2) Home Health • (2) Vision • (2) Dietary services • (2) Outpatient infusion	evidentiary standards described for FFS/MS OP) • (2, 3) Imaging • (2) DME

2. Comparability of Strategy: Why is the NQTL assigned to these benefits?

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
• (1) The State requires PA of HCBS in order to meet federal requirements	• (1) The State requires PA of HCBS in order to meet federal requirements	• (2) Ensures treatment is medically necessary, in least restrictive setting, not-	• (2) Ensures treatment is medically necessary, in least restrictive setting, not-	• (2) To prevent services being delivered in violation of relevant OARs,

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
regarding PCSPs and ensure services are provided in accordance with a participant's PCSP and in the least restrictive setting.	regarding PCSPs and ensure services are provided in accordance with a participant's PCSP and in the least restrictive setting.	over-utilized and is treatment for a funded condition. • (3) Services are associated with increased health or safety risks. • (4) Preservation of limited resources.	over-utilized and is treatment for a funded condition. • (3) Services are associated with increased health or safety risks. • (4) Preservation of limited resources.	associated HERC PL and guidelines and federal regulations. • (3) Services are associated with increased health or safety risks.

3. Comparability of Evidentiary Standard: What evidence supports the rationale for the assignment?

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
• (1) Federal requirements regarding PCSPs for 1915(c) and 1915(i) services (e.g., 42 CFR 441.301 and 441.725) and the applicable approved 1915(c) waiver application/1915(i) State plan amendment. • (1) Oregon Performance Plan (OPP) requires that all BH services are	• (1) Federal requirements regarding PCSPs for 1915(c), 1915(k), and 1915(j) services (e.g., 42 CFR 441.301, 441.468, and 441.540) and the applicable approved 1915(c) waiver application/State plan amendment. • (1) Federal requirements regarding 1915(c) and 1915(i) services	• (2, 3) OARs, ASAM, HERC PL and guidelines, federal guidelines. • (2) Oregon Performance Plan (OPP) requires that BH services be provided in least restrictive setting possible. The OPP is a DOJ-negotiated Olmsted settlement. • (2) Medical literature demonstrates high cost of unnecessary	• (2, 3) OARs, HERC PL and guidelines, federal guidelines. Services such as OP surgeries may pose an increased health and safety risk. • (2) 19% of requests are denied or modified, most often for services that are not funded for treatment, don't meet HERC guidelines, or are not the least costly	• (2) HERC PL • (2) PA requests with insufficient documentation demonstrate MNC are not being met or HERC PL guidelines are not being followed. • (3) HERC Guidelines - Recommended limits on services for member safety.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
provided in the least restrictive setting possible as do federal requirements regarding 1915(c) and 1915(i) services.	require that HCBS are provided in the least restrictive setting possible.	medical care (i.e. 30% of medical costs). (Institute of Medicine Report, (2012). Also see Fisher, Elliott S., MD, MPH, Wennberg, David E., MD, MPH, Stukel, Therese A., PhD et al., The Implications of Regional Variations in Medicare Spending: Part 2. Health Outcomes and Satisfaction with Care, Center for the Evaluative Clinical Sciences, Dartmouth Medical School, VA Outcomes Group, White River Junction VT, Center for Outcomes Research and Evaluation, Maine Medical Center, & Institute for the Evaluative Clinical Sciences, Toronto, Canada, Financial support was provided	alternative that will meet the need. • (2) Cost and utilization reports and how frequently a service is denied. Over 60% of outpatient spending is in categories requiring PA. • (2) Medical literature demonstrates high cost of unnecessary medical care (i.e. 30% of medical costs). (Institute of Medicine Report, (2012). Also see Fisher, Elliott S., MD, MPH, Wennberg, David E., MD, MPH, Stukel, Therese A., PhD et al., The Implications of Regional Variations in Medicare Spending: Part 2. Health Outcomes and Satisfaction with Care, Center for the Evaluative Clinical Sciences, Dartmouth	

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
		by grants from the Robert, Wood Johnson Foundation, the National Institutes of Health (Grant Number CA52192) and the National Institute of Aging (Grant Number 1PO1AG19783-01), 2002, pp 1-32. • (4) Frequency and numbers of providers who close practices to new referrals.	Medical School, VA Outcomes Group, White River Junction VT, Center for Outcomes Research and Evaluation, Maine Medical Center, & Institute for the Evaluative Clinical Sciences, Toronto, Canada, Financial support was provided by grants from the Robert, Wood Johnson Foundation, the National Institutes of Health (Grant Number CA52192) and the National Institute of Aging (Grant Number 1PO1AG19783-01), 2002, pp 1-32. • (4) Frequency and numbers of providers who close practices to new referrals.	

4. Comparability and Stringency of Processes: Describe the NQTL procedures (e.g., steps, timelines and requirements from the CCO, member, and provider perspectives).

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Timelines for authorizations: • A PCSP must be approved within 90 days from the date a completed application is submitted. **Documentation requirements:** • (c)The PCSP is based on a functional needs assessment and other supporting documentation. It is developed by the individual, the	**Timelines for authorizations**: • A PCSP must be approved within 90 days from the date a completed application is submitted. **Documentation requirements**: • The PCSP is based on a functional needs assessment and other supporting documentation. It is developed by the individual, the	**Timelines for authorizations:** • Review completed within 14 days includes eligibility and benefit coverage, as well as review for medical appropriateness. Stat/urgent requests processed in 24 hours or 72 hours if additional info is necessary. • PA processed within 5 business days, but immediate requests with 1 business day. **Documentation requirements:** • PA: One page PA form and clinical notes supporting the need.	**Timelines for authorizations:** • Review completed within 14 days includes eligibility and benefit coverage, as well as review for medical appropriateness. Stat/urgent requests processed in 24 hours or 72 hours if additional info is necessary. **Documentation requirements:** • PA: One page PA form with requesting and performing provider, diagnosis and CPT codes, and clinical notes supporting the need.	**Timelines for authorizations**: • Urgent requests are processed in 72 hours and immediate requests in 24 hours. Routine requests are processed in 14 days. **Documentation requirements**: • A cover page form is required. In addition, diagnostic information, a CPT code(s), a rationale for medical necessity plus any additional

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
individual's team and the individual's case manager. • (i)The PCSP is based on an assessment, service plan, plan-of-care, Level-of-Care Utilization System (LOCUS), Level of Service Inventory (LSI) or other relevant documentation. The PCSP is developed by the member's treatment team in consultation with the member. **Method of document submission**: • All 1915(c) services must be included in a participant's PCSP and approved by a qualified case manager at the local case management entity (CME) prior to service delivery.	individual's team and the individual's case manager. **Method of document submission**: • All 1915(c), 1915(k), and 1915(j) services must be included in a participant's PCSP and approved by a qualified case manager at the local case management entity (CME) prior to service delivery.	**Method of document submission:** • CR: telephonic reviews; fax supporting documentation may be used. • Secure email is also available.	**Method of document submission:** Fax, email and phone.	supporting documentation are required. **Method of document submission**: • Paper (fax) or online PA/POC submitted prior to the delivery of services.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
• Information is obtained during a face-to-face meeting, often at the individual's location. • (i) Providers submit authorization requests to KEPRO by mail, fax email or via portal, but documentation must still be faxed if the request is submitted via portal. **Qualifications of reviewers**: • (c) A case manager must have at least: – A bachelor's degree (BA) in behavioral science, social science, or a closely related field; or – A BA in any field AND one year of human services	• Information is obtained during a face-to-face meeting, often at the individual's location. **Qualifications of reviewers**: • A case manager must have at least: – A BA in behavioral science, social science, or a closely related field; or – A BA in any field AND one year of human services	**Qualifications of reviewers:** • QMHPs (i.e., physician, nurse practitioner, substance abuse certification candidate) review, authorize, and deny services. The CCO plans to ensure only professional peers make denial determinations.	**Qualifications of reviewers:** • Trained, unlicensed reviewers or nurses may authorize services meeting guidelines or deny services for administrative reasons (patient is not eligible on the date of service.) • Physicians review is required for all denials based on	**Qualifications of reviewers:** • Nurses may authorize and deny services.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
related experience; or – An associate's degree (AA) in a behavioral science, social science, or a closely related field AND two years human services related experience; or – Three years of human services-related experience. (i) **Qualifications of reviewers**: • KEPRO QMHPs must meet minimum qualifications (see below) and demonstrate the ability to conduct and review an assessment, including identifying precipitating events, gathering histories of	related experience; or – An associate's degree (AA) in a behavioral science, social science, or a closely related field AND two years human services related experience; or – Three years of human services-related experience.		treatments not funded, not meeting guidelines, or not medically appropriate.	

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
mental and physical health, substance use, past mental health services and criminal justice contacts, assessing family, cultural, social and work relationships, and conducting/reviewing a mental status examination, complete a DSM diagnosis, write and supervise the implementation of a PCSP. • A QMHP must meet one of the following conditions: – Bachelor's degree in nursing and licensed by the State or Oregon; – Bachelor's degree in occupational therapy and				

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
licensed by the State of Oregon; – Graduate degree in psychology; – Graduate degree in social work; – Graduate degree in recreational, art, or music therapy; – Graduate degree in a behavioral science field; or – A qualified Mental Health Intern, as defined in 309-019-0105(61).				
Criteria: • (c) Qualified case managers approve or deny services in the PCSP consistent with waiver and OAR requirements. • Once a PCSP is approved, services in the PCSP are entered into the	**Criteria**: • Qualified case managers approve or deny services in the PCSP consistent with waiver/state plan and OAR requirements. • Once a PCSP is approved, it is entered into the payment	**Criteria:** • Authorizations are based on ASAM criteria, mental health/addictions/medical literature, SAMHSA recommendations; HERC PL and guideline notes	**Criteria:** • Authorizations are based on HERC PL and guideline notes and Oregon statute.	**Criteria:** • Authorizations are based on the HERC PL and guidelines, Oregon Statute, Oregon Administrative rules, federal regulations, and evidence-based guidelines from private and

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
payment management system by the CME staff as authorizations. • (i) QMHPs approve or deny services in the PCSP consistent with State plan and OAR requirements. • QMHPs enter prior authorizations into the MMIS based on the member's PCSP. **Reconsideration/RR**: • (c) N/A • (i) Within 10 days of a denial, the provider may send additional documentation to KEPRO for reconsideration. • (i) A provider may request review of a denial decision, which occurs in weekly MMC meetings or KEPRO's own	management system as authorization by the CME staff. **Reconsideration/RR**: • N/A	**Reconsideration/RR:** • RR available in limited circumstances. (See below.)	**Reconsideration/RR:** • Retroactive requests may be submitted when waiting for authorization would put the patient's health at significant risk.	professional associations such as the Society of American Gastrointestinal and Endoscopic Surgeons where no State or federal guidelines exist. **Reconsideration/RR**: • A review of a denial decision can be requested and is reviewed in weekly MMC meetings.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
comparable MMC meeting. **Consequences for failure to authorize**: • Failure to obtain authorization may result in non-payment. **Appeals**: Notice and fair hearing rights apply.	**Consequences for failure to authorize**: • Failure to obtain authorization may result in non-payment. **Appeals**: Notice and fair hearing rights apply.	**Consequences for failure to authorize:** • Failure to obtain PA results in non-payment. **Appeals:** • Notice and fair hearing rights apply.	**Consequences for failure to authorize:** • Failure to obtain PA results in non-payment. **Appeals:** • Notice and fair hearing rights apply.	**Consequences for failure to authorize**: • Failure to obtain authorization may result in non-payment. **Appeals**: • Members may request a hearing on any denial decision.

5. Stringency of Strategy: How frequently or strictly is the NQTL applied?

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Frequency of review: • PCSPs are reviewed and revised as needed, but at least every 12 months.	**Frequency of review:** • PCSPs are reviewed and revised as needed, but at least every 12 months.	**Frequency of review:** • PA: MH authorizations are typically for 3- 6 months but may be as long as 12 months (e.g., psychiatric medication management). Varies by service type and clinical circumstances.	**Frequency of review:** • PA: Varies by service type and clinical circumstances. • Physician office visits: 1 visit to multiple visits over 12 mo. depending on condition and treatment plan.	**Frequency of review**: • PA is granted for different authorization periods depending on the service and can be adjusted. Authorizations for extensive services usually range from 6 months to 1 year.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
RR conditions and timelines: • (c) N/A • (i) Within 10 days of a denial, the provider may send additional documentation to KEPRO for reconsideration • (i) A provider may request review of a denial decision, which occurs in weekly Medical Management meetings or KEPRO's	**RR conditions and timelines:** • N/A	• Youth day treatment is reviewed monthly. **RR conditions and timelines** • RR is available in special circumstances including continuity of care circumstances, provider having made good faith attempts to submit requests, delivery of emergency/critical care within 30 days of service.	• Surgery/procedures: 1 service including global period • DME: 1-12 mo depending on HERC guidelines and Oregon statute • PT/OT/ST: 8-12 visits depending on treatment plan • Diagnostics: usually 1 **RR conditions and timelines** • RR is available in special circumstances including change in coverage, urgent medical need, planned procedure changed inter-operatively due to findings, submitted within 30 days of service.	• PT, ST, OT authorizations are usually for one year (i.e., 30 visits). • Exceptions may be made at the discretion of the MMC which is led by the HSD medical director. **RR conditions and timelines:** • RR available for retro eligibility circumstances.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
own comparable MM meeting. **Methods to promote consistent application of criteria:** • For 1915(c), DHS Quality Assurance Review teams review a representative sample of PCSPs as part of quality assurance and case review activities to assure that PCSPs meet program standards. • Additionally, OHA staff review a percentage of 1915(c) participant files to assure quality and compliance. • For 1915(i), monthly clinical team meetings in which randomly audited charts are reviewed/discussed by peers using the KEPRO compliance	**Methods to promote consistent application of criteria:** • DHS Quality Assurance Review teams review a representative sample of PCSPs as part of quality assurance and case review activities to assure that PCSPs meet program standards. • Additionally, OHA staff review a percentage of files to assure quality and compliance.	**Methods to promote consistent application of criteria:** • MNC application is overseen via case conference and supervision.	**Methods to promote consistent application of criteria:** • MNC application is overseen via case conference and supervision.	**Methods to promote consistent application of criteria**: • Nurses are trained on the application of the HERC guidelines, which is spot-checked through ongoing supervision.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
department-approved audit tool. • Results of the audit are compared, shared and discussed by the team and submitted to Compliance Department monthly for review and documentation. • Individual feedback is provided to each clinician during supervision on their PA. • For 1915(i), on a quarterly basis a representative sample of cases are reviewed for ability to address assessed member needs, whether the PCSPs are updated annually, whether OARs are met, and whether member's choices regarding services and providers were documented.				

6. Stringency of Evidentiary Standard: What standard supports the frequency or rigor with which the NQTL is applied?

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Evidence for UM frequency: • Federal requirements regarding PCSPs and 1915(c) and 1915(i) services (e.g., 42 CFR 441.301 and 441.725) and the applicable approved 1915(c) waiver application/1915(i) State plan amendment.	**Evidence for UM frequency**: • Federal requirements regarding PCSPs and 1915(c), 1915(k), and 1915(j) services (e.g., 42 CFR 441.301, 441.468, and 441.540) and the applicable approved 1915(c) waiver application/State plan amendment.	**Evidence for UM frequency:** • PA and CR: Frequency of CR based on provider's determination of needed number of sessions/expected LOS, improvement timelines, typical courses of care for the requested service and scarcity of resources. • ASAM criteria, mental health/addictions/medical literature, SAMHSA recommendations; HERC PL and guidelines.	**Evidence for UM frequency:** • PA: Frequency of PA requirements based on expected LOS, improvement timelines and scarcity of resources. • HERC PL and guidelines • Varies by service type and clinical circumstances. • Evidence includes utilization reports and guidelines from professional organizations.	**Evidence for UM frequency**: • HERC PL and guidelines of which there are more M/S than MH/SUD because 1) there are more technological procedures (e.g., surgery, devices, procedures and diagnostic tests); and 2) the literature is more robust. • The amount of time a PA covers for services is limited by OAR 410-120-1320(7) which states that PAs can be approved and renewed up to 1 year at a time. • Whenever possible, practice guidelines from clinical professional organizations such as the American Medical

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
				Association or the American Psychiatric Association, are used to establish PA frequency.
Data reviewed to determine UM application: • N/A	**Data reviewed to determine UM application**: • N/A	**Data reviewed to determine UM application:** • Denial/Appeal rates • Number of authorizations required • Overall utilization patterns and availability of resources	**Data reviewed to determine UM application:** • Denial/Appeal rates • Number of authorizations submitted per category • Overall utilization patterns and availability of resources	**Data reviewed to determine UM application**: • A physician-led group of clinical professionals conducts an annual review to determine which services receive or retain a PA; items reviewed include: – Utilization – Approval/denial rates – Documentation/ justification of services – Cost data
IRR standard: • N/A	**IRR standard:** • N/A	**IRR standard:** • N/A	**IRR standard:** • N/A	**IRR standard:** • N/A

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Results of criteria application (appeal overturn rates): • (c): 0 appeal overturns • (i) (KEPRO) 11% appeal overturn rate (1 out of 9 hearings)	**Results of criteria application (appeal overturn rates):** • (c) for I/DD: 0 appeal overturns • (c) for APD plus (k) and (j): 0.8% appeal overturn rate	**Results of criteria application (appeal overturn rates):** • Appeal overturn rate was 0 (8 denials, no appeals)	**Results of criteria application (appeal overturn rates):** • Appeal overturn rates were 26% (6,440 denials, 193 appeals, and 50 overturns (less than 1% of denials, 26% of appeals)	**Results of criteria application (appeal overturn rates):** • 0 appeal overturns

7. Compliance Determination for Benefit Packages CCO A and B

OP Benefits: UM applies to the FFS MH/SUD and M/S HCBS benefits and the CCO MH/SUD and M/S OP benefits listed in Section 1. Most CCO MH/SUD OP services (approximately 75%) are provided by a CMHP/OP SUD program because the population has chronic MH/SUD conditions and the two CMHPs/ADAPT are best equipped to deliver needed programmatic services. UM for these benefits is incorporated into the CMHP's/ADAPT's supervision processes. Historically, all MH/SUD OP benefits delivered by contracted providers required PA after 3 sessions to confirm that the provider has the skills necessary to deliver the needed services and to preserve scarce resources. Not all in-network M/S OP benefits require PA, however. As a result, the CCO has determined that PA or CR will only be required for network providers if services may be over-utilized (e.g., exceed the number of sessions the provider indicated were needed for completion) or are associated with potential safety risks. Otherwise, only outliers will require CR. The CCO will continue to manage access by tracking member no-show rates and providers that are no longer accepting new referrals, but this will no longer be done through a PA process.

Comparability of Strategy and Evidence: UM of MH/SUD and M/S HCBS benefits is required to meet federal HCBS requirements regarding PCSPs, providing benefits in the least restrictive environment, and applicable waiver applications/State plan amendments. Evidence includes the federal requirements regarding PCSPs for 1915(c), 1915(i), 1915(k), and 1915(j) services and applicable approved waiver applications/State plan amendments. These strategies and evidence are comparable.

Some non-HCBS CCO MH/SUD and M/S OP services are assigned UM to confirm coverage relative to the HERC PL and guidelines. Non-HCBS MH/SUD services are also reviewed to ensure services are medically necessary relative to practice guidelines and offered in the least restrictive environment, as required by the OPP Olmstead settlement for MH/SUD. A subset of CCO MH/SUD and M/S OP services are also assigned UM to assure the individual's safety. Evidence for safety issues includes HERC guidelines. In addition, UM is conducted to preserve

scarce resources as evidenced by the frequency and number of practices that stop accepting new referrals. These strategies and evidence are comparable.

Comparability and Stringency of Processes: HCBS MH/SUD benefits are administered by DHS and KEPRO while HCBS M/S benefits are administered by DHS. PCSPs for both M/S and MH/SUD must be developed within 90 days. The PCSP for both MH/SUD and M/S is based on an assessment and other relevant supporting documentation. It is developed by the individual, the individual's team and the individual's case manager. MH/SUD and M/S DHS reviewers must have a BA in a related field; a BA in any field plus one year experience; an AA with two years' experience; or three years' experience. KEPRO reviewers for 1915(i) services must have a nursing or OT license, a graduate degree in a related field or be a qualified MH intern. KEPRO's higher education requirements do not present a parity concern because they impact quality not the stringency of criteria application. MH/SUD and M/S review documentation relative to waiver application/State plan amendment requirements, and the approved PCSP is entered as service authorization. KEPRO offers reconsideration and RR, although DHS does not offer RR when services are not authorized. Failure to obtain authorization may result in non-payment for MH/SUD and M/S. Notice and fair hearing rights apply. Accordingly, UM processes are comparable and no more stringently applied to HCBS MH/SUD benefits than to M/S benefits.

Non-HCBS CCO MH/SUD and M/S OP benefit reviews are conducted by QMHPs who evaluate clinical information that is submitted via phone, email, or fax, relative to ASAM, HERC, or OARs. QMHPs may deny MH/SUD services, and nurses may deny M/S services for administrative reasons, but a physician is required for all other denials. *The CCO plans to ensure only professional peers make denial determinations.* Timelines for authorization decisions are the same for MH/SUD and M/S and defined in OARs. Failure to obtain authorization may result in non-payment for MH/SUD and M/S services; although an exception process allows RR, and standard appeal processes apply. There are no differences in processes for children and adults that are not tied to practice guidelines. Inclusive of the CCO action plan, UM processes are comparable to, and no more stringently applied, to non-HCBS CCO MH/SUD benefits than to M/S benefits.

Stringency of Strategy and Evidence: MH/SUD and M/S HCBS PCSPs are reviewed annually (or more frequently if needed) consistent with OARs and federal requirements. Quality review is conducted by DHS, OHA, and KEPRO to assure PCSPs meet standards. In 2017, appeal overturn rates for 1915(i) services were 11% (1 of 9). Appeal overturn rates for 1915(c)(k)(j) services were less than 1%. Because the 11% MH/SUD appeal overturn rate resulted from one overturned appeal, the difference in appeal overturn rates for MH/SUD and M/S is not meaningful. As a result, UM strategy and evidence are no more stringently applied to MH/SUD than to M/S OP benefits in operation or in writing for HCBS services.

Non-HCBS CCO MH/SUD service authorizations vary by service type and clinical circumstances but are typically intended to cover 3-6 months of services (although they range from 1-12 months). Youth day treatment is typically authorized monthly. M/S authorization lengths also vary by service type and clinical circumstances, ranging one visit or service to a year. Service authorization lengths are based on expected LOS,

improvement timelines, typical courses of care, and scarcity of resources, ASAM, and practice guidelines. Because MH/SUD authorization lengths appear to be more stringent*, the CCO will strengthen the evidence associated with MH/SUD CR frequency*. CCO MH/SUD and M/S offer RR in certain circumstances. CCO MH/SUD and M/S consistency of MNC application is evaluated during case conferences and supervision. The CCO reviews utilization and other data to determine if UM requires adjustment. CCO reports MH/SUD and M/S appeal overturn rates of 0 and 26% respectively. Inclusive of OHA and CCO action plans, the UM strategy and evidence are no more stringently applied to MH/SUD than to M/S OP benefits in operation or in writing.

Compliance Determination: Inclusive of the OHA IP action plans for benefit packages A and B and the CCO action plans below, the UM processes, strategies and evidentiary standards are comparable and no more stringently applied to MH/SUD OP benefits than to M/S OP benefits, in writing or in operation, in the child or adult benefit packages.

Below are the CCO-specific action plans, which will be implemented by the end of 2018:

1. *The CCO will make referrals to network providers without conducting PA unless the service is over-utilized or is associated with safety concerns. Access will be tracked and monitored through quality improvement processes rather than UM.*
2. *The CCO will ensure that only peers make denial determinations.*
3. *The CCO will strengthen evidence for MH/SUD OP CR frequency using its own utilization data.*

8. Compliance Determination for Benefit Packages CCO E and G

OP Benefits: UM applies to the FFS MH/SUD and M/S HCBS benefits, and the CCO MH/SUD and FFS M/S OP benefits listed in Section 1. Most CCO MH/SUD OP services (approximately 75%) are provided by a CMHP/OP SUD program because the population has chronic MH/SUD conditions and the two CMHPs/ADAPT are best equipped to deliver needed programmatic services. UM for these benefits is incorporated into the CMHP's/ADAPT's supervision processes. Historically, all MH/SUD OP benefits delivered by contracted providers required PA after 3 sessions to confirm that the provider has the skills necessary to deliver the needed services and to preserve scarce resources. Not all in-network M/S OP benefits require PA, however. As a result, the CCO has determined that PA or CR will only be required for network providers if services may be over-utilized (e.g., exceed the number of sessions the provider indicated were needed for completion) or are associated with potential safety risks. Otherwise, only outliers will require CR. The CCO will continue to manage access by tracking member no-show rates and providers that are no longer accepting new referrals, but this will no longer be done through a PA process.

Comparability of Strategy and Evidence: UM of MH/SUD and M/S HCBS benefits is required to meet federal requirements regarding HCBS, including requirements regarding PCSPs, providing benefits in the least restrictive environment, and applicable waiver applications/State plan amendments. Evidence includes the federal requirements regarding PCSPs for 1915(c), 1915(i), 1915(k), and 1915(j) services and applicable approved waiver applications/State plan amendments. These strategies and evidence are comparable.

Some non-HCBS CCO MH/SUD and FFS M/S OP services are assigned UM to confirm coverage relative to the HERC PL and guidelines. Non-HCBS MH/SUD services are also reviewed to ensure services are medically necessary relative to ASAM and practice guidelines and offered in the least restrictive environment, which is related to the OPP Olmstead settlement for MH/SUD. A subset of CCO MH/SUD and FFS M/S OP services are also assigned UM to assure the individual's safety. Evidence for safety issues includes HERC guidelines. These strategies and evidence are comparable.

Comparability and Stringency of Processes: HCBS MH/SUD benefits are administered by DHS and KEPRO while HCBS M/S benefits are administered by DHS. PCSPs for MH/SUD and M/S must be developed within 90 days. The PCSP for both MH/SUD and M/S is based on an assessment and other relevant supporting documentation and developed by the individual, the individual's team and the individual's case manager. MH/SUD and M/S DHS reviewers must have a BA in a related field; a BA in any field plus one year experience; an AA with two years' experience; or three years' experience. KEPRO reviewers must have a nursing or OT license, a graduate degree in a related field or be a qualified MH intern. KEPRO's higher education requirements do not present a parity concern because they impact quality, not stringency. MH/SUD and M/S review documentation relative to waiver application/State plan amendment requirements, and the approved PCSP is entered as service authorization KEPRO offers reconsideration and RR, although DHS does not offer RR when services are not authorized. Failure to obtain authorization may result in non-payment for MH/SUD and M/S. Notice and fair hearing rights apply. Accordingly, UM processes are comparable, and no more stringently applied, to HCBS MH/SUD benefits than to M/S benefits.

Non-HCBS CCO MH/SUD benefit reviews are conducted by QMHPs who evaluate clinical information that is submitted via phone, fax, or email relative to ASAM, HERC, and OARs. Because OHA plans to require professional peers make denial determinations, the CCO also plans to only allow professional peers to deny. CCO MH/SUD requires submission of clinical notes. Similarly, FFS M/S benefit reviews are conducted by qualified clinicians that evaluate clinical information that supports medical necessity (which may include POCs) submitted via paper (fax) or online relative to OARs and HERC. Timelines for authorization decisions are the same for MH/SUD and M/S and defined in OARs. Failure to obtain authorization may result in non-payment for MH/SUD and M/S services; although an exception process allows RR for CCO MH/SUD and FFS M/S benefits. Appeal processes apply for both CCO MH/SUD and FFS M/S. There are no differences in processes for children and adults that are not tied to practice guidelines. Accordingly, UM processes are comparable to, and no more stringently applied, to non-HCBS MH/SUD benefits than to M/S benefits.

Stringency of Strategy and Evidence: MH/SUD and M/S HCBS PCSPs are reviewed annually (or more frequently if needed) consistent with OARs and federal requirements. Quality review is conducted by KEPRO, DHS and OHA to assure PCSPs meet standards. In 2017, appeal overturn rates for 1915(i) services were 11% (1 of 9). Appeal overturn rates for 1915(c)(k)(j) services were less than 1%. Because the 11% MH/SUD appeal overturn rate resulted from one overturned appeal, the difference in appeal overturn rates for MH/SUD and M/S is not

meaningful. As a result, UM strategy and evidence are no more stringently applied to MH/SUD than to M/S OP benefits in operation or in writing for HCBS.

In general, non-HCBS MH/SUD service authorizations are intended to cover 3-6 months of services (although they range from 1-12 months). Service authorization lengths are based on practice guidelines. FFS M/S authorization lengths range from 6 months to one year. These lengths are tied to HERC. Because the frequency of review appears to be more stringent for MH/SUD, *the CCO will strengthen the evidence for MH/SUD CR frequency.* CCO MH/SUD offers RR in certain circumstances. FFS offers RR in retro eligibility circumstances. CCO MH/SUD MNC application is evaluated during case reviews and supervision. Similarly, FFS M/S application is spot-checked through supervision and chart review. The CCO and State review utilization and other data to determine if UM requires adjustment. MH/SUD and M/S reported appeal overturn rates of 0. Inclusive of the CCO action plan, the UM strategy and evidence are no more stringently applied to MH/SUD than to M/S OP benefits in operation or in writing.

Compliance Determination: Inclusive of OHA IP action plans for benefit packages A and B above and the CCO OP action plans for benefit packages A and B above, the UM processes, strategies and evidentiary standards are comparable and no more stringently applied to MH/SUD OP benefits than to M/S OP benefits, in writing or in operation, in the child or adult benefit packages.

PRIOR AUTHORIZATION FOR PRESCRIPTION DRUGS

NQTL: Prior Authorization for Prescription Drugs
Benefit Package: A and B for Adults and Children
Classification: Prescription Drugs
CCO: Advanced Health (AH)

1. To which benefits is the NQTL assigned?

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• Prior authorization must be obtained for medications not on formulary and exceeding formulary limitations in usual quantity or price threshold. • A, F, P, S drug groups	• A and F drug groups	• Prior authorization must be obtained for medications not on formulary and exceeding formulary limitations in usual quantity or price threshold. • A, F, P, S drug groups

2. Comparability of Strategy: Why is the NQTL assigned to these benefits?

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• These services are selected for PA because they represent a significant proportion of costs and have the potential to be used for conditions not funded for treatment or for which specific criteria must be met. • Authorization review also allows for care coordination and optimization of the medications to improve outcomes as well as controlling unnecessary costs.	• To promote appropriate and safe treatment of funded conditions.	• These services are selected for PA because they represent a significant proportion of costs and have the potential to be used for conditions not funded for treatment or for which specific criteria must be met. • Authorization review also allows for care coordination and optimization of the medications to improve outcomes as well as controlling unnecessary costs.

3. Comparability of Evidentiary Standard: What evidence supports the rationale for the assignment?

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• The Prioritized List. • Cost and utilization trends, medical literature supporting cost-effective and high value care, and local needs and utilization patterns. • Additional evidence is obtained from primary medical literature, FDA indications, and the Oregon State DURM group and State P&T committee reviews, together with financial data from the CCO's pharmacy benefits manager (PBM).	• FDA prescribing guidelines, medical evidence, best practices, professional guidelines, and P&T Committee review and recommendations. • Federal and state regulations/OAR and the Prioritized List.	• The Prioritized List. • Cost and utilization trends, medical literature supporting cost-effective and high value care, and local needs and utilization patterns. • Additional evidence is obtained from primary medical literature, FDA indications, and the Oregon State DURM group and state P&T committee reviews, together with financial data from the CCO's PBM.

4. Comparability and Stringency of Processes: Describe the NQTL procedures (e.g., steps, timelines and requirements from the CCO, member, and provider perspectives).

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• Requests are made via fax with a one page form indicating patient information, diagnosis, medication, dose and duration. PA requests can be made without the form as long as all necessary information is present. • Requests should be accompanied by pertinent clinical information, most often the most recent chart note. • If the information submitted is not adequate to reach a decision, additional	• PA requests are typically faxed to the Pharmacy Call Center, but requests can also be submitted through the online portal, by phone, or by mail. • The standard PA form is one page long, except for nutritional supplement requests. Most PA criteria require clinical documentation such as chart notes.	• Requests are made via fax with a one page form indicating patient information, diagnosis, medication, dose and duration. PA requests can be made without the form as long as all necessary information is present. • Requests should be accompanied by pertinent clinical information, most often the most recent chart note. • If the information submitted is not adequate to reach a decision, additional

CCO MH/SUD	FFS MH Carve Out	CCO M/S
information is requested via fax back to the provider, or phone call. • All PA requests are responded to within 24 hours. • The PA criteria are developed by pharmacists in consultation with the P&T Committee. • Medications requiring authorization are not paid if authorization is not approved.	• All PA requests are responded to within 24 hours. • The PA criteria are developed by pharmacists in consultation with the P&T Committee. • Failure to obtain PA in combination with an absence of medical necessity results in no provider reimbursement.	information is requested via fax back to the provider, or phone call. • All PA requests are responded to within 24 hours. • The PA criteria are developed by pharmacists in consultation with the P&T Committee. • Medications requiring authorization are not paid if authorization is not approved.

5. Stringency of Strategy: How frequently or strictly is the NQTL applied?

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• Medications for chronic conditions are approved for 3 to 12 months depending on the frequency of monitoring, cost, and risk of the medication. • Medications for acute conditions are approved for one course of treatment, whatever length of treatment is indicated in the medical literature. • Approximately 31% of MH/SUD drugs are subject to PA criteria for clinical reasons. • Retroactive authorizations can be obtained in special circumstances including recent insurance change for the member and exceptions to criteria can be made when clinically appropriate.	• The State approves PAs for up to 12 months, depending on medical appropriateness and safety, as recommended by the P&T Committee. • Approximately 17% of MH drugs are subject to PA criteria for clinical reasons. • The State allows providers to submit additional information for reconsideration of a denial.	• Medications for chronic conditions are approved for 3 to 12 months depending on the frequency of monitoring, cost, and risk of the medication. • Medications for acute conditions are approved for one course of treatment, whatever length of treatment is indicated in the medical literature. • Approximately 18% of M/S drugs are subject to PA criteria for clinical reasons. • Retroactive authorizations can be obtained in special circumstances including recent insurance change for the member and exceptions to criteria can be made when clinically appropriate.

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• Providers can appeal denials on behalf of a member, and members have appeal and fair hearing rights. • The appeal overturn rate for CY 2017 was 33% (1 of 3 requests for stimulants). • The CCO assesses stringency through review of the percent of pharmacy claims requiring PA, the number of PA requests, PA denial/approval rates, complaints and appeals related to pharmacy, and feedback from the CCO's P&T Committee and other providers treating members. • PA requirements are reviewed yearly to ensure that the medications requiring authorization have one or more of the following characteristics: high cost, high risk, low value, likely to be used for conditions not funded on the Prioritized List, or medications without good evidence of effectiveness.	• Providers can appeal denials on behalf of a member, and members have fair hearing rights. • The appeal overturn rates for MH carve out drugs was 8:2 (25%). • The State assesses stringency through review of PA denial/approval and appeal rates; number of drugs requiring PA; number of PA requests; and pharmacy utilization data/reports. • PA criteria are reviewed as needed due to clinical developments, literature, studies, and FDA medication approvals.	• Providers can appeal denials on behalf of a member, and members have appeal and fair hearing rights. • The appeal overturn rate for CY 2017 was 25% (7 of 28 requests). • The CCO assesses stringency through review of the percent of pharmacy claims requiring PA, the number of PA requests, PA denial/approval rates, complaints and appeals related to pharmacy, and feedback from the CCO's P&T Committee and other providers treating members. • PA requirements are reviewed yearly to ensure that the medications requiring authorization have one or more of the following characteristics: high cost, high risk, low value, likely to be used for conditions not funded on the Prioritized List, or medications without good evidence of effectiveness.

6. Stringency of Evidentiary Standard: What standard supports the frequency or rigor with which the NQTL is applied?

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• The Prioritized List. • Cost and utilization trends, medical literature supporting cost-effective and high value care, and local needs and utilization patterns. • Additional evidence is obtained from the primary medical literature, FDA	• FDA prescribing guidelines, medical evidence, best practices, professional guidelines, and P&T Committee review and recommendations. • Federal and state regulations/OAR and the Prioritized List.	• The Prioritized List. • Cost and utilization trends, medical literature supporting cost-effective and high value care, and local needs and utilization patterns. • Additional evidence is obtained from the primary medical literature, FDA

CCO MH/SUD	FFS MH Carve Out	CCO M/S
indications, and the Oregon State DURM group and state P&T committee reviews, together with financial data from the CCO's PBM.		indications, and the Oregon State DURM group and state P&T committee reviews, together with financial data from the CCO's PBM.

7. Compliance Determination for Benefit Packages CCO A and B

Comparability of Strategy and Evidence: The CCO applies prior authorization (PA) criteria to certain MH/SUD and M/S drugs to ensure the appropriate and cost-effective use of prescription drugs. The State applies PA to certain MH FFS carve out drugs to promote appropriate treatment. While the State does not consider cost in developing PA criteria for MH drugs, this is less stringent than CCO M/S so is not a parity concern. Evidence used by the CCO and State to determine which MH/SUD and M/S drugs are subject to PA includes FDA prescribing guidelines, medical evidence, best practices, professional guidelines, and P&T Committee review and recommendations. Since the State does not consider cost in developing PA criteria for MH FFS carve out drugs, this evidence is not applicable to MH FFS carve out drugs and is not a parity concern. Thus, the strategy and evidence for applying prior authorization to prescription drugs are comparable for MH/SUD and M/S drugs.

Comparability and Stringency of Processes: The PA criteria for both MH/SUD and M/S drugs are developed by pharmacists in consultation with the applicable P&T Committee. PA requests for both MH/SUD and M/S drugs may be submitted by fax (with additional modes available for FFS MH drugs), and are responded to within 24 hours. For both MH/SUD and M/S drugs, most PA criteria require clinical documentation such as chart notes. Failure to obtain PA for MH/SUD and M/S drugs subject to prior authorization in combination with an absence of medical necessity results in no reimbursement for the drug. The PA processes for MH/SUD and M/S drugs are comparable and applied no more stringently to MH/SUD drugs.

Stringency of Strategy and Evidence: Both the State and CCO approve PAs for up to 12 months. For both MH/SUD (FFS and CCO) and M/S drugs, the length of prior authorization depends on medical appropriateness and safety, as recommended by the applicable P&T Committee based on evidence such as FDA prescribing guidelines, best practices, and professional guidelines. The CCO and the State assess the stringency of strategy through review of PA denial/approval and appeal rates; in addition, the CCO assesses stringency through review of the percent of pharmacy claims requiring PA, the number of PA requests, and feedback from the CCO's P&T Committee and other providers treating members. The percent of MH/SUD drugs subject to PA requirements is comparable to M/S drugs. In addition, the appeal overturn rates are comparable. As a result, the strategies and evidentiary standards for prior authorization of prescription drugs are applied no more stringently to MH/SUD drugs than to M/S drugs.

Compliance Determination: As a result, the processes, strategies, and evidentiary standards for prior authorization of MH/SUD prescription drugs are comparably and no more stringently applied, in writing and in operation, to M/S drugs.

PROVIDER ADMISSION — CLOSED NETWORK

NQTL: Provider Admission — Closed Network (Restriction from admitting new providers [all or a subset thereof] into the CCO's network)
Benefit Package: A, B, E, and G for Adults and Children
Classification: Inpatient and Outpatient
CCO: Advanced Health (AH)

1. To which provider type(s) is the NQTL assigned?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• CCO does not close its network for new MH/SUD providers of inpatient services. • CCO does not close its network for new MH/SUD providers of outpatient services.	• The State does not restrict new providers of inpatient or outpatient MH/SUD services from enrollment.	• N/A	• The State does not restrict new providers of inpatient or outpatient M/S services from enrollment.

2. Comparability of Strategy: Why is the NQTL assigned to these provider type(s)?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• N/A	• N/A	• N/A	• N/A

3. Comparability of Evidentiary Standard: What evidence supports the rationale for the assignment?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• N/A	• N/A	• N/A	• N/A

4. Comparability and Stringency of Processes: Describe the NQTL procedures (e.g., steps, timelines and requirements from the CCO and Provider perspectives).

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• N/A	• N/A	• N/A	• N/A

5. Stringency of Strategy: How frequently or strictly is the NQTL applied?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• N/A	• N/A	• N/A	• N/A

6. Stringency of Evidentiary Standard: What standard supports the frequency or rigor with which the NQTL is applied?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• N/A	• N/A	• N/A	• N/A

7. Compliance Determination for Benefit Packages CCO A and B

The CCO does not close its network for new providers of MH/SUD inpatient or outpatient services. Accordingly, the NQTL does not apply and parity was not analyzed.

8. Compliance Determination for Benefit Packages CCO E and G

Provider network admission limits do not apply to FFS benefits, and the application of provider network admission NQTLs for benefits delivered under managed care is supported by 42 CFR 438.206 and 42 CFR 438.12. Accordingly, parity was not analyzed.

PROVIDER ADMISSION — NETWORK CREDENTIALING AND REQUIREMENTS IN ADDITION TO STATE LICENSING

NQTL: Provider Admission — Network Credentialing and Requirements in Addition to State Licensing
Benefit Package: A, B, E, and G for Adults and Children
Classification: Inpatient and Outpatient
CCO: Advanced Health (AH)

1. To which provider type(s) is the NQTL assigned?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• CCO requires all participating providers to meet credentialing and re-credentialing requirements. • CCO does not apply provider requirements in addition to State licensing.	• All FFS providers must be enrolled as a provider with Oregon Medicaid. • The State does not apply provider requirements in addition to State licensing.	• CCO requires all participating providers to meet credentialing and re-credentialing requirements. • N/A	• All FFS providers must be enrolled as a provider with Oregon Medicaid. • The State does not apply provider requirements in addition to State licensing.

2. Comparability of Strategy: Why is the NQTL assigned to these provider types?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• CCO applies credentialing and re-credentialing requirements to: – Meet State and Federal requirements – Ensure capabilities of provider to deliver high quality of care – Ensure provider meets minimum competency standards	• Provider enrollment is required by State law and Federal regulations. • The State also specifies requirements for provider enrollment in order to ensure beneficiary health and safety and to reduce Medicaid provider fraud, waste, and abuse.	• CCO applies credentialing and re-credentialing requirements to: – Meet State and Federal requirements – Ensure capabilities of provider to deliver high quality of care – Ensure provider meets minimum competency standards	• Provider enrollment is required by State law and Federal regulations. • The State also specifies requirements for provider enrollment in order to ensure beneficiary health and safety and to reduce Medicaid provider fraud, waste, and abuse.

3. Comparability of Evidentiary Standard: What evidence supports the rationale for the assignment?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Credentialing/re-cred requirements are supported by the following evidence: – State law and Federal regulations, including 42 CFR 438.214. – State contract requirement.	• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E - Provider Screening and Enrollment.	• Credentialing/re-cred requirements are supported by the following evidence: – State law and Federal regulations, including 42 CFR 438.214. – State contract requirement. – Accreditation guidelines (NCQA).	• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E - Provider Screening and Enrollment.

4. Comparability and Stringency of Processes: Describe the NQTL procedures (e.g., steps, timelines and requirements from the CCO and Provider perspectives).

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• All providers must meet credentialing and re-credentialing requirements. • MH Providers must complete and Oregon Provider Credentialing Application (OPCA) or a 6 page credentialing packet and include CV, proof of insurance, license, professional references and fee schedule (although fee schedule does not factor into credentialing decision).	• All providers are eligible to enroll as a provider and receive reimbursement provided they meet all relevant Federal and State licensing and other rules and are not on an exclusionary list. • Providers must complete forms and documentation required for their provider type. This includes information demonstrating the provider meets provider	• All providers must meet credentialing and re-credentialing requirements. • Providers must complete and provide OPCA; 20 pages for initial credentialing.	• All providers are eligible to enroll as a provider and receive reimbursement provided they meet all relevant Federal and State licensing and other rules and are not on an exclusionary list. • Providers must complete forms and documentation required for their provider type. This includes information demonstrating the provider meets provider

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Providers may submit supporting documentation by fax, secure email or mail. • CCO's credentialing process involves review/verification of information on application, verification of license in good standing, verification of liability insurance within required amounts, verification that provider is not on excluded provider list, and verification of approval by Health systems division (for Certificate of Approval organizations). Review EBPs being used in practice. Ensure provider has NPI number and gains DMAP provider number. • CCO's credentialing process averages 2 weeks. • CCO's human resources staff are responsible for reviewing required information and making provider credentialing decisions.	enrollment requirements such as NPI, tax ID, disclosures, and licensure/certification. • The provider enrollment forms vary from 1 to 19 pages, depending on the provider type. Supporting documentation includes the provider's IRS letter, licensure, SSN number, and/or Medicare enrollment as applicable to the provider type. • The enrollment forms and documentation can be faxed in or completed and submitted electronically to the State's provider enrollment unit. • The State's provider enrollment process includes checking the forms for completeness, running the provider name against exclusion databases, and verifying any licenses, certifications or equivalents.	• Supporting documentation, e.g., peer references, work history, malpractice claims history may be faxed, emailed, or mailed. • CCO's credentialing process involves review of the OPCA, primary source verification of training, licensure, adequate insurance. Verification of plan for coverage 24/7, call group. Review of National Practitioner Data Bank, OIG, Medicaid and Medicare exclusions, attestations, work history and peer references. Clean files may be approved by Medical Director review; others are reviewed by the Credentialing Committee. All are presented to the Credentialing Committee. • CCO's credentialing process averages 51 days. • CCO's Medical Director and Credentialing Committee are responsible for reviewing required information and	enrollment requirements, such as NPI, tax ID, disclosures, and licensure/certification. • The provider enrollment forms vary from 1 to 19 pages, depending on the provider type. Supporting documentation includes the provider's IRS letter, licensure, SSN number, and/or Medicare enrollment as applicable to the provider type. • The enrollment forms and documentation can be faxed in or completed and submitted electronically to the State's provider enrollment unit. • The State's provider enrollment process includes checking the forms for completeness, running the provider name against exclusion databases, and verifying any licenses, certifications or equivalents.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• CCO performs re-credentialing every 2 years. Excluded provider checks are completed monthly. • Providers who do not meet credentialing/re-credentialing requirements are not eligible for reimbursement as an in-network provider. • Providers who are adversely affected by credentialing or re-credentialing decisions may challenge the decision by appealing to the Clinical Management Group	• The State's enrollment process averages 7 to 14 days. • State staff in the provider enrollment unit are responsible for reviewing information and making provider enrollment decisions. • The State reviews all provider enrollment every three years, as required by Federal regulations. • Providers who are not enrolled/re-enrolled are not eligible for Medicaid reimbursement. • Providers who are denied enrollment or re-enrollment may appeal the decision to the State.	making provider credentialing decisions. • CCO performs re-credentialing every two years. • Providers who do not meet credentialing/re-credentialing requirements are excluded from the network as an in-network provider. • Providers who are adversely affected by credentialing or re-credentialing decisions may challenge the decision by appealing to the credentialing committee.	• The State's enrollment process averages 7 to 14 days. • State staff in the provider enrollment unit are responsible for reviewing information and making provider enrollment decisions. • The State reviews all provider enrollment every three years, as required by Federal regulations. • Providers who are not enrolled/re-enrolled are not eligible for Medicaid reimbursement. • Providers who are denied enrollment or re-enrollment may appeal the decision to the State.

5. Stringency of Strategy: How frequently or strictly is the NQTL applied?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• All providers/provider types must be credentialed. • There are no exceptions to meeting these requirements. • No providers were denied admission or terminated from	• All providers/provider types are subject to enrollment/re-enrollment requirements. • There are no exceptions to meeting provider	• All contracted providers/provider types must be credentialed • There are no exceptions to meeting these requirements.	• All providers/provider types are subject to enrollment/re-enrollment requirements. • There are no exceptions to meeting provider

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
the network in the last contract year as a result of credentialing and re-credentialing.	enrollment/re-enrollment requirements. • Less than 1% of providers were denied admission, and .005% of providers were terminated last CY for failure to meet enrollment/re-enrollment requirements.	• No providers were denied admission or terminated from the network in the last contract year as a result of credentialing and re-credentialing.	enrollment/re-enrollment requirements. • Less than 1% of providers were denied admission, and .005% of providers were terminated last CY for failure to meet enrollment/re-enrollment requirements.

6. Stringency of Evidentiary Standard: What standard supports the frequency or rigor with which the NQTL is applied?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Requirement to conduct credentialing for all new providers is established by State law and Federal regulations. • The frequency with which CCO performs re-credentialing is based upon: – State law and Federal regulations – State CCO contract requirements and State IGA contracts – Monitoring of provider performance, including member complaints • CCO monitors the following data/information to determine	• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E — Provider Screening and Enrollment. • The frequency with which the State re-enrolls providers is based on State law and Federal regulations.	• Requirement to conduct credentialing for all new providers is established by State law and Federal regulations. • The frequency with which CCO performs re-credentialing is based upon: – State law and Federal regulations – State contract requirements – Monitoring of provider performance including member complaints – National accreditation standards (NCQA)	• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E — Provider Screening and Enrollment. • The frequency with which the State re-enrolls providers is based on State law and Federal regulations.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
how strictly to apply credentialing/ re-credentialing criteria: – Denial/termination rates for providers as a result of credentialing/ re-credentialing reviews. – Provider appeals/disputes. – Network adequacy data, such as access to care, provider specialties.		• CCO monitors the following data/information to determine how strictly to apply credentialing/ re-credentialing criteria: – Denial/termination rates for providers as a result of credentialing/ re-credentialing reviews. – Provider appeals/disputes. – Network adequacy data, such as access to care, provider specialties.	

7. Compliance Determination for Benefit Packages CCO A and B

Comparability of Strategy and Evidence: All IP and OP providers of MH/SUD and M/S services are subject to CCO credentialing and re-credentialing requirements. Credentialing and re-credentialing is conducted for both providers of MH/SUD and M/S services to meet State and Federal requirements, ensure capabilities of provider to deliver high quality of care and to ensure provider meets minimum competency standards. Credentialing and re-credentialing of MH/SUD and M/S providers is supported by State law and Federal regulations and the CCO's contract with the State. In addition, the CCO uses national accreditation guidelines (NCQA) to support the credentialing and re-credentialing strategy for M/S providers. While the CCO does not similarly use NCQA standards for applying the NQTL for MH/SUD services, the application of a more restrictive standard for M/S providers is not a parity compliance concern. Based upon these findings, the CCO's strategy and evidence for conducting credentialing and re-credentialing are comparable for providers of MH/SUD and M/S services.

Comparability and Stringency of Processes: All providers of MH/SUD and M/S services must successfully meet credentialing and re-credentialing requirements in order to be admitted to and continue to participate in the CCO's network. The information and documentation that new providers are required to complete and submit as part of the credentialing process is substantially the same. Both MH/SUD and M/S providers are offered several methods of submitting their application and supporting documentation, including by fax, by mail or electronically.

The CCO's credentialing process for both MH/SUD and M/S providers includes primary source verification of licensing (or certification for certain MH/SUD COA organizations), liability insurance, and Medicare Excluded Providers (Office of Inspector General). While the CCO does not review exactly the same documentation and information for MH/SUD and M/S providers, the type and extent of documentation required is comparable. The credentialing process on average takes approximately two weeks for MH/SUD providers and over seven weeks for M/S providers. The CCO's Medical Director and Credentialing Committee are responsible for reviewing required information and making provider credentialing decisions for M/S providers; Human Resources similarly conducts the credentialing function, reviewing information and making credentialing decisions for MH/SUD providers (based upon staff model of service delivery). Re-credentialing for both MH/SUD and M/S providers is conducted every two years. Failure for MH/SUD and M/S providers to meet credentialing and re-credentialing requirements result in the denial or termination of participation as an in-network provider for the CCO. MH/SUD and M/S providers who are adversely affected by credentialing or re-credentialing decisions may challenge the decision by appealing to the Clinical Management Group (MH/SUD providers) or the credentialing committee (M/S providers).

Based upon these findings, the credentialing and re-credentialing processes of the CCO for providers of MH/SUD services are comparable and applied no more stringently that to providers of M/S services.

Stringency of Strategy and Evidence: All MH/SUD and M/S providers are subject to meeting credentialing and re-credentialing requirements; there are no exceptions. In operation, MH/SUD and M/S providers have been comparably impacted by the application of credentialing and re-credentialing requirements, with no MH/SUD or M/S providers terminated or denied admission to the network in the last contract year.

The CCO monitors similar metrics related to applying credentialing and re-credentialing requirements for MH/SUD and M/S providers, including reviewing provider denial/termination rates, appeals and disputes, and network adequacy data (e.g. access to care and provider specialties). As a result, the strategies and evidentiary standards for credentialing and re-credentialing are no more stringently applied to MH/SUD providers than to M/S providers.

Compliance Determination: Based upon the analysis, the processes, strategies, and evidentiary standards for credentialing and re-credentialing providers, in writing and in operation, are comparably and no more stringently applied to MH/SUD providers than to providers of M/S services.

8. Compliance Determination for Benefit Packages CCO E and G

Provider network admission limits do not apply to FFS benefits, and the application of provider network admission NQTLs for benefits delivered under managed care is supported by 42 CFR 438.206 and 42 CFR 438.12. Accordingly, parity was not analyzed.

PROVIDER ADMISSION — PROVIDER EXCLUSIONS

NQTL: Provider Admission — Provider Exclusions (Categorical exclusion of a particular provider type from the CCO's network of participating providers.)
Benefit Package: A, B, E, and G for Adults and Children
Classification: Inpatient and Outpatient
CCO: Advanced Health (AH)

1. To which provider type(s) is the NQTL assigned?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• The CCO does not categorically exclude certain provider types from participating in their network.	• The State does not categorically exclude certain provider types from enrolling as Medicaid providers.	• N/A	• The State does not categorically exclude certain provider types from enrolling as Medicaid providers.

2. Comparability of Strategy: Why is the NQTL assigned to these provider type(s)?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• N/A	• N/A	• N/A	• N/A

3. Comparability of Evidentiary Standard: What evidence supports the rationale for the assignment?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• N/A	• N/A	• N/A	• N/A

4. Comparability and Stringency of Processes: Describe the NQTL procedures (e.g., steps, timelines and requirements from the CCO and Provider perspectives).

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• N/A	• N/A	• N/A	• N/A

5. Stringency of Strategy: How frequently or strictly is the NQTL applied?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• N/A	• N/A	• N/A	• N/A

6. Stringency of Evidentiary Standard: What standard supports the frequency or rigor with which the NQTL is applied?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• N/A	• N/A	• N/A	• N/A

7. Compliance Determination for Benefit Packages CCO A and B

The CCO does not exclude particular types of providers of MH/SUD from admission and participation in the CCO's network. As a result, the NQTL does not apply and parity was not analyzed.

8. Compliance Determination for Benefit Packages CCO E and G

Provider network admission limits do not apply to FFS benefits, and the application of provider network admission NQTLs for benefits delivered under managed care is supported by 42 CFR 438.206 and 42 CFR 438.12. Accordingly, parity was not analyzed.

OUT OF NETWORK (OON)/OUT OF STATE (OOS)

NQTL: Out of Network (OON)/Out of State (OOS) Standards
Benefit Package: A, B, E, and G for Adults and Children
Classification: Inpatient and Outpatient
CCO: Advanced Health (AH)

1. To which benefits is the NQTL assigned?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Out of Network (OON) and Out of State (OOS) Benefits	Out of State (OOS) Benefits	Out of Network (OON) and Out of State (OOS) Benefits	Out of State (OOS) Benefits

2. Comparability of Strategy: Why is the NQTL assigned to these benefits?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• CCO seeks to maximize use of in-network providers because the use of local, contracted providers when available is convenient to members and allows the CCO to ensure that providers meet regulatory requirements and ensure quality care. • The purpose of providing OON/OOS coverage is to provide needed services when they are not available in-network/in-State.	• The State seeks to maximize use of in-State providers because the State has determined that they meet applicable requirements, and they have a provider agreement with the State, which includes agreemet to comply with Oregon Medicaid requirements and accept DMAP rates. • The purpose of providing OOS coverage is to provide needed services when the service is not available in the State of Oregon or the client is OOS and requires covered services.	• CCO seeks to maximize use of in-network providers because the use of local, contracted providers when available is convenient to members and allows the CCO to ensure that providers meet regulatory requirements and ensure quality care. • The purpose of providing OON/OOS coverage is to provide needed services when they are not available in-network/in-State.	• The State seeks to maximize use of in-State providers because the State has determined that they meet applicable requirements, and they have a provider agreement with the State, which includes agreement to comply with Oregon Medicaid requirements and accept DMAP rates. • The purpose of providing OOS coverage is to provide needed services when the service is not available in the State of Oregon or the client is OOS and requires covered services.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
The purpose of prior authorizing non-emergency OON/OOS benefits is to determine the medical necessity of the requested benefit and the availability of an in-network/in-State provider.	The purpose of prior authorizing non-emergency OOS services is to ensure the criteria in OAR 410-120-1180 are met.	The purpose of prior authorizing non-emergency OON/OOS benefits is to determine the medical necessity of the requested benefit and the availability of an in-network/in-State provider.	The purpose of prior authorizing non-emergency OOS services is to ensure the criteria in OAR 410-120-1180 are met.

3. Comparability of Evidentiary Standard: What evidence supports the rationale for the assignment?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
The CCO covers OON/OOS benefits in accordance with Federal and State requirements, including OAR and the CCO contract.	The State covers OOS benefits in accordance with OAR.	The CCO covers OON/OOS benefits in accordance with Federal and State requirements, including OAR and the CCO contract.	The State covers OOS benefits in accordance with OAR.

4. Comparability and Stringency of Processes: Describe the NQTL procedures (e.g., steps, timelines and requirements from the CCO, member, and provider perspectives).

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Except as otherwise required by OHA, non-emergency OON/OOS services are not covered unless medically necessary services are not available within network/in-State. • The CCO's criteria for non-emergency OON/OOS coverage include:	• Non-emergency OOS services are not covered unless the service meets the OAR criteria. • The OAR criteria for OOS coverage of non-emergency services include the service is not available in the State of Oregon or the client is OOS	• Except as otherwise required by OHA, non-emergency OON/OOS services are not covered unless medically necessary services are not available within network/in-State. • The CCO's criteria for non-emergency OON/OOS coverage include:	• Non-emergency OOS services are not covered unless the service meets the OAR criteria. • The OAR criteria for OOS coverage of non-emergency services include the service is not available in the State of Oregon or the client is OOS

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
– If services are not available locally. – If services are not available in-State or the member if out of State. – Wait time for local specialist not clinically appropriate. – Collaboration with another provider (OON only). • The CCO developed its criteria for non-emergency OON/OOS coverage following OHA guidelines, CCO contract, and OAR. • Requests for non-emergency OON/OOS services are made through the prior authorization process. • The PA request for OON must include justification of need for OON provider. Requests for OOS must include evidence that treatment cannot reasonably be delivered within the State. • Authorization for OON/OOS is granted based on an expected course of treatment,	and requires covered services. • Requests for non-emergency OOS services are made through the State prior authorization process.	– If services are not available locally. – If services are not available in-State or the member if out of State. – Wait time for local specialist not clinically appropriate. – Collaboration with another provider (OON only). • The CCO developed its criteria for non-emergency OON/OOS coverage following OHA guidelines, CCO contract, and OAR. • Requests for non-emergency OON/OOS services are made through the prior authorization process. • The PA request for OON must include justification of need for OON provider. Requests for OOS must include evidence that treatment cannot reasonably be delivered within the State. • Authorization for OON/OOS is granted based on an expected course of treatment,	and requires covered services. • Requests for non-emergency OOS services are made through the State prior authorization process.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
which is based on medical literature and utilization data. • The timeframe for approving or denying a non-emergency OON/OOS request is the same as for other prior authorizations (14 days for standard request). • The CCO establishes a single case agreement (SCA) with an OON/OOS provider if the provider is not willing to accept DMAP rates. • The CCO's process for establishing a SCA includes collecting information necessary to complete the SCA, including, for example, the provider's NPI and DMAP number, information to complete a provider exclusion check, the rate, and relevant terms of service. • The average length of time to negotiate a SCA is 14 days. • Only providers enrolled in Oregon Medicaid who are not on the exclusions list can qualify as an OON/OOS provider.	• The timeframe for approving or denying a non-emergency OOS request is the same as for other prior authorizations (14 days for standard and 72 hours for urgent). • OOS providers must enroll with Oregon Medicaid. The State pays OOS providers the Medicaid FFS rate.	which is based on medical literature and utilization data. • The timeframe for approving or denying a non-emergency OON/OOS request is the same as for other prior authorizations (14 days for standard request). • The CCO establishes a single case agreement (SCA) with an OON/OOS provider if the provider is not willing to accept DMAP rates. • The CCO's process for establishing a SCA includes collecting information necessary to complete the SCA, including, for example, the provider's NPI and DMAP number, information to complete a provider exclusion check, the rate, and relevant terms of service. • The average length of time to negotiate a SCA is 14 days. • Only providers enrolled in Oregon Medicaid who are not on the exclusions list can qualify as an OON/OOS provider.	• The timeframe for approving or denying a non-emergency OOS request is the same as for other prior authorizations (14 days for standard and 72 hours for urgent). • OOS providers must enroll with Oregon Medicaid. The State pays OOS providers the Medicaid FFS rate.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
The CCO pays OON/OOS providers the Medicaid FFS rate (DMAP) or a negotiated rate with the provider when no reasonable options are available for specialized care.		The CCO pays OON/OOS providers the Medicaid FFS rate (DMAP) or a negotiated rate with the provider if the facility is not a DRG facility (e.g., a children's hospital).	

5. Stringency of Strategy: How frequently or strictly is the NQTL applied?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• If a request for a non-emergency OON/OOS benefit does not meet the CCO's OON/OOS criteria, it will not be prior authorized. • If a non-emergency OON/OOS benefit is not prior authorized, the service will not be covered, and payment for the service will be denied. Retrospective requests can be made in special circumstances. • Members/providers may appeal the denial of an OON/OOS request. • In CY 2017 the CCO received 251 non-emergency OON/OOS requests for MH; 38 requests (15%) were denied; zero denied requests	• If a request for a non-emergency OOS benefit does not meet the OAR criteria, it will not be prior authorized. • If a non-emergency OOS benefit is not prior authorized, the service will not be covered, and payment for the service will be denied. • Members/providers may appeal the denial of an OOS request.	• If a request for a non-emergency OON/OOS benefit does not meet the CCO's OON/OOS criteria, it will not be prior authorized. • If a non-emergency OON/OOS benefit is not prior authorized, the service will not be covered, and payment for the service will be denied. Retrospective requests can be made in special circumstances. • Members/providers may appeal the denial of an OON/OOS request. • In CY 2017 the CCO received 4,770 non-emergency OON/OOS requests; 918 requests (19%) were denied for various reasons; three	• If a request for a non-emergency OOS benefit does not meet the OAR criteria, it will not be prior authorized. • If a non-emergency OOS benefit is not prior authorized, the service will not be covered, and payment for the service will be denied. • Members/providers may appeal the denial of an OOS request.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
were appealed (0% appeal overturn rate). • In CY 2017 the CCO received 28 non-emergency OON/OOS requests for SUD; zero requests were denied (0% appeal overturn rate). • The CCO measures the stringency of the application of OON/OOS requirements by analyzing and monitoring denial/appeal rates, the adequacy of the provider network, number of requests for out of network care, the number of admissions per facility, and feedback from PCPs regarding timeliness of referrals. The CCO evaluates the number of SCAs/OON/OOS requests at least annually to determine network need.	The State measures the stringency of the application of OOS requirements by reviewing OOS denial/appeal rates.	denials were appealed, and two of those were overturned (.2% appeal overturn rate). • The CCO measures the stringency of the application of OON/OOS requirements by analyzing and monitoring denial/appeal rates, the adequacy of the provider network, number of requests for out of network care, the number of admissions per facility, and feedback from PCPs regarding timeliness of referrals. The CCO evaluates the number of SCAs/OON /OOS requests at least annually to determine network need.	The State measures the stringency of the application of OOS requirements by reviewing OOS denial/appeal rates.

6. Stringency of Evidentiary Standard: What standard supports the frequency or rigor with which the NQTL is applied?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Federal and State requirements, including OAR and the CCO contract.	OAR	Federal and State requirements, including OAR and the CCO contract.	OAR

7. Compliance Determination for Benefit Packages CCO A and B

Comparability of Strategy and Evidence: The CCO seeks to maximize the use of in-network providers because the use of local, contracted providers is convenient to members and allows the CCO to ensure that providers meet regulatory requirements and ensure quality care. While the State has not established a network of MH/SUD providers, the State seeks to maximize the use of in-State providers for similar reasons. The CCO's purpose for providing OON/OOS coverage is to provide needed MH/SUD and M/S benefits when they are not available in-network or in-State. Similarly, for MH/SUD FFS benefits, the State provides OOS coverage to provide needed benefits when they are not available in-State.

For both non-emergency MH/SUD and M/S OON/OOS benefits, the CCO (and the State for FFS MH/SUD OOS benefits) requires prior authorization to determine medical necessity and to ensure no in-network/in-State providers are available to provide the benefit. OON/OOS coverage requirements are based on Federal and State requirements, including OAR (for both the State and the CCO) and the CCO contract (for the CCO). As a result, the strategy and evidence for OON/OOS coverage of non-emergency inpatient and outpatient benefits are comparable for MH/SUD and M/S benefits.

Comparability and Stringency of Processes: Requests for non-emergency OON/OOS CCO MH/SUD and M/S benefits are made through the CCO's prior authorization process and are reviewed for medical necessity and in-network/in-State coverage. The prior authorization timeframes (14 days for standard requests and 72 hours for urgent requests) apply. Similarly, the State reviews requests for non-emergency OOS MH/SUD services through its prior authorization process, and the prior authorization timeframes (14 days for standard requests and 72 hours for urgent requests) apply. OOS providers are reimbursed the Medicaid FFS rate. If the OOS MH/SUD provider is not enrolled in Oregon Medicaid, the provider must enroll in Oregon Medicaid. Similarly, the CCO requires OON/OOS providers to be enrolled with Oregon Medicaid. If the OON/OOS MH/SUD or M/S provider does not agree to the DMAP rate, then the CCO will establish a single case agreement (SCA). The CCO's process for establishing a SCA is the same for MH/SUD and M/S providers and includes collecting information necessary to complete the SCA and establishing the rate and terms of service. The average time to negotiate a SCA is 14 days. Both MH/SUD and M/S OON/OOS providers are paid either the Medicaid FFS rate or a negotiated rate. Based on this, the processes for MH/SUD and M/S non-emergency OON/OOS benefits are comparable and applied no more stringently to MH/SUD non-emergency OON/OOS benefits.

Stringency of Strategy and Evidence: For both MH/SUD and M/S, if a request for a non-emergency OON/OOS benefit does not meet applicable criteria, which are based on Federal and State requirements, it will not be authorized, and payment for the service will be denied by the CCO/State. Members and providers may appeal the denial of OON/OOS authorization requests to the CCO/State as applicable. While the

State does not have statistics regarding OOS requests, the CCO states that in CY 2017 approximately 14% of MH/SUD and 19% of M/S OON/OOS requests were denied in 2017, with a 0% appeal overturn rate for MH/SUD and a .2% appeal overturn rate for M/S. This indicates that OON/OOS standards are not applied more stringently to MH/SUD benefits. As a result, the strategies and evidentiary standards for OON/OOS are no more stringently applied to MH/SUD benefits than to M/S benefits.

Compliance Determination: As a result, the processes, strategies, and evidentiary standards for the application of OON/OOS to non-emergency MH/SUD benefits are comparably and no more stringently applied, in writing and in operation, than to non-emergency M/S benefits.

8. Compliance Determination for Benefit Packages CCO E and G

Comparability of Strategy and Evidence: For both MH/SUD and M/S benefits the State seeks to maximize the use of in-State providers because the State has determined that they meet applicable requirements and they have a provider agreement, which includes agreement to comply with Oregon Medicaid requirements and accept DMAP rates. Similarly, the CCO seeks to maximize the use of in-network providers because the use of local, contracted providers is convenient to members and allows the CCO to ensure that providers meet regulatory requirements and ensure quality care. The State provides OOS coverage to provide needed MH/SUD and M/S benefits when they are not available in-State. Similarly, the CCO provides OON/OOS coverage to provide needed MH/SUD benefits when they are not available in-network or in-State. For both non-emergency MH/SUD and M/S OOS benefits, the State (and the CCO for MH/SUD OON/OOS benefits) requires prior authorization to determine medical necessity and to ensure no in-State providers (and in-network providers for OON requests to the CCO) are available to provide the benefit. The State's OOS coverage requirements are based on OAR. The CCO's OON/OOS coverage requirements are based on OAR and the CCO contract. As a result, the strategy and evidence for OON/OOS coverage of non-emergency inpatient and outpatient benefits are comparable for MH/SUD and M/S benefits.

Comparability and Stringency of Processes: Requests for non-emergency OOS FFS MH/SUD and M/S benefits are made through the State's prior authorization process and are reviewed for medical necessity and in-State coverage. The prior authorization timeframes (14 days for standard requests and 72 hours for urgent requests) apply. Similarly, the CCO reviews requests for non-emergency OON/OOS MH/SUD services through its prior authorization process, and the prior authorization timeframes (14 days for standard requests and 72 hours for urgent requests) apply. OOS FFS MH/SUD and M/S providers are reimbursed the Medicaid FFS rate. If the OOS provider is not enrolled in Oregon Medicaid, the provider must enroll in Oregon Medicaid. The CCO also requires OON/OOS MH/SUD providers to be enrolled with Oregon Medicaid. If the OON/OOS MH/SUD provider does not agree to the DMAP rate, then the CCO will establish a single case agreement (SCA). While this is an additional step for CCO MH/SUD providers, it is the provider's choice to not accept the DMAP rate, and this option is not available to M/S providers in FFS. The CCO pays OON/OOS MH/SUD providers either the Medicaid FFS rate or a negotiated rate. Based on this, the processes for MH/SUD non-emergency OON/OOS benefits are comparable and applied no more stringently to non-emergency MH/SUD OON/OOS benefits than to M/S benefits.

Stringency of Strategy and Evidence: For both MH/SUD and M/S FFS, if a request for a non-emergency OOS benefit does not meet applicable criteria, which are based on OAR, it will not be authorized, and payment for the service will be denied by the State. Similarly, if a request for a non-emergency MH/SUD OON/OOS benefit does not meet the CCO's criteria, which are based on OAR and the CCO contract, it

will not be authorized, and payment for the service will be denied by the CCO. For both MH/SUD and M/S, members and providers may appeal the denial of an OON/OOS request. The strategies and evidentiary standards for OON/OOS are no more stringently applied to MH/SUD benefits than to M/S benefits.

Compliance Determination: As a result, the processes, strategies, and evidentiary standards for the application of OON/OOS standards to non-emergency MH/SUD benefits are comparably and no more stringently applied, in writing and in operation, to non-emergency M/S benefits.