HEALTH WEALTH CAREER

ALLCARE HEALTH (ALLCARE) 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 AllCare 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: AllCare

Benefit package A and B: MH/SUD benefits in columns 1 (CCO MH/SUD) and 2 (FFS MH/SUD) compared using strategies1-4 to M/S benefits in column 3 (CCO M/S). These benefit packages include MH/SUD IP benefits managed by the CCO (in two counties the CCO administers SUD benefits and sub-capitates Options for MH; in the other county the CCO sub-capitates Curry for both MH and SUD), 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) 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) Emergency admissions require notification within 48 hours of admission and subsequent CR. • (1, 4) Extra-contractual and experimental/investigational/ unproven benefit requests	• (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,	• (1, 2, 3, 4) PA and CR are required for planned non-emergency admissions to IP hospital, (in and OON) and IP hospice/palliative care. • (1, 2, 3, 4) Emergency admissions require notification within 48 hours of admission and subsequent CR. • (1, 2, 3, 4) Skilled nursing facility benefits (first 20 days) require PA. • (1, 4) Extra-contractual and experimental/investigational/unproven benefit requests (i.e.,	• (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
(i.e., exceptions) are submitted through a PA-like process.	SAIP and subacute care that 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.	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 benefits (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 overutilization (e.g., in violation of relevant OARs and associated Health Evidence Review Commission (HERC) guidelines[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.	• (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	• (1) To ensure coverage, medical necessity and prevent unnecessary overutilization (e.g., in violation of relevant OARs and associated Health Evidence Review Commission (HERC) guidelines). • (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.	• (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] Reference to HERC PL and/or guidelines includes 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
	of services and associated risk.		

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, 2 and 4) ASAM, HERC PL and guidelines. AllCare plans to purchase MCG for use by AllCare, Options and Curry to make authorization decisions. • (1) Annual cost and utilization reports that confirm IP as a cost driver based on percentage of spend. AllCare currently uses its own cost and utilization reports to identify overutilization. Options looks at change in trend or against benchmark (historical). Once overutilization is identified, Options drills down to determine the root cause. Curry has low hospitalization rates and compares data year-to-year and reviews changes.	• (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) 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
• (1) Options reviews UM data relative to benchmark for high utilizing members (e.g., excessive readmissions relative to diagnosis), trends or patterns (e.g., rise in hospitalization of a specific age group) and adverse events (e.g., a school suicide) and add or connect to resources to address. • (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 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	• (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 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, &	• (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 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, &	

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
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 Care, Sage Journals, Oct. 1, 2005, 1-13. Accessed May 25, 2018. http://journals.sagepub.com/doi/10.1177/1077558705279307	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.	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
• (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	• (4) Applicable federal and State requirements.

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: • PA must be obtained prior to IP admission, except in the case of emergencies, when notification is required following the admission.	**Timelines for gender reassignment surgery authorizations (for benefit packages E and G):** **(OHA)**	**Timelines for authorizations:** • PA must be obtained prior to IP admission, except in the case of emergencies, when notification is required following the admission.	**Timelines for authorizations**: • All in-state and out-of-state (OOS) emergency admissions, LTAC, and IP rehabilitation require notification. Notification is

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• CR occurs on the last covered day of an authorization. • Emergency requests are processed within 24 hours. Urgent requests are processed within 72 hours. Standard requests are to be processed within 14 days.	• Standard requests are to be processed within 14 days. **Timelines for child residential authorizations**: **(OHA)** • 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.	• CR occurs on the last covered day of an authorization • Emergency requests are processed within 24 hours. Urgent requests are processed within 72 hours. Standard requests are to be processed within 14 days.	preferred within 24 hours of admission, but there is no timeline requirement. Notification allows the State to conduct case management and discharge planning, but 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.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Documentation requirements: • Options may review via EHR. Admission H&P, evaluation and information supporting medical necessity review. • Curry reviews H&P and evaluation. • AllCare requires admit notice with attestation that ASAM is met. Supporting information may be provided. CR requires updated ASAM or progress notes.	**Documentation requirements (OHA):** • PA documentation requirements for non-residential MH/SUD benefits 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:	**Documentation requirements:** • UM is electronically notified of the admission, enabling review of the medical record. • AllCare requires admission information and updated progress notes for OON.	**Documentation requirements**: • PA documentation requirements 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.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	(a) A cover sheet detailing relevant provider and recipient Medicaid numbers; (b) Requested dates of service; (c) HCPCS or CPT Procedure code requested; and (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.		

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 EMR. • The reviewer may attend an individual's treatment review every 3 months, but goes to the hospital daily.	• 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 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	**Method of document submission:** • An RN has access to the EMR and reviews admission for authorization • Hospitals without RN access to EMR fax records daily.	**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
	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. 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: • Both Options and Curry refer all potential IP denials to AllCare psychiatrist for review.	**Qualifications of reviewers (OHA)**: • OHA M/S staff conduct PA and CR (if applicable) for gender reassignment surgery	**Qualifications of reviewers:** • Licensed nurses gather relevant clinical information from the provider and conduct medical necessity review.	**Qualifications of reviewers**: • Nurses may authorize and deny authorization requests relative to OAR, HERC PL guidelines and associated notes, and other industry

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Licensed mental health professionals gather relevant clinical information from the provider and conduct medical necessity review. • Only a physician make denial decisions	(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 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,	• Only a physician can make denial decisions	guidelines (e.g., AIM for radiology).

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	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, 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		

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. AllCare plans to purchase MCG for use by AllCare, Options and Curry to make authorization decisions.	– A qualified Mental Health Intern, as defined in 309-019-0105(61). **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.	**Criteria:** • Authorization decisions for adults and children are based on OARs, ORS, HERC PL and guidelines, guidelines issued from appropriate professional associations and health organizations (such as N.I.C.E), current peer-reviewed medical literature, and Up-to-date, a service providing ongoing review of peer reviewed literature and current 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
	• The PCSP components are entered into MMIS as an authorization.		
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	**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**: • 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 and fair hearing rights apply.	decision) will review the documentation and discuss 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 and fair hearing rights 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	**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**: • Failure to obtain authorization can result in non-payment for benefits for which it is required. • Failure to obtain notification does not result in a financial penalty.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	benefits for which it is required.		

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Frequency of review (and method of payment): • Current AllCare hospital contracts are DRG-based. • CR occurs every 1- 3 days for acute IP reviewed by Curry. The reviewer may attend an individual's treatment review every 3 months, but goes to the hospital daily. • Authorizations and re-authorizations for AllCare and Options acute IP MH range from 2–5 days, depending on the facility's recommendation, medical necessity, diagnosis and expected length of stay and the member's needs. • Both Curry and Options review subacute and PRTS every 30 days • Options just changed the review frequency for SUD residential due to an absence	**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):** • Current hospital contracts are DRG-based, Critical Access Hospitals (CAH) are paid a percentage of billed charges consistent with State law. • CR occurs daily for IP hospital. • Qualifying SNF stays are reviewed weekly at a minimum.	**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
of denials with prior CR frequency. New policy is, if a facility needs more than 90 days, will review. Curry reviews SUD residential every 30 days. **RR conditions and timelines:** • RR is offered (with some limitations) for providers who fail to PA medically necessary care (for a good reason) and file within 180 days consistent with timely filing requirements.	**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	**RR conditions and timelines:** • RR is offered (with some limitations) for providers who fail to PA medically necessary care (for a good reason) and file within 180 days consistent with timely filing requirements.	**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
	could not have been obtained within 30 days of the date of service.		
Methods to promote consistent application of criteria: • No IRR because Options only recently added a second reviewer (Curry only has one). Review criteria application during consultation and through chart reviews. • Options and Curry plan to review 3-5 IP and OP MH/SUD charts for each reviewer annually to evaluate criteria application to a score of 90%.	**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:** • Conducts IRR testing. Outliers receive additional training.	**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
	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)**: • 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 it is applied?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Evidence for UM frequency: • Cost trends. Expected ALOS or a time at which progress is anticipated, so reviews are scheduled to recur at the time of expected progress or to confirm D/C planning. AllCare plans to purchase MCG, which will provide another evidence base for determining frequency of review. • Oregon CCO contract. • 42 CFR Part 441, Subpart D requiring PRTF is reviewed at least every 30 days (§441.155) for child providers.	**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. • 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	**Evidence for UM frequency**: • Cost trends. • The UM RN reviews a SNF stay based on an appropriate timeframe for monitoring the member's response to the skilled care. OAR Chapter 411, Division 70 is utilized for criteria.	**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 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.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	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 less standardization in interventions).		• 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.
Data reviewed to determine UM application: • Utilization review reports • Denial/overturn rates. • Approval rates. • Number of PA and CR requests.	**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	**Data reviewed to determine UM application:** • Utilization reports • Denial/overturn rates. • Approval rates. • Number of PA and CR requests.	**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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
IRR standard: • No IRR because only recently added a second reviewer. **Results of criteria application:** • In 2017, there were 4 denials (3 IP and 1 OP), three of which were overturned on internal appeal (75%).	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 **IRR standard:** • OHA: N/A • HIA: N/A • KEPRO: N/A **Results of criteria application**: • OHA: 0 appeal overturns. • HIA: 0 appeal overturns. • KEPRO: 0 appeal overturns.	**IRR standard:** • 2017 had a 90% concordance rate. Outliers receive additional training. **Results of criteria application:** • In 2017, there were 2,800 IP and OP denials, 75 of which were overturned on internal appeal (2.7%).	– Documentation/ justification of services – Cost data **IRR Standard**: • N/A **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. SUD detoxification is reviewed for lengths of stay exceeding 10 days. Emergency CCO MH/SUD and M/S IP admissions require notification within 48 hours and most ongoing IP services require subsequent CR. 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 four strategies: 1) To ensure coverage, medical necessity and prevent unnecessary overutilization (e.g., in violation of relevant OARs, the HERC PL and guidelines). Evidence of MH/SUD overutilization includes HERC, research demonstrating 30% of IP costs are unnecessary; and for MH/SUD and M/S benefits administered by the CCO, utilization reports. 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. 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 CCO documentation requirements for MH/SUD include an admission note and records submitted via telephone, fax, or electronically. A few Options MH/SUD facilities are reviewed via EHR or through the reviewer's daily visits to the facility. CCO M/S is electronically notified of an admission and care is reviewed via EHR. Alternatively, documentation is submitted via fax. Curry attends review meetings at the only hospital in their region. 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

[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.

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 UM applying OARs, HERC, national guidelines, and ASAM for CCO SUD. *The CCO plans to purchase MCG for use by all its subcontractors to make MH/SUD authorization decisions. OHA plans to enhance the evidence base for FFS child residential authorization decisions through additional research, resulting in admission and CR criteria development.* CCO MH/SUD and M/S requires all denials are made by physicians. 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 offers peer-to-peer review and makes RR available for MH/SUD and M/S when providers fail to obtain authorization. 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: MH/SUD conducts CR every 1-5 days while M/S conducts CR daily. CCO MH/SUD residential (e.g., SUD, subacute and PRTS) frequency of review averages 30-90 days. *The CCO plans to purchase MCG, which will be used to establish review frequencies*. 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. *OHA plans to task 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.* The CCO makes RR available for MH/SUD and M/S. 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 M/S, the CCO conducts IRR to a standard of 90%. *The CCO plans to formalize criteria application review for Options and Curry to a standard of 90%*

once MCG is implemented. 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 2 (of 3) IP denials that were overturned and FFS reported 0 appeal overturns for MH/SUD in 2017. M/S reported a 2.7% appeal overturn rate based on 2,800 denials. Given the small number of MH/SUD denials, the MH/SUD overturn rate cannot be interpreted to reflect more stringent operations. Inclusive of OHA and CCO 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 and CCO 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.

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.*

Below are the CCO-specific action plans:

1. *AllCare will purchase MCG for use by AllCare, Options and Curry by the end of 2018.*
2. *The CCO will formalize criteria application review for Options and Curry to a standard of 90% once MCG is implemented.*

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, utilization reports. 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 48 hours of admission. Emergency child residential authorization requests must be submitted within 14 days of the admission. SUD detoxification is reviewed 10 days post-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 include an admission summary and records submitted via telephone, fax, or electronically. A few MH/SUD facilities are reviewed via EHR or through the reviewer's daily visits to the facility. Alternatively, documentation is submitted via fax. Similarly, FFS M/S documentation is submitted on paper (fax) or web portal. 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 clinical policy/guidelines. *AllCare plans to purchase MCG for use by AllCare, Options and Curry*. 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 FFS child residential authorization decisions through additional research, resulting in admission and CR criteria development.* CCO MH/SUD requires physicians to make denial determinations. 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 when providers fail to obtain authorization. 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 and CCO 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: MH/SUD CCO conducts CR every 1-5 days. CCO MH/SUD residential (e.g., SUD, subacute and PRTS) frequency of review averages 30-90 days. Evidence for frequency of review includes expected length of stay, ASAM and denial frequency. In 2019, MCG will support review frequency. 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 SUD is ASAM and the expected rate of improvement and average length of stay for MH. *OHA plans to task 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.* CCO MH/SUD offers RR. 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, 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 MH/SUD the CCO conducts chart review 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 two appeal overturns for IP MH/SUD in 2017. FFS M/S's appeal overturn rate was 0. The number of MH/SUD appeal overturns is too small to assess stringency in operation. Inclusive of OHA and CCO 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 and CCO IP 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, RR)
Benefit Packages: A, B, E, and G for Adults and Children
Classification: Outpatient (OP)
CCO: AllCare

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, 3, 4) OON OP services • (2, 3) Investigational and Experimental Services • (2, 3) ABA • (2) Acupuncture • (2) DME • (2) Medical nutritional • (2) Medical specialty visits • (2) Neuro-psych testing • (2, 3) OP Hospice/palliative care	• (2, 3, 4) OON • (2, 3) Investigational and Experimental Services • (2) Acupuncture • (2) DME • (2) Medical nutritional • (2) Medical specialty visits • (2) Neuro-psych testing • (1, 2) OP Hospice/palliative care • OP surgery 1,2	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	• (2) OP Mental Health Services for Options for Southern Oregon. Options conducts OP UM through chart audits of a random sample of closed and open cases. • (2) Curry requires notification for INN OP and begins review If care goes beyond 3 sessions. OON requires PA. • (2) Psych evaluation for bariatric surgery • (2) PT, OT, ST • (2) Sleep study • (2, 3) Transcranial Magnetic Stimulation (TMS) • (2) Video EEG	• (2) Psych evaluation for bariatric surgery • (2) Sleep study • (2) Video EEG	evidentiary standards described for FFS/MS OP) • (2, 3) Imaging • (2) DME

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

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 regarding PCSPs and ensure services are	• (1) The State requires PA of HCBS in order to meet federal requirements regarding PCSPs and ensure services are	• (2) To ensure coverage, medical necessity and prevent unnecessary overutilization.	• (2) To ensure coverage, medical necessity and prevent unnecessary overutilization.	• (2) To prevent services being delivered in violation of relevant OARs, associated HERC PL

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 accordance with a participant's PCSP and in the least restrictive setting.	provided in accordance with a participant's PCSP and in the last restrictive setting.	• (3) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. • (4) Maximize use of INN providers to promote cost-effectiveness when appropriate.	• (3) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. • (4) Maximize use of INN providers to promote cost-effectiveness when appropriate.	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) OARs, HERC PL and guidelines, and federal guidelines. • (2) UM and claims reports are reviewed for trends in overutilization on a quarterly basis. • (2) Annual cost and utilization reports. • (2) Medical literature demonstrates high cost of unnecessary medical care (i.e. 30% of medical costs). (Institute of Medicine Report, (2012).	• (2) OARs, HERC PL and guidelines, and federal guidelines. • (2) UM and claims reports are reviewed for trends in overutilization on a quarterly basis. • (2) Annual cost and utilization reports. • (2) Medical literature demonstrates high cost of unnecessary medical care (i.e. 30% of medical costs). (Institute of Medicine Report, (2012).	• (2) HERC PL • (2) PA requests with insufficient documentation demonstrate MNC are not being met or HERC PL guidelines are not being followed.

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.	• (3) Oregon Performance Plan (OPP) requires that BH services be provided in least restrictive setting possible. The OPP is a DOJ-negotiated Olmsted settlement. • (3) HERC guidelines re safety concerns • (4) Network providers' credentials have been verified and they have contracted to accept the network rate.	• (3) HERC guidelines re safety concerns. • (4) Network providers' credentials have been verified and they have contracted to accept the network rate.	• (3) HERC Guidelines - Recommended limits on services for member safety.

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.	**Timelines for authorizations**: • A PCSP must be approved within 90 days from the date a completed application is submitted.	**Timelines for authorizations:** • Provider expected to wait for authorization to deliver service but 14 day retro submission permitted. • Emergency requests are processed within 24 hours. Urgent	**Timelines for authorizations:** • Provider expected to wait for authorization to deliver service but 14 day retro submission permitted. • Emergency requests are processed within 24 hours. Urgent	**Timelines for authorizations**: • Urgent requests are processed in 72 hours and immediate requests in 24 hours. Routine requests are processed in 14 days.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Documentation requirements: • (c)The PCSP is based on a functional needs assessment and other supporting documentation. It is developed by the individual, the 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	**Documentation requirements**: • The PCSP is based on a functional needs assessment and other supporting documentation. It is developed by the individual, the individual's team and the individual's case manager.	requests are processed within 72 hours. Standard requests are to be processed within 14 days. **Documentation requirements:** • Prior to service delivery, provider makes request via telephone, fax or online, one-page form with supporting medical documentation, diagnostic and CPT code.	requests are processed within 72 hours. Standard requests are to be processed within 14 days. **Documentation requirements:** • Prior to service delivery provider makes request via telephone, fax or 1 page online form with supporting medical documentation, diagnostic and CPT code.	**Documentation requirements**: • A cover page form is required. In addition, diagnostic information, a CPT code(s), a rationale for medical necessity plus any additional supporting documentation are required.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
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. • 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	**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. • Information is obtained during a face-to-face meeting, often at the individual's location.	**Method of document submission:** • Curry Community Health requires telephonic screening for PA. After 3 sessions, provider submits assessment and POC with request for number of sessions. • Subsequent UM involves completion of 1 page form and supporting documentation, telephonic review may be required for additional information. • Options for Southern Oregon: State regulatory requirements (e.g., a	**Method of document submission:** • Documentation may be submitted via fax, telephone and/or online.	**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
request is submitted via portal. **Qualifications of reviewers**: • (c) A case manager must have at least:	 **Qualifications of reviewers**: • A case manager must have at least:	service plan, mental health assessment in the last year, and information supporting medical necessity) are obtained to confirm related requirements are met for non-Options providers. (Options' providers' requirements are reviewed electronically.) • No referral or PA needed for evaluation. Automatic 3 month authorization (i.e., no document submission) for in-network providers. • UM is necessary for continuing services and requires a 1 page form. **Qualifications of reviewers:** • Nurses authorize services, but only a	 **Qualifications of reviewers:** • Nurses authorize services, but only a	 **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
– 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 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**:	– A BA in behavioral science, social science, or a closely related field; or – A BA in any field AND one year of human services 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.	physician can issue a denial.	physician can issue a denial.	

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
• 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, write and supervise the implementation of a PCSP. • A QMHP must meet one of the following conditions:				

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
– 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).				
Criteria: • (c) Qualified case managers approve or deny services in the	**Criteria**: • Qualified case managers approve or deny services in the	**Criteria:** • Authorizations are based on HERC PL and guidelines,	**Criteria:** • Authorizations are based on HERC PL and guidelines, OARs	**Criteria:** • Authorizations are based on the HERC PL and guidelines,

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
PCSP consistent with waiver and OAR requirements. • Once a PCSP is approved, services in the PCSP are entered into the 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	PCSP consistent with waiver/state plan and OAR requirements. • Once a PCSP is approved, it is entered into the payment management system as authorization by the CME staff. **Reconsideration/RR**: • N/A	ASAM, OARs and Oregon Statute, guidelines from medical associations/health organizations and peer- reviewed literature. MCG will be used in 2019. **Reconsideration/RR:** • If providers fail to obtain authorization in advance, they may submit a post-service claim for review.	and Oregon Statute, guidelines from medical associations/health organizations (e.g. NICE and UpToDate) and peer- reviewed literature. **Reconsideration/RR:** • If providers fail to obtain authorization in advance, they may submit a post-service claim for review.	Oregon Statute, Oregon Administrative rules, federal regulations, and evidence-based guidelines from private and 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
denial decision, which occurs in weekly MMC meetings or KEPRO's own 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 authorization can result in non-payment for benefits for which it is required. **Appeals:** • Initial decisions for non-payment may be appealed to AllCare and to the State. • Fair hearing processes apply. • There are no differences in processes for children and adults that are not tied to practice guidelines.	**Consequences for failure to authorize:** • Failure to obtain authorization can result in non-payment for benefits for which it is required. **Appeals:** • Initial decisions for non-payment may be appealed to AllCare and to the State. • Fair hearing processes apply. • There are no differences in processes for children and adults that are not tied to practice guidelines.	**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 UM 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:** • Curry Community Health: Typically 3 months are approved after the initial notification. • In general, Options MH frequency of review varies by type of service or program with authorizations averaging 3 months for OON providers and 6 months for INN providers (although review INN every 90 days to collects MOTS information). • AllCare Health: Continuing approvals range from 3-6 months depending on the service. • Length of authorization can be less, but not more restrictive than HERC,	**Frequency of review:** • Approvals are most commonly for a year, unless requested for less time by the ordering provider. • When PA is exhausted, additional 3 months can be approved. • DME and therapies are based on need and prescription. • Length of authorization can be less, but not more restrictive than HERC, if the provider requests it.	**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. • 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.

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 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	**RR conditions and timelines:** • N/A **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	if the provider requests it. **RR conditions and timelines:** • Post-claim review process available for 14 days. **Method to promote consistent application of criteria:** • No IRR because only recently added a second reviewer. Annually, Options and Curry plan to review 3-5 IP and OP MH charts for each	**RR conditions and timelines:** • Post-claim review process available for 14 days. **Method to promote consistent application of criteria:** • IRR testing. Outliers receive additional training.	**RR conditions and timelines:** • RR available for retro eligibility circumstances. **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
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 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	meet program standards. • Additionally, OHA staff review a percentage of files to assure quality and compliance.	reviewer to evaluate criteria application with a goal of 90%.		

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
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 it 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	**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)	**Evidence for UM frequency:** • Every 3 months to collect MOTS data. • Every 6 months, conduct a review consistent with expectations for improvement and	**Evidence for UM frequency:** • One year authorization is used based on Medicare standard. • Oregon CCO contract.	**Evidence for UM frequency**: • 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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
application/1915(i) State plan amendment. **Data reviewed to determine UM application**: • N/A	waiver application/State plan amendment. **Data reviewed to determine UM application**: • N/A	progress toward goals. • Oregon CCO contract • MCG will be used in 2019. **Data reviewed to determine UM application:** • Denial/overturn rates • Approval rates	**Data reviewed to determine UM application:** • Denial/overturn rates • Approval rates	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 Association or the American Psychiatric Association, are used to establish PA frequency. **Data reviewed to determine UM application**: • A physician-led group of clinical professionals

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
IRR standard: • N/A **Results of criteria application (appeal overturn rates)**: • (c): 0 appeal overturns • (i) (KEPRO) 11% appeal overturn rate (1 out of 9 hearings)	**IRR standard:** • N/A **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	• Number of PA and concurrent review requests • Cost trends **IRR standard:** • N/A. In 2019 will have a 90% concordance rate. **Results of criteria application (appeal overturn rates):** • In 2017, there was one denial, which was overturned.	• Number of PA and concurrent review requests • Cost trends **IRR standard:** • In 2017 had a 90% concordance rate. **Results of criteria application (appeal overturn rates):** • In 2017, there were 2,800 IP and OP denials of which 75 were overturned for a rate of 2.6%.	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 **Results of criteria application (appeal overturn rates):** • 0 appeal overturns

7. Compliance Determination for Benefit Packages CCO A and B (including HCBS services)

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. Options conducts UM of OP benefits through quarterly chart audits of random open and closed cases.

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 that is safe, as required by the OPP Olmstead settlement for MH/SUD. A subset of CCO 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 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 OP benefits are managed by AllCare, Curry Community Health (Curry) and Options of Southern Oregon (Options). While CCO M/S requires PA prior to service delivery, Curry requires an initial telephone screening, and does not require documentation (e.g., assessment and plan-of-care) until after the third session. Options automatically authorizes the first three months of most INN OP care. Because these authorization processes are less restrictive than M/S, they are permissible. Benefit reviews are conducted by qualified clinicians (nurses) who evaluate clinical information that is submitted via telephone, fax or online relative to ASAM, HERC, OARs and national guidelines. AllCare plans to purchase MCG for use by AllCare, Options and Curry. 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 both MH/SUD and M/S OP non-HCBS benefits and standard appeal processes apply. 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 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.

In general, non-HCBS CCO MH/SUD service authorizations average 3-6 months and are tied to data collection needs and/or expected improvements. M/S reported authorization lengths of a year tied to the Medicare standard. *In 2019, MH/SUD will use MCG to determine review frequencies.* CCO M/S conducts IRR to a concordance rate of 90% in 2017. CCO MH/SUD MNC application is evaluated through chart review. CCO MH/SUD only recently hired a second reviewer and has not yet started IRR testing. *MH/SUD plans to implement a more formal assessment of criteria application to a standard of 90%.* CCO RR is offered through post-claim submission for 14 days. The CCO reviews utilization and other data to determine if UM requires adjustment. CCO reported one OP MH/SUD denial. It was overturned on appeal. M/S reported a 2.7% overturn rate for M/S IP and OP. 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 OHA and CCO IP 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.

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.

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 practice guidelines and offered in the least restrictive environment that is safe, which is related to the OPP Olmstead settlement for MH/SUD. A subset of 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 OP benefits are managed by AllCare, Curry Community Health (Curry) and Options of Southern Oregon (Options). While FFS M/S requires PA prior to service delivery, Curry requires an initial telephone screening, and does not require documentation (e.g., assessment and plan-of-care) until after the third session. Options automatically authorizes the first three months of most INN OP care. Because these authorization processes are less restrictive than M/S, they are permissible. Benefit reviews are conducted by qualified clinicians who evaluate MH/SUD clinical information that is submitted via fax, phone or electronically relative to ASAM, HERC, OARs and national guidelines. *The CCO will use MCG for MH/SUD in 2019.* 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, inclusive of the CCO action plan, 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 services.

In general, non-HCBS MH/SUD OP service authorizations range from 3-6 months. These authorization lengths are tied to reporting requirements. FFS M/S authorization lengths range from 6 months to one year. These lengths are tied to HERC. *The CCO will use MCG to determine review frequency in 2019*. CCO MH/SUD offers RR through post-claim submission for 14 days. CCO MH/SUD MNC application is evaluated through chart review*. In 2019, the CCO will review criteria application through a meaningful sample of charts with a concordance rate of 90%.* FFS M/S application is spot-checked through supervision and chart review. At a minimum, the CCO and State review utilization and other data to determine if UM requires adjustment. MH/SUD reported one OP denial in 2017. It was overturned on appeal. FFS M/S reported 0 appeal overturns. 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 and CCO IP 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: AllCare

1. To which benefits is the NQTL assigned?

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• A, F, P, S drug groups	• A and F drug groups	• 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
• To promote appropriate and safe treatment of funded conditions and to encourage use of preferred and cost-effective agents.	• To promote appropriate and safe treatment of funded conditions.	• To promote appropriate and safe treatment of funded conditions, to encourage use of preferred and cost-effective agents.

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• Medical evidence, best practices, professional guidelines, and the FDA prescribing guidelines for indication, dosing, and duration.	• 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.	• Medical evidence, best practices, professional guidelines, and the FDA prescribing guidelines for indication, dosing, and duration.

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
• Providers, patients, or pharmacies can make a PA request by phone, fax, or through the CCO's provider portal. There is no required form (though one is available upon request). Most PA criteria require documentation to support medical appropriateness and FDA-approved use and dosing. • All PA requests are responded to within 24 hours. • The PA criteria are developed by pharmacists and in consultation with the P&T Committee. • Failure to obtain PA in combination with an absence of medical necessity results in no provider reimbursement.	• 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. • 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.	• Providers, patients, or pharmacies can make a PA request by phone, fax, or through the CCO's provider portal. There is no required form (though one is available upon request). Most PA criteria require documentation to support medical appropriateness and FDA-approved use and dosing. • All PA requests are responded to within 24 hours. • The PA criteria are developed by pharmacists and in consultation with the P&T Committee. • Failure to obtain PA in combination with an absence of medical necessity results in no provider reimbursement.

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• Typically, the frequency range is three months to a year, depending on medical appropriateness and safety, as recommended by the P&T Committee. • Approximately 38% of MH/SUD drugs are subject to PA criteria for clinical reasons.	• 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.	• Typically, the frequency range is three months to a year, depending on medical appropriateness and safety, as recommended by the P&T Committee. • Approximately 37% of M/S drugs are subject to PA criteria for clinical reasons.

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• Inter-rater reliability testing is performed on an annual basis between reviewers to ensure consistency in the review process. • Providers may provide additional information for a reconsideration of a denial. • Providers and members may appeal any denial; members may request a fair hearing. • PA denial/approval and appeal rates are monitored by pharmacy staff and reported to the Quality Committee. • The appeal overturn rate for CY 2017 was 28%. • PA criteria are reviewed for appropriateness on a biennial basis.	• The State allows providers to submit additional information for reconsideration of a denial. • 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.	• Inter-rater reliability testing is performed on an annual basis between reviewers to ensure consistency in the review process. • Providers may provide additional information for a reconsideration of a denial. • Providers and members may appeal any denial; members may request a fair hearing. • PA denial/approval and appeal rates are monitored by pharmacy staff and reported to the Quality Committee. • The appeal overturn rate for CY 2017 was 13%. • PA criteria are reviewed for appropriateness on a biennial basis.

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
• Medical evidence, best practices, professional guidelines, and the FDA prescribing guidelines for indication, dosing, and duration.	• 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.	• Medical evidence, best practices, professional guidelines, and the FDA prescribing guidelines for indication, dosing, and duration.

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 safe, appropriate, and cost-effective use of prescription drugs. The State applies PA to certain MH FFS carve out drugs to promote appropriate and safe 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. As a result, 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, phone, or online portal 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 conducts interrater reliability (IRR) testing for MH/SUD and M/S drugs covered by the CCO. 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 ADMISSIONS — CLOSED NETWORK

NQTL: Provider Admissions — 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: AllCare

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, due to the limited pool of providers of these services. • CCO may close its network for new providers of outpatient MH/SUD services when CCO determines there is no further community need for new providers to meet service capacity and access standards.	• The State does not restrict new providers of inpatient or outpatient MH/SUD services from enrollment.	• N/A • CCO may close its network for new providers of outpatient M/S services when CCO determines there is no further community need for new providers to meet service capacity and access standards.	• The State does not restrict new providers of inpatient or outpatient MH/SUD 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
• When CCO closes its network to new MH/SUD providers, it is done to balance the ready and timely access of members to MH/SUD services, while maintaining and assuring the integrity,	• N/A	• When CCO closes its network to new M/S providers, it is done to balance the ready and timely access of members to M/S services, while maintaining and assuring the integrity, safety,	• N/A

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
safety, and quality of the network providers and facilities. The network must be cost effective and maintain the triple aim.		and quality of the network providers and facilities. The network must be cost effective and maintain the triple aim.	

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
• Network sufficiency standards are required by 42 CFR 438.206. • Requirements related to the selection and retention of providers are specified in 42 CFR 438.214. • Requirements in 42 CFR 438.12 for the non-discrimination of provider participation states that this does not require an MCO (CCO) to contract beyond the needs of its enrollees to maintain quality and control costs. • State rule related to network sufficiency standards, OAR 410-141-0220.	• N/A	• Network sufficiency standards are required by 42 CFR 438.206. • Requirements related to the selection and retention of providers are specified in 42 CFR 438.214. • Requirements in 42 CFR 438.12 for the non-discrimination of provider participation states that this does not require an MCO (CCO) to contract beyond the needs of its enrollees to maintain quality and control costs. • State rule related to network sufficiency standards, OAR 410-141-0220.	• 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
• CCO closes its network to new providers of outpatient MH/SUD services when CCO determines there is no further community need for new providers to meet capacity and access standards. • The result of the NQTL is that the provider may not participate in the network and may not be reimbursed for services provided. • CCO monitors the provider capacity report/mapping on a quarterly basis to ensure adequate geographic coverage. CCO reviews the provider capacity report by county and/or zip code, provider specialty and the number of covered lives in each county. • When determining whether to close the network, the CCO also considers access to care complaints, timeliness of accessing care from the date of referral to first	• NA	• CCO closes its network to new providers of outpatient MH/SUD services when CCO determines there is no further community need for new providers to meet capacity and access standards. • The result of the NQTL is that the provider may not participate in the network and may not be reimbursed for services provided. • CCO Contract manager compiles monthly report on network capacity by zip code for each specialty and providers per 1,000 members. The Contract manager makes recommendations to the Credentialing Committee to close or open the network to particular provider types. The CCO is in the process of developing a validated report to review other access to care factors in determining	• NA

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
appointment, and the number of behavioral health integration sites in the community. This information is shared with the Network Capacity Committee. The Network Capacity Committee reviews this information and makes the decision about network closure. • CCO Credentialing Committee (CCO CMO, CCO Behavioral Health Director) are responsible for the decision-making process to close the network.		whether to close the network to particular provider types. • CCO uses data and information from the Network Adequacy Report to support decisions to close the network. • The CCO Credentialing Committee is responsible for the decision-making process to close the network.	

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• When the CCO decides to close the network to particular providers/provider types, all new outpatient providers applying for those particular providers/provider types are subject to this NQTL. • CCO network may be closed to general mental health or substance abuse providers, but at any time a specialty	• N/A	• When the CCO decides to close the network to particular providers/provider types, all new outpatient providers applying for those particular providers/provider types are subject to this NQTL. • 4 providers were impacted by CCO's decision to close all or part of its network to new	• N/A

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
provider is needed or a provided in an underserved geographic, an exception is made. • 4 providers were impacted by CCO's decision to close all or part of its network to new providers in the last contract year.		providers in the last contract year.	

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
• Ongoing monitoring by the CCO's provider services department of access standards and provider capacity as defined by State criteria, along with regular review of grievances or complaints from members, PCPs, or other providers.	• N/A	• Ongoing monitoring by the CCO's provider services department of access standards and provider capacity as defined by State criteria, along with regular review of grievances or complaints from members, PCPs, or other providers.	• N/A

7. Compliance Determination for Benefit Packages CCO A and B

Comparability of Strategy and Evidence: The CCO may close its network to outpatient providers of MH/SUD and M/S services when the CCO determines there is no need community need for new providers to meet service capacity and access standards. When the CCO closes its network to new MH/SUD and M/S providers, it is done to balance the ready and timely access of members to services; maintain and assure the integrity, safety, and quality of the network providers and facilities; and maintain a network that is cost-effective and meets the triple aim.

Developing a network based upon network adequacy and sufficiency standards is supported by Federal regulation, including the ability of a MCO (CCO) to limit contracting beyond the needs of its enrollees to maintain quality and control costs (42 CFR 438.12). OAR 410-141-0220 also requires the CCO to meet network sufficiency standards, which impacts the application of this NQTL. Based upon these findings, the

CCO's strategy and evidence for closing the network to outpatient providers when the CCO determines that it has met network adequacy and sufficiency standards are comparable for providers of MH/SUD and M/S services.

Comparability and Stringency of Processes: All requests for network admission of providers of MH/SUD and M/S services are reviewed for need based on the network adequacy of the current provider network. When the CCO determines that particular provider types are not needed, provider requests to join the network are declined, and the provider may not be reimbursed for provided services. For MH/SUD providers, monitoring includes reviewing provider capacity report/mapping on a quarterly basis to ensure adequate geographic coverage, provider capacity reports by county and/or zip code and provider specialty and the number of covered lives in each county. Access to care complaints, timeliness of accessing care from the date of referral to first appointment, and the number of behavioral health integration sites in the community are also reviewed when determining whether or not to close the MH/SUD network, and this information is shared with the Network Capacity Committee. For M/S, the CCO uses a more limited set of indicators to track network access and adequacy: a monthly network capacity report of capacity by zip code for each specialty and providers per 1,000 members. The CCO is in the process of developing a validated report to expand the factors considered when making a decision to close the network. For both MH/SUD and M/S providers, the CCO Credentialing Committee reviews this information and makes the decision about network closure. Exceptions are made for providers who demonstrate a unique or specialized service that fills a particular need or in a particular geographic region. Based upon these findings, the CCO's network closure processes for providers of MH/SUD services are comparable and applied no more stringently than to providers of M/S services.

Stringency of Strategy and Evidence: When the CCO decides to close the network to particular specialties/provider types, all new outpatient providers applying for those particular specialties/provider types are subject to the NQTL. This is applied both to providers of MH/SUD and M/S services in the same way. In operation, MH/SUD and M/S providers have been comparably impacted by the application of a closed network, with 4 MH/SUD providers and 4 M/S providers impacted by the CCO's decision to close all or part of its network.

The CCO monitors similar metrics related to decisions to close the network across MH/SUD and M/S, reviewing information such as access standards and provider capacity as defined by State criteria, along with regular review of grievances or complaints from members, PCPs, or other providers. As a result, the strategies and evidentiary standards for network closure 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 closing the network to outpatient 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 ADMISSIONS — NETWORK CREDENTIALING AND REQUIREMENTS IN ADDITION TO STATE LICENSING

NQTL: Provider Admissions — 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: AllCare

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 type(s)?

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-credentialing requirements are required by State law and Federal regulations, including 42 CFR 438.214. • NCQA	• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E - Provider Screening and Enrollment.	• Credentialing/re-credentialing requirements are required by State law and Federal regulations, including 42 CFR 438.214. • 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. • Providers must complete and provide OPCA/OPRA (~12 pages long), formal background check, professional license, original primary source transcripts, OIG verification, copies of any certificates and continuing education additional board certification, DEA lic, professional references, Medicare sanction (EPLS/SAM), Medicare opt-out (if applicable).	• 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 enrollment requirements such as NPI, tax ID, disclosures, and licensure/certification. • The provider enrollment forms vary from 1 to 19	• All providers must meet credentialing and re-credentialing requirements. • Providers must complete and provide OPCA/OPRA (~12 pages long), formal background check, professional license, original primary source transcripts, OIG verification, copies of any certificates and continuing education additional board certification, and DEA lic, Medicare sanction (EPLS/SAM), Medicare opt-out (if applicable).	• 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 enrollment requirements such as NPI, tax ID, disclosures, and licensure/certification. • The provider enrollment forms vary from 1 to 19

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Providers may submit supporting documentation by fax, electronically, mail, etc. • CCO's decision making body responsible for reviewing required information and making provider credentialing decisions is the Options credentialing committee meets as needed. The clinical director, medical director, human resource director, COO, and compliance director as needed review each application and determine if they meet the credentialing standards. A letter is then sent to the staff with the credentialing decision. • NPDB query match. Look for unexplained gaps in work Hx >6 months • CCO's credentialing process averages 0-30 days depending upon completeness of application and timeliness of primary source verification documents.	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. • 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.	• Providers may submit supporting documentation by fax, electronically, mail, etc. • The credentialing committee meets as needed review each application and determine if they meet the credentialing standards. A letter is then sent to the staff with the credentialing decision, sent to provider. • CCO's credentialing committee is responsible for reviewing required information and making provider credentialing decisions. • M/S credentialing committee, meet monthly, within 30 days of meeting, letter to the provider indicating approval or denial • CCO's credentialing process averages 0-30 days depending upon completeness of application and timeliness of primary source verification documents.	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. • 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.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• CCO performs re-credentialing every 3 years or as needed due to background checks and special populations. If there is a self-disclosed incident for example, the person commits a crime, the re-credentialing process, background check may happen sooner. • Providers who are not credentialed/re-credentialed are excluded from the network. • Providers who are adversely affected by credentialing or re-credentialing decisions may challenge the decision through the appeal process.	• 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.	• CCO performs re-credentialing at least every 3 years or as needed based upon self-disclosure of certain kinds of incidents or background checks. • Providers who are not credentialed/re-credentialed are excluded from the network. • Providers who are adversely affected by credentialing or re-credentialing decisions may challenge the decision through an appeal process.	• 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 are subject to credentialing and re-credentialing. • There are no exceptions to meeting these requirements. • 0 providers were denied admission and 1 provider was terminated from the network	• All providers/provider types are subject to enrollment/re-enrollment requirements. • There are no exceptions to meeting provider enrollment/re-enrollment requirements.	• All providers/provider types are subject to credentialing and re-credentialing. • There are no exceptions to meeting these requirements. • No providers were denied admission from the network in the last contract year as a	• All providers/provider types are subject to enrollment/re-enrollment requirements. • There are no exceptions to meeting provider enrollment/re-enrollment requirements.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
in the last contract year as a result of credentialing and re-credentialing.	• Less than 1% of providers were denied admission, and .005% of providers were terminated last CY for failure to meet enrollment/re-enrollment requirements.	result of credentialing. The CCO was not able to report the number of providers terminated as a result of re-credentialing.	• 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 regulation. • The frequency with which CCO performs re-credentialing is based upon: – State law and Federal regulations – State contract requirements – National accreditation standards (NCQA) – Special Populations Rules (self-disclosure requirements)	• 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 – National accreditation standards (NCQA) – Special Populations Rules (self-disclosure requirements)	• 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.

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 national accreditation guidelines (NCQA). 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 new providers are required to complete and submit as part of the credentialing process is comparable. Both MH/SUD and M/S providers are given several methods of submitting their application and supporting documentation, including by fax, by mail or electronically.

The CCO's credentialing process for MH/SUD providers includes the primary source verification of licensing, board certification, Medicare Excluded Providers (Office of Inspector General), Medicare sanction (Excluded Parties List System/System for Award Management), Medicare opt-out (if applicable) and a National Practitioner Database query match to look for unexplained gaps in work history greater than 6 months. The CCO's credentialing process for M/S providers involves a similar review of each application to determine whether standards are met. For both MH/SUD and M/S providers, after submitted documents are reviewed, a letter is sent to the staff with the credentialing decision, and then sent to the provider.

The credentialing process for both MH/SUD and M/S providers averages 0-30 days depending upon the completeness of application and timeliness of primary source verification documents. The CCO's credentialing committee is responsible for reviewing required information and making provider credentialing decisions for both MH/SUD and M/S providers. Re-credentialing for both MH/SUD and M/S providers is conducted every three years, or as needed based upon self-disclosure of certain kinds of incidents or background checks. Failure for MH/SUD and M/S providers to meet credentialing and re-credentialing requirements results in exclusion from the CCO's network. MH/SUD and M/S providers who are adversely affected by credentialing or re-credentialing decisions may challenge the decision through an appeal process.

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 than 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 providers denied admission into the network. While the number of M/S provider terminations were reportedly unknown, given there was only one MH/SUD provider termination from the network in the last contract year, re-credentialing, in operation, is comparable and no more stringently applied to MH/SUD providers.

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 ADMISSIONS — PROVIDER EXCLUSIONS

NQTL: Provider Admissions — 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: AllCare

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 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
• NA	• N/A	• NA	• 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
• NA	• N/A	• NA	• 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
• NA	• N/A	• NA	• 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
• NA	• N/A	• NA	• 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: AllCare

1. To which provider type(s) 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 our provider network consists of local providers that have been credentialed and contracted with the CCO. • The purpose of providing OON/OOS coverage is to provide needed services when they are not available in-network/in-State. • The purpose of prior authorizing non-emergency OON/OOS benefits is to determine the medical necessity of the requested benefit and the availability of	• 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 seeks to maximize use of in-network providers because our provider network consists of local providers that have been credentialed and contracted with the CCO. • The purpose of providing OON/OOS coverage is to provide needed services when they are not available in-network. • The purpose of prior authorizing non-emergency OON/OOS benefits is to determine the medical necessity of the requested benefit and the availability of	• 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
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.	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/within the State. • The CCO's criteria for non-emergency OON/OOS coverage include children in DHS custody, member temporarily relocated (e.g., college), special needs of the	• 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 and requires covered services. • Requests for non-emergency OOS services are made	• Except as otherwise required by OHA, non-emergency OON/OOS services are not covered unless medically necessary services are not available within network/within the State. • The CCO's criteria for non-emergency OON/OOS coverage include children in DHS custody, member temporarily relocated (e.g., college), special needs of the	• 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 and requires covered services. • Requests for non-emergency OOS services are made

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
member, service cannot be provided locally. • Requests for non-emergency OON/OOS services are made through the prior authorization process. • The timeframe for approving or denying a non-emergency OON/OOS request is the same as for other prior authorizations (14 days for standard requests). • The CCO establishes a single case agreement (SCA) with all OON /OOS providers. • The CCO collects relevant information from the provider and establishes a SCA, which is about a page long. • The average length of time to establish a SCA is 14 days. • Only providers enrolled in Oregon Medicaid can qualify as an OON/OOS provider. • The CCO pays OON/OOS providers either the Medicaid FFS (DMAP) rate or a negotiated rate.	through the State prior authorization process. • 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.	member, service cannot be provided locally. • Requests for non-emergency OON/OOS services are made through the prior authorization process. • The timeframe for approving or denying a non-emergency OON/OOS request is the same as for other prior authorizations (14 days for standard requests). • The CCO establishes a single case agreement (SCA) with all OON/OOS providers. • The CCO collects relevant information from the provider and establishes a SCA. • The average length of time to establish a SCA is 14 days. • Only providers enrolled in Oregon Medicaid can qualify as an OON/OOS provider. • The CCO pays OON/OOS providers either the Medicaid FFS (DMAP) rate or a negotiated rate.	through the State prior authorization process. • 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.

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. • Members/providers may appeal the denial of an OON/OOS request. • In CY 2017 the CCO received 12 non-emergency OON/OOS requests, and zero OON/OOS requests were denied (appeal overturn rate of 0%). • The CCO measures the stringency of the application of OON/OOS requirements by reviewing provider capacity.	• 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. • The State measures the stringency of the application of OOS requirements by reviewing OOS denial/appeal rates.	• 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. • Members/providers may appeal the denial of an OON/OOS request. • In CY 2017 the CCO received 5,623 non-emergency OON/OOS requests; 341 (6%) requests were denied; and zero denied OON/OOS requests were overturned on appeal (appeal overturn rate of 0%). • The CCO measures the stringency of the application of OON/OOS requirements by reviewing provider capacity. • The CCO evaluates the number of SCAs quarterly to determine whether the	• 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. • The State measures the stringency of the application of OOS requirements by reviewing OOS denial/appeal rates.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• The CCO evaluates the number of SCAs quarterly to determine whether the network should be expanded or a particular OON/OOS should be recruited to be a network provider.		network should be expanded or a particular OON/OOS should be recruited to be a network provider.	

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 since the CCO's provider network consists of local providers that have been credentialed and contracted by the CCO. 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. The CCO establishes a SCA with all OON/OOS MH/SUD and M/S providers. The CCO's process for establishing a SCA is the same for MH/SUD and M/S providers and includes collecting relevant information from the provider and establishing the SCA. 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. 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 2017 approximately 0% of MH/SUD and 6% of M/S OON/OOS requests were denied, with a 0% appeal overturn rate for both MH/SUD and 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 since the CCO's provider network consists of local providers that have been credentialed and contracted by the CCO. 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. Both MH/SUD and M/S OON/OOS providers are paid either the Medicaid FFS rate or a negotiated rate. 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 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 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 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.