Oregon Health Authority

2020 Mental Health Parity Analysis Report

for

Columbia Pacific CCO, LLC

February 2021

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Introduction

Overview of Oregon's Mental Health Parity Analysis

Mental Health Parity (MHP) regulations are intended to ensure that coverage and access to services for the treatment of mental health (MH) and substance use disorder (SUD) conditions are provided in parity with treatments provided for medical and surgical (M/S) needs. The required analysis of MH benefits is governed by federal regulations. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) governs how MH/SUD treatments delivered by managed care organizations and limitations on MH/SUD benefits are comparable to and applied no more stringently than the limitations applied to M/S benefits. Provisions of the MHPAEA became applicable to the Oregon Health Plan (OHP) in October 2017 when the Medicaid Parity Final Rule (42 Code of Federal Regulations [CFR] §438 Subpart K) went into effect. The rule requires parity in key areas:

- Aggregate lifetime and annual dollar limits (AL/ADLs).
- Financial requirements (FRs—such as copays).
- Quantitative treatment limitations (QTLs—such as day and visit limits).
- Non-quantitative treatment limitations (NQTLs—such as prior authorization [PA] and provider network admission requirements).

Additional MHP regulations require that criteria for medical necessity determinations for MH/SUD benefits must be made available to beneficiaries and providers upon request, as well as the reason for denial of reimbursement or payment for MH/SUD benefits. States must also implement monitoring procedures to ensure continued compliance and to identify when changes in benefit design or operations could affect compliance and require an updated analysis.

To meet the requirements, the Oregon Health Authority (OHA) conducted an initial MHP Analysis of OHP's full delivery system in 2018. OHA's 15 coordinated care organizations (CCOs) and Oregon Health Plan Fee-for-Service (OHP FFS) participated in the initial MHP Analysis, which included an inventory of all MH/SUD and M/S benefits offered to OHP members and the limitations applied to those benefits to ensure that limitations (e.g., day limits, PA requirements, or network admission standards) for MH and SUD services were comparable to and applied no more stringently than those for M/S services provided under OHP. Results of the initial analysis were reported in August 2018; and in 2019, the CCOs implemented corrective actions in areas lacking parity.

For 2020, OHA tasked Health Services Advisory Group, Inc. (HSAG), with conducting a follow-up MHP Analysis across the CCOs, in part due to each of the CCOs entering into new five-year contracts with the State, to determine if the existing benefits and any NQTLs remained compliant with the MHP regulations in 42 CFR §438 Subpart K. HSAG conducted the MHP Analysis in 2020 based on the August 2018 results, any implemented corrective actions, and any additional changes to benefits design or operations that may impact parity. This report provides information on and results of the 2020 MHP Analysis for Columbia Pacific CCO, LLC (CPCCO).

Components of the 2020 MHP Analysis

In accordance with 42 CFR §438 Subpart K, MHP applied to all OHP benefits delivered through OHA's managed care delivery system, including those delivered through a combination of managed care and FFS delivery systems. HSAG developed a protocol and tools to carry out the analysis activity based on the initial 2018 MHP Analysis and in alignment with guidance outlined in the toolkit provided by the Centers for Medicare & Medicaid Services (CMS): *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*.[1-1] The 2020 MHP Analysis also referenced Oregon's Mapping Guide[1-2] that assigned benefits to MH/SUD and M/S groupings based on International Classification of Diseases, Tenth Revision (ICD-10) diagnoses and mapped into four prescribed classifications as published in the March 30, 2016, Federal Register, Vol. 81, No. 61[1-3] as illustrated in Figure 1-1.

Figure 1-1—MHP: Four Prescribed Classifications

OHP Benefit Packages

While all OHP benefit packages were delivered in accordance with the same Medicaid essential health benefits structure, the delivery of those benefits was categorized by OHP benefit package based on enrollment. Table 1-1 identifies the four OHP benefit packages evaluated in the 2020 MHP Analysis. Since each benefit package involves the delivery of Medicaid essential health benefits covered by both CCOs and OHP FFS, HSAG conducted an analysis of each CCO's NQTLs, and then against the OHP FFS NQTLs.

Table 1-1—OHP Benefit Packages

Benefit Package	Benefit Types Covered	Evaluation
CCOA	Physical Health, Behavioral Health, Dental Health	CCO MH/SUD and FFS MH/SUD compared to CCO M/S
CCOB	Physical Health, Behavioral Health	
CCOE	Behavioral Health	CCO MH/SUD and FFS MH/SUD compared to FFS M/S
CCOG	Behavioral Health, Dental Health	

[1-1] The CMS *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs* and additional CMS resources related to MHP can be accessed at: https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/parity/index.html.

[1-2] The Oregon Mapping Guide includes definitions, links, and resources important for the MHP Analysis. It also maps all Oregon Medicaid benefits to the classifications required for the MHP Analysis. It can be accessed on OHA's MHP webpage at: https://www.oregon.gov/OHA/HSD/OHP/Pages/MH-Parity.aspx.

[1-3] Federal Register. Volume 81, No. 61/Wednesday, March 30, 2016. Available at: https://www.govinfo.gov/content/pkg/FR-2016-03-30/pdf/FR-2016-03-30.pdf. Accessed on: Dec 4, 2020.

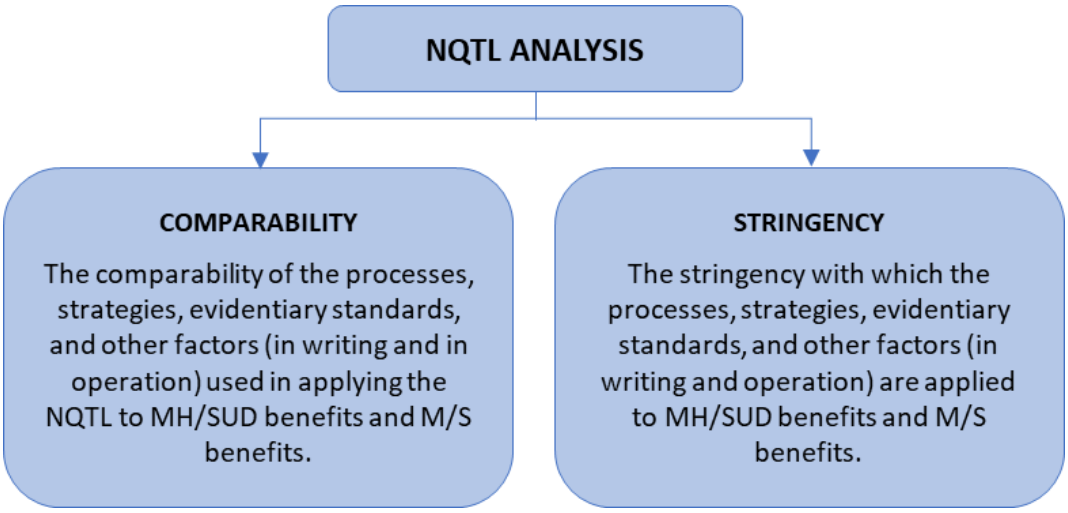
Non-Quantitative Treatment Limitations

Because Oregon Medicaid does not permit the use of QTLs (e.g., day and visit limits), HSAG's analysis focused on assessing NQTLs in the OHP delivery system. NQTLs are health care management limitations on the scope or duration of benefits through the use of managed care processes, such as PA or network admission standards. "Soft limits," benefit limits that allow for an individual to exceed limits or allow for limits to be "waived" based on medical necessity, are also considered NQTLs. Examples of NQTLs include:

- Medical management standards limiting or excluding benefits based on medical necessity or appropriateness criteria.
- Standards for provider admission to participate in a network and reimbursement rates.
- Restrictions based on geographic location, facility type, or provider specialty.
- Fail-first policies or step therapy protocols.
- Exclusions based on failure to complete a course of treatment prior to allowing authorization of a subsequent treatment.

MHP regulations hold that no NQTL can be applied to MH/SUD benefits and services that is not comparable to or is more stringent than those applied to M/S benefits and services in each benefit classification regarding processes, strategies, evidentiary standards, or other factors. HSAG assessed policies and procedures as written and operational processes for compliance with parity requirements by classification (e.g., inpatient [IP] and outpatient [OP]) of services. The 2018 MHP Analysis compared NQTLs for services that address MH/SUD diagnoses with services that address M/S diagnoses across the OHP benefit packages. Comparability was assessed as to the reason an NQTL was used, the evidence that supported its use, and the process for its implementation. The stringency criterion assessed the rigor with which the NQTLs were applied, the evidence for the level of stringency, and penalties and exceptions associated with limitations. Comparability and stringency are defined in Figure 1-2.

Figure 1-2—MHP Analysis Comparability and Stringency



NQTL Categories

Similar to the Initial 2018 MHP Analysis, HSAG assessed for comparability and stringency criteria across six specific NQTL categories in the OHP delivery system. The six categories are described below.

- **Category I—Utilization Management Limits Applied to Inpatient Services:** Utilization management (UM) processes implemented through PA, concurrent review (CR), and retrospective review (RR) that may also be used to ensure medical necessity for MH/SUD and M/S services.
- **Category II—Utilization Management Limits Applied to Outpatient Services:** UM processes applied to OP MH/SUD and M/S services through PA, CR, and RR to ensure medical necessity.
- **Category III—Prior Authorization for Prescription Drug Limits:** PA as a means of determining whether particular medications will be dispensed. PA of prescription drugs limits the availability of specific medications.
- **Category IV—Provider Admission—Closed Network:** Closed networks as they impose limits to providers seeking to join a panel of approved providers.
- **Category V—Provider Admission—Network Credentialing:** Network enrollment/credentialing requirements imposed, including provider admission requirements such as state licensing requirements and exclusions of specific provider types, that may result in limitations.
- **Category VI—Out-of-Network/Out-of-State Limits:** Out-of-network (OON) and out-of-state (OOS) limits that affect how members access OON and OOS providers and address how OHA and the CCOs ensure necessary access to providers not eligible to be reimbursed or not in a CCO's network.

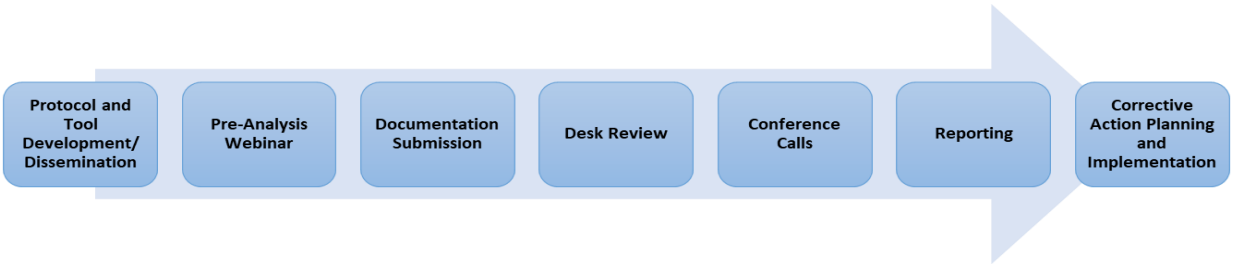
2. Process and Methodology

Building from the initial 2018 MHP Analysis, HSAG worked with OHA and the CCOs to conduct a follow-up MHP Analysis that evaluated changes to benefits design and operations that may impact parity. The 2020 MHP Analysis identified and addressed differences between the policies and standards governing limitations applied to MH/SUD services as compared to M/S services. Differences in how limits were applied to MH/SUD services as compared to M/S services were evaluated for continued compliance with MHP regulations to ensure evidence-based, quality MH/SUD care.

Analysis Activities for 2020

The 2020 MHP Analysis activities are illustrated in Figure 2-1 and described below.

Figure 2-1—2020 MHP Analysis Activities



1. **Protocol and Tool Development and Dissemination:** HSAG developed and disseminated an MHP Analysis Protocol that presented details and guidance to OHA and CCOs on the analysis process and included tools in which to conduct the 2020 MHP Analysis Activity. The tools utilized for the analysis, identified below, were based on OHA's initial analysis of MHP and were developed using guidance outlined in the CMS *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*.
   - **MHP Evaluation Questionnaire**—Questions referencing the six NQTL categories, to identify changes that may impact parity.
   - **MHP Reporting Template**—Documentation of changes and additions to NQTLs previously reported in 2018, organized by the six NQTL categories.
   - **MHP Required Documentation Template**—UM and credentialing data across MH/SUD and M/S benefits and providers.
2. **Pre-Analysis Webinar:** HSAG conducted a pre-analysis webinar on July 15, 2020, with OHA and the CCOs to provide an overview of MHP regulations, details of the protocol and tools, specifics of the analysis timeline, and examples of MHP scenarios for reference.
3. **Documentation Submission:** OHA and the CCOs were required to submit documentation that included responses to the MHP Evaluation Questionnaire and completed templates, along with supporting documentation, by August 31, 2020.

4. **Desk Review:** HSAG conducted a desk review of all submitted MHP Evaluation Questionnaires, the MHP Reporting Template, and required and supporting documentation (e.g., policies and procedures, benefit schedules, and delegate agreements) to analyze policies and operational practices that impact MHP and determine preliminary analysis findings.
5. **Conference Calls:** HSAG conducted conference calls to discuss preliminary analysis findings and areas in need of clarification. Additional information and documentation were requested at that time, as necessary to support the MHP Analysis.
6. **Reporting:** HSAG compiled analysis results and documented MHP determinations for each CCO and as compared to OHP FFS, identifying areas in which MHP had not been achieved and corrective actions were required to ensure future parity. OHA and each CCO had an opportunity to review report drafts prior to finalizing the reports.
7. **Corrective Action Planning and Implementation:** HSAG will work with OHA and the CCOs to develop and implement corrective action plans to achieve compliance with MHP requirements.

MHP Analysis Methodology

HSAG reviewers conducted a desk review of submitted MHP Analysis tools and supporting documentation to further clarify reported changes and additions to previously reported NQTLs from the initial MHP Analysis conducted in 2018. More specifically, HSAG evaluated responses to the MHP Evaluation Questionnaire to identify changes to benefits design and operations within OHA and each CCO that may impact MHP, cross-referenced questionnaire responses with changes and additions reported in the MHP Reporting Template, and reviewed supporting documentation submitted by OHA and the CCOs. Supporting documentation included, but was not limited to, UM policies, workflow diagrams, program descriptions, prescription drug formularies, and network admission/credentialing policies. HSAG conducted the 2020 MHP Analysis based on this information to determine compliance with parity guidelines, including ensuring that policies followed standard industry practice, allowed for little to no exception or variation, incorporated established State definitions and guidelines, included staff members qualified to make the decisions and complete the tasks assigned and appropriate oversight.

Information obtained via scheduled conference calls was also evaluated in relation to changes and additions reported. Differences in how limits were applied to MH/SUD services as compared to M/S services, in relation to comparability and stringency standards displayed in Table 2-1, were evaluated across the six NQTL categories for continued compliance with MHP regulations. Each CCO's NQTLs were additionally evaluated against OHP FFS MH/SUD and M/S NQTLs based on the structure of OHP benefit packages referenced in Section 1 of this report.

Table 2-1—Comparability and Stringency Standards

Comparability and Stringency Standard	Question Description
Benefits in Which NQTLs Apply	**1. To which benefits is an NQTL assigned?** *Purpose: To describe the NQTL assigned to MH/SUD and M/S benefits (e.g., PA, scope of services, and time frames).*
Comparability of Strategy	**2. Why is the NQTL assigned to these benefits?** *Purpose: To describe for what reasons or purpose the NQTL is assigned (e.g., ensure medical necessity, prevent overutilization, and comply with State and federal requirements).*
Comparability of Evidentiary Standard	**3. What evidence supports the rationale for the assignment?** *Purpose: To describe the evidence to support the rationale (e.g., benchmarks, standards that form the basis of the rationale, and State and federal requirements).*
Comparability of Processes	**4. What are the NQTL procedures?** *Purpose: To describe the NQTL process and evidence needed to support NQTL determinations (e.g., documentation requirements, timelines, and steps for the CCO and members/providers).*
Stringency of Strategy	**5. How frequently or strictly is the NQTL applied?** *Purpose: To describe the frequency of application, frequency of medical necessity and appropriateness reviews, level of discretion in how the NQTL is applied, triggers for review and re-review, etc.*
Stringency of Evidentiary Standard	**6. What standard supports the frequency or rigor with which the NQTL is applied?** *Purpose: To describe standards that the CCO uses to determine the frequency or rigor of NQTL procedures.*

Analysis Results for 2020

Results of the analysis are incorporated in Section 3 of this report. The results identify overall compliance with MHP regulations across the six NQTL categories in relation to comparability and stringency. Limitations or other operational processes found to impact parity are reported as findings. Required actions are also presented to support future compliance with MHP requirements as applicable.

3. MHP Analysis Results

HSAG derived 2020 MHP Analysis results from the evaluation and observation of information obtained from CPCCO. More specifically, the information and observations used for the evaluation included the following tools, documentation, and conversations:

- Responses to the 2020 MHP Evaluation Questionnaire.
- Reported data in the 2020 MHP Reporting Templates pertaining to NQTL categories.
- Information obtained from CPCCO's submitted 2020 MHP data using the Required Documentation Template and supporting documentation as provided.
- Observations from conversations during the conference call conducted with the CCO.

Results of the MHP Analysis are detailed below. Limitations or other operational processes found to impact parity are reported as findings, along with corresponding required actions. Appendices A and B include CPCCO's completed MHP questionnaire and finalized MHP reporting details by each NQTL category, respectively.

Overall Assessment

CPCCO was responsible for delivering MH/SUD and M/S Medicaid benefits to members in all four benefit packages (CCOA, CCOB, CCOE, and CCOG), whereas OHP FFS was fully managing M/S benefits for CCOE and CCOG benefit packages CPCCO's UM and provider admission processes were managed by the CCO's parent company, CareOregon. HSAG evaluated CPCCO's application of NQTLs to MH/SUD and M/S benefits in terms of comparability and stringency across the six NQTL categories.

Based on the strategy and evidence provided by CPCCOCPCCO, including reported changes in operations and practices, PA and credentialing data, and discussions during prescheduled conference calls, HSAG analyzed the parity of MH/SUD benefits as compared to M/S benefits. Most of CPCCO's policies included standardized processes that applied to both MH/SUD and M/S benefits, including a PA policy, a behavioral health levels of review policy, and the CCO's formulary. The CCO did not have separate policies for the management of benefits based on benefit package (i.e., CCOA, CCOB, CCOE, and CCOG).

For limits applied to IP and OP health benefits, CPCCO used UM processes to manage MH/SUD and M/S benefits. The purpose of the CCO's UM processes was to ensure coverage, medical necessity, appropriate treatment in the least restrictive environment that maintains the safety of the individual, compliance with federal and State requirements, and the prevention of unnecessary overutilization. CPCCO reported that the evidence used to apply UM to MH/SUD and M/S included Oregon Administrative Rules (OARs), Health Evidence Review Commission (HERC) Prioritized List (PL) and guidelines, and Milliman Care Guidelines (MCG). The application of MH/SUD authorization limits and the frequency and rigor in which they were applied to authorization requests was comparable to and no

more stringently applied than for M/S benefits across all benefit packages. Both the CCO and OHP FFS allowed RR for MH/SUD and M/S when providers failed to obtain authorization. CPCCO did not have a time frame for RR for IP MH/SUD or M/S PA requests, which HSAG determined was less stringent than OHP FFS's 90-day time frame applied to M/S requests. MH/SUD and M/S denial decisions could be appealed through appeals and/or State fair hearing processes. Regarding IRR, the CCO was conducting reviews at least annually, applying an 80 percent testing standard, which was consistent with OHP FFS IRR processes and standards. HSAG's analysis determined that the rationale, documentation requirements, processes, and frequency of UM applied to IP and OP MH/SUD benefits were comparable to and no more stringently applied to IP and OP M/S benefits.

HSAG's analysis of CPCCO processes and operations did not reveal any MHP parity concerns for the authorization of prescription drugs across the benefit packages; however, HSAG's analysis of the CCO's data identified a high denial rate for prescription drug PA requests, indicating possible opportunities for improvement. Of the total 1,002 prescription drug PA requests reported, 73.45 percent were denied. Less than 1 percent of the 736 prescription drug PA request denials were appealed, with only two PA denials resulting in an overturned decision. The prescription drug PA request denials were primarily due to a "not covered" categorical reason. HSAG identified the high denial rate as a finding to ensure CPCCO evaluates PA request denials to determine whether barriers or opportunities for improvement exist in the CCO's UM process or formulary.

HSAG evaluated CPCCO's provider admission processes and operations to determine compliance with MH parity provisions. For Category IV—Provider Admission—Closed Network, the CCO's processes were comparable across the benefit packages; however, the inability of the CCO to provide information on how many providers were impacted by the CCO's decision to close all or part of its network to new providers in the last contract year was a parity concern that was indeterminate as to the impact of the stringency applied to network closures, in operation, as documented in the CCO's findings. HSAG's analysis found CPCCO's MH/SUD and M/S provider credentialing and recredentialing processes, operations, and data to be comparable and no more stringently applied to, in writing and in operation, than those for M/S providers. CPCCO shared the same network of providers with Jackson Care Connect CCO (JCC), which was also managed by CareOregon as its parent company, with a reported average number of 13,292 providers enrolled during the reporting period and no denials for MH/SUD providers seeking credentialing.

HSAG determined CPCCO's processes, strategies, and evidentiary standards for OON/OOS limits applied to MH/SUD to be comparable and no more stringently applied, in writing and in operation, to M/S OON/OOS limits across all benefit packages. The same PA processes and evidentiary standards described in NQTL categories I, II, and III were applied to OON/OOS coverage of MH/SUD and M/S requests.

Findings related to areas that impact MHP were documented in the details of each area of NQTL outlined in Appendix B of this report. In addition, HSAG identified required actions for CPCCO to pursue to mitigate any parity concerns. Table 3-1 presents specific findings of non-parity organized by NQTL category. HSAG's MHP Analysis for CPCCO resulted in two findings across two NQTL categories.

Table 3-1—Overall MHP Analysis Results—Comparability and Stringency

NQTL Category	Comparability	Stringency
Category I—UM Limits Applied to Inpatient Services	Compliant	Compliant
Category II—UM Limits Applied to Outpatient Services	Compliant	Compliant
Category III—Prior Authorization for Prescription Drug Limits	Compliant	Non-Compliant
Category IV—Provider Admission—Closed Network	Compliant	Non-Compliant
Category V—Provider Admission—Network Credentialing	Compliant	Compliant
Category VI—Out-of-Network/Out-of-State Limits	Compliant	Compliant

Findings and Required Actions

Based on the strategy and evidence provided by CPCCOCPCCO, including reported changes in operations and practices, PA and credentialing data, and discussions during prescheduled conference calls, HSAG analyzed the parity of MH/SUD benefits as compared to M/S benefits. Findings related to areas that impact MHP were documented in the details of each area of NQTL outlined in Appendix B of this report and identified in this section as either parity findings or inconclusive findings that required more information for a parity determination. In addition, HSAG identified required actions for CPCCO to pursue to mitigate any parity concerns.

Table 3-2 presents specific findings of non-parity organized by NQTL category. HSAG's analysis for CPCCO did not reveal any parity findings, but did result in two inconclusive findings across two NQTL categories.

Table 3-2—Inconclusive Findings and Required Actions by NQTL Category

#	NQTL Category	Finding	Required Action
1.	Category III—Prior Authorization for Prescription Drugs	Although not a parity concern due to the inability to separately analyze prescription drugs by benefit type, CPCCO's reported data revealed a high denial rate (73.45 percent) for prescription drug PA requests. This resulted in an inconclusive finding, in operation.	CPCCO must evaluate PA request denials by benefit type to determine whether there are parity concerns or whether barriers or opportunities for improvement exist in the CCO's UM process or formulary.
2.	Category IV—Provider Admission—Closed Network	While CPCCO documented and described comparable processes and evidentiary standards for decisions to close its network to MH/SUD and M/S providers, the CCO was unable to provide information on how many providers were impacted by the CCO's decision to close all or part of its network to new providers in the last contract year as denied requests were not formally tracked. This resulted in an inconclusive finding.	CPCCO must develop a mechanism to document and track network closures for MH/SUD and M/S providers to determine whether parity concerns exist in operation.

Data Analysis Results

CPCCO submitted UM data in the MHP Required Documentation Template, identifying PA counts and denial data for IP, OP, and prescription drug benefits. The reporting also included data on provider admission counts and terminations/denials. The completed templates included data from the period of January 1, 2020, through June 30, 2020. An analysis of the data reported is presented in the text below pertaining to the following categories:

- Utilization Management for Inpatient/Outpatient Services (NQTL Categories I and II).
- Utilization Management for Prescription Drugs (NQTL Category III).
- Enrollment/Credentialing Decisions (NQTL Categories IV and V).

Any findings related to the data analysis were incorporated into the MHP findings and required actions identified in Table 3-2 above according to the corresponding NQTL category to which the data apply.

Utilization Management for Inpatient/Outpatient Services

CPCCO provided requested UM data for IP and OP services pertaining to authorization request counts and outcomes of requests. Table 3-3 presents CPCCO's counts for IP and OP PAs by benefit type, identifying the number of PA requests denied, appealed, and overturned.

Table 3-3—Prior Authorization Counts for Inpatient and Outpatient Services

Prior Authorization Counts by Benefit Type							
Benefit Type	**# of PA Requests**	**# of PA Requests Denied**	**% of PA Requests Denied**	**# of PA Denials Appealed**	**% of PA Denials Appealed**	**# of PA Denials Overturned**	**% of PA Denials Overturned**
MH/SUD	394	11	2.79%	0	0.00%	0	0.00%
M/S	5,966	516	8.65%	60	11.63%	31	6.01%
Total	**6,360**	**527**	**8.29%**	**60**	**11.39%**	**31**	**5.88%**

Observations

HSAG's analysis of CPCCO's PA data for IP and OP benefits did not reveal any concerns related to MHP. The following data points were observed:

- Of the total 6,360 IP and OP PA requests reported, only 8.29 percent were denied.
- Of the 11 MH/SUD PA requests denied, representing 2.79 percent of the 394 MH/SUD PA requests, none were appealed.
- The majority of the MH/SUD PA request denials were requests for IP benefits, all denied for a "benefit exclusion" categorical reason.

Utilization Management for Prescription Drugs

CPCCO provided requested data pertaining to prescription drug authorization request counts and outcomes. Table 3-4 presents CPCCO's PA counts for formulary and non-formulary prescription drug PA requests, identifying the number of requests overturned.

Table 3-4—Prior Authorization Counts for Prescription Drugs

Prior Authorization Counts (Formulary and Non-Formulary)						
# of PA Requests	# of PA Requests Denied	% of PA Requests Denied	# of PA Denials Appealed	% of PA Denials Appealed	# of PA Denials Overturned	% of PA Denials Overturned
1,002	736	73.45%	7	0.95%	2	0.27%

Observations

HSAG's analysis of CPCCO's counts for prescription drug PA requests did not reveal any concerns related to parity but did identify a high denial rate, indicating possible opportunities for improvement. The following data points were observed:

- Of the total 1,002 prescription drug PA requests reported, 73.45 percent were denied.
- Less than 1 percent of the 736 prescription drug PA request denials were appealed, with only two PA denials resulting in an overturned decision.
- The prescription drug PA request denials were primarily due to a "not covered" categorical reason.

High denial rates for prescription drugs can be due to a variety of reasons such as exclusions, medical necessity criteria, and dosage limits; however, a determination of parity was inconclusive due to the inability to separate MH/SUD prescription drug denials from M/S prescription drug denials. CPCCO should evaluate PA request denials to determine whether parity concerns or barriers or opportunities for improvement exist in the CCO's UM process or formulary.

Enrollment/Credentialing

CPCCO provided requested data pertaining to provider enrollment requests and outcomes. Table 3-5 presents CPCCO's enrollment/credentialing counts by provider type, identifying the number of terminations and denials, which includes applications not accepted.

Table 3-5—Enrollment/Credentialing Counts by Provider Type

Enrollment/Credentialing Counts by Provider Type						
Provider Type	**Avg. # Enrolled Providers**	**# Providers Terminated**	**% Terminated**	**# of Cred. Requests**	**# of Cred. Requests Denied/Not Accepted**	**% of Cred. Requests Denied/Not Accepted**
MH/SUD	978	Not Reported	--	101	0	0.00%
M/S	12,314	Not Reported	--	375	2	0.53%
Total	**13,292**	**--**	**--**	**476**	**2**	**0.42%**

Observations

HSAG's analysis of CPCCO's provider credentialing data did not reveal any parity concerns due low denial rates for both MH/SUD and M/S providers seeking credentialing during the reporting period. CPCCO shared the same network of providers with JCC, which was equally managed by CareOregon as its parent company. The following data points were observed:

- Of the 13,292 reported average number of providers credentialed during the reporting period, 7.36 percent were MH/SUD providers.
- There were no reported denials for any MH/SUD providers seeking credentialing during the reporting period.

Additional Requirement Results

HSAG requested information from CPCCO on the required availability of medical necessity determinations regarding MH/SUD benefits to members, potential members, and contracting providers upon request, and how reasons for denial of reimbursement or payment for MH/SUD benefits were made available to members. CPCCO provided its notice of adverse benefit determination template that confirmed denial reasons were being communicated to members and requesting providers. A review of CPCCO's website showed that the CCO had resources available on its website for members and providers that included information on MH benefits available, a prescription drug formulary, and authorization guidelines. HSAG determined that CPCCO was compliant with the additional administrative MHP requirements.

4. Improvement Plan Process

To the extent MHP findings or concerns were found, OHP and all CCOs are required to complete and submit an improvement plan addressing corrective actions/interventions to resolve all MHP findings. The improvement plan template is provided in Appendix C. For each of the findings documented in Section 3 of this report, CPCCO must identify the following:

- Interventions planned by the organization to achieve MHP compliance.
- Individual(s) responsible for ensuring that the planned interventions are completed.
- Proposed timeline for completing each planned intervention with the understanding that most corrective actions/interventions can be completed within three months and no longer than six months. Corrective actions/interventions requiring additional time will need to include specific information to determine the appropriateness of the extended time frame.

The improvement plan is due to HSAG no later than 30 days following the organization's receipt of the final 2020 MHP Analysis report. The improvement plan should be uploaded electronically to OHA's deliverables reporting email address: CCO.MCODeliverableReports@dhsoha.state.or.us. HSAG will review the improvement plan using the following criteria to evaluate the sufficiency of each corrective action/intervention identified in the improvement plan to bring performance into compliance:

- Completeness of the improvement plan document in addressing each finding and identifying a responsible individual, a timeline/completion date, and specific corrective actions/interventions that the organization will take.
- Degree to which the planned corrective actions/interventions are anticipated to bring the organization into compliance with MHP requirements.
- Appropriateness of the timeline for the corrective actions/interventions given the nature of the finding.

Once reviewed, HSAG will communicate to the organization whether the improvement plan is approved. If any corrective actions/interventions are determined to not meet the requirements related to correlating findings, HSAG will identify the discrepancies and require resubmission of the improvement plan until it is approved by HSAG. Quarterly reviews of improvement plan progress will be conducted with each CCO via desk reviews and conference calls as necessary to ensure that all planned activities and interventions are completed.

HSAG will be available for technical assistance related to corrective actions/interventions. The CCO may contact either of the following HSAG representatives for assistance:

Melissa Isavoran, Associate Executive Director
misavoran@hsag.com
503.839.9070

Barb McConnell, Executive Director
bmcconnell@hsag.com
303.717.2105

Appendix A. MHP Evaluation Questionnaire

CPCCO submitted its completed MHP Evaluation Questionnaire, which identified changes or additions to benefits design and operations that may impact MHP corresponding with the six NQTL categories. The questionnaire served as a guide for OHA and the CCOs in that responses were used to identify and further document such changes and additions in the finalized MHP NQTL Reporting Tables located in Appendix B of this report.

General Questions for CCOs		
Question		**Yes/No**
1.	Did the CCO add, change, or eliminate delegated administrative functions to a new or for an existing subcontractor (e.g., UM, provider admission, etc.)? ***Documentation Required:*** *Provide contractual requirements (e.g., scope of work) for delegated administrative functions.*	☒ Yes ☐ No
2.	Did the CCO add or exclude any specific classifications of drugs from its formulary?	☐ Yes ☒ No
Utilization Management (IP, OP, and Rx) Changes in CCO—MH Parity Analysis Sections I, II, and III		
Question		**Yes/No**
1.	Did the CCO change payment arrangements with some/all providers (e.g., FFS to sub-capitation, per diem to DRG, reduction in payment levels to specific provider types or for specific benefits)?	☒ Yes ☐ No
2.	Did the CCO add or remove numerical limits (e.g., number of units) to MH/SUD or M/S benefits?	☒ Yes ☐ No
3.	Did the CCO add or remove non-numerical benefit limits (e.g., scope or duration of benefits, medical necessity criteria, etc.) to MH/SUD or M/S benefits?	☒ Yes ☐ No
4.	Did the CCO change timelines for authorization requests for MH/SUD or M/S benefits?	☒ Yes ☐ No

5.	Did the CCO change documentation requirements for UM requests for MH/SUD or M/S benefits (e.g., evidence of medical necessity, documentation submission requirements)?	☒ Yes ☐ No
6.	Did the CCO change qualifications for reviewers that can authorize or deny requests?	☐ Yes ☒ No
7.	Did the CCO develop or add medical necessity/level of care criteria for MH/SUD or M/S benefits?	☒ Yes ☐ No
8.	Did the CCO change the method for monitoring consistency of MNC application for MH/SUD or M/S benefits (e.g., standards for consistency of MNC, reliability adherence criteria)?	☒ Yes ☐ No
9.	Did the CCO change/modify penalties for failure to request/receive authorization for MH/SUD or M/S benefits (e.g., payment reductions, exceptions or waivers of penalties)?	☐ Yes ☒ No
10.	Did the CCO change frequency, time frames, or conditions of utilization review for MH/SUD or M/S benefits (e.g., RR or CR time frames or conditions)?	☒ Yes ☐ No
11.	What is the number of coverage requests, denials, appeals, appeal overturns, hearings, and hearing overturns experienced during the last full calendar year separately for MH/SUD and M/S for each classification (IP, OP, and Rx)? ***Documentation Required:*** *Provide lists that identify the number of coverage requests, denials, appeals, appeal overturns, hearings, and hearing overturns for the last full calendar year separately for MH/SUD and M/S for each classification (i.e., IP, OP, and Rx). For Rx, include a list identifying the number of drugs subject to PA.*	☒ Yes ☐ No
Provider Network Admission Changes in CCO—MH Parity Analysis Sections IV and V		
Question		**Yes/No**
1.	Did the CCO change its network status from open (accepting new provider applications) to closed (not accepting new provider applications for certain provider types) or from closed to open?	☐ Yes ☒ No
2.	Did the CCO add, remove, or change provider admission requirements (e.g., special training, education, experience), including as a result of State licensing changes, for any MH/SUD or M/S providers?	☒ Yes ☐ No
3.	Were any of the CCO's providers denied credentialing due to network closure (if applicable) or based on credentialing requirements? ***Documentation Required:*** *Provide a list of the number and percentage of providers denied credentialing*	☒ Yes

	(relative to those seeking credentialing, including the number of applications not accepted) or terminated from credentialing and provide the credentialing determination.	☐ No
4.	Did the CCO add or remove any MH/SUD or M/S provider types that are eligible for credentialing/reimbursement for services?	☒ Yes ☐ No
Out-of-Network/Out-of-State Limit Changes in CCO—MH Parity Analysis Section VI		
Question		**Yes/No**
1.	Did the CCO change processes for accessing OON/OOS coverage for MH/SUD or M/S benefits? ***Documentation Required:*** *Provide the number and percentage of OON/OOS requests, denials, etc. received during the last calendar year.*	☐ Yes ☒ No
2.	Did the CCO change its standards for providing OON/OOS coverage for MH/SUD or M/S benefits?	☐ Yes ☒ No

Appendix B. Finalized MHP NQTL Reporting Tables

CPCCO submitted a completed MHP Reporting Template, which identified changes or additions to NQTLs that may impact MHP. HSAG synthesized the changes and additions to NQTLs with those reported in the CCO's 2018 MHP Analysis. Below are the finalized MHP NQTLs reported and assessed for the 2020 MHP Analysis by each of the six areas of NQTLs across MH/SUD and M/S benefits. Each NQTL was addressed based on comparability and stringency standards.

Category I—Utilization Management Limits Applied to Inpatient Services

NQTL: UM limits including PA, CR, RR, and IRR

Benefit Package: CCOA, CCOB, CCOE, and CCOG for adults and children

Classification: IP and emergency care

Overview: MH/SUD and M/S IP benefits require notification for emergency admissions. PA is not required for emergency care, but is applied to most other IP benefits including residential treatment. PA and CR are applied to IP benefits to confirm coverage, assure services are medically necessary and delivered in the least restrictive environment, and reduce overutilization of these high-cost services. These rationalizations were identified as indicators 1, 2, and 4 as listed in comparability and stringency Standard #2 below, which cross-reference to indicators used by OHP FFS. HSAG analyzed NQTLs applied to IP benefits based on information provided related to all six comparability and stringency standards as listed below. The benefit packages were analyzed as follows:

- **Benefit packages A and B:** MH/SUD benefits in columns 1 (CCO MH/SUD) and 2 (FFS MH/SUD) compared using indicators 1–4 to M/S benefits in column 3 (CCO M/S). These benefit packages include MH/SUD IP benefits managed by the CCO and OHP FFS through its subcontractors, Comagine Health and Keystone Peer Review Organization (KEPRO), as compared to M/S IP benefits in column 3 managed by the CCO.
- **Benefit packages E and G:** MH/SUD benefits in columns 1 (CCO MH/SUD) and 2 (FFS MH/SUD) compared using indicators 1, 2, and 4 to M/S benefits in column 4 (FFS M/S). These benefit packages include MH/SUD IP benefits managed by the CCO and OHP FFS through Comagine Health and KEPRO, as compared to M/S IP benefits in column 4 managed by OHA.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
1. To which benefit is the NQTL assigned?			
• (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). • (1, 2, 3, 4) Emergency and urgent admissions require notification within 1-3 days of admission. • (1, 4) Extra-contractual and experimental/investigational/ unproven benefit requests (i.e., exceptions) are submitted through a PA-like process.	• (1, 4) PA (only) for MH/SUD procedures performed in a medical facility (e.g., gender reassignment surgery authorizations, experimental/investigational, and extra-contractual benefits are conducted by OHA consistent with the information in column 2). • (2, 4) A level-of-care review is required for SCIP, SAIP and subacute care that is conducted by an OHA designee. • (1, 4) PA for SCIP, SAIP and subacute admission is obtained through a peer-to-peer review between a Comagine psychiatrist and the referring psychiatrist. • (1, 2, 4) CR Comagine RR for SCIP and SAIP are performed by Comagine. • (1, 2, 4) CR and RR for subacute care are conducted by Comagine. • (1, 2, 4) PA, inclusive of a Certificate of Need (CONS)	• (1, 2, 3, 4) PA and CR are required for planned non-emergency admissions to IP hospital (except no CR for DRG hospitals), (in and OON) and IP hospice/palliative care. • (1, 2, 3, 4) Emergency admissions require notification within 1-3 days 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/un proven benefit requests (i.e., exceptions) are submitted through a PA-like process.	• (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 inpatient 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.) • (1, 2, 4) PA, CR and RR for Behavior Rehabilitation Services (BRS) are performed by OHA, DHS or OYA designee. • (1, 2, 4) PA and CR of skilled nursing facility (SNF) services. • (1, 4) Requests for extra-contractual and experimental/investigational /unproven benefits (i.e., exceptions) are submitted through a PA-like process.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	process, and CR, is conducted by Comagine for PRTS. • (1, 2, 4) PA, CR for AFH, SRTF, SRTH, YAP, RTF, and RTH are performed by Comagine.		
2. Why is the NQTL assigned to these benefits?			
• (1) These processes are meant to eliminate or reduce overutilization of higher levels of care through medical necessity and HERC1 review, reduce costs and promote faster community integration • (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. • (3) Promote health and safety • (4) To comply with federal and State requirements.	• (1) UM is assigned to ensure medical necessity of services and prevent overutilization. • (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 or PCSP – Person Centered Service Plan and IBL – Individually-Based Limitations). • (4) To comply with federal and State requirements.	• (1) These processes are meant to eliminate or reduce overutilization of higher levels of care through medical necessity and HERC review, reduce costs and promote faster community integration • (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. • (3) Promote health and safety • (4) To comply with federal and State requirements.	• (1) PA and CR are assigned to ensure medical necessity of services and prevent overutilization (e.g., requests for care that are not medically necessary or 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.
3. What evidence supports the rationale for the assignment?			
• (1-4) HERC PL and guidelines. • (1) UM and claims reports are reviewed for trends in	• (1, 2, and 4) Health Evidence Review Commission (HERC) Prioritized List (PL) and	• (1-4) HERC PL and guidelines. • (1) UM and claims reports are reviewed for trends in	• (1, 2 and 4) The HERC PL and guidelines. There are more guidelines for M/S than for

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
overutilization quarterly. Review utilization relative to frequent users, percentage of spend, average cost per episode, provider to provider and prior year costs. • (1) Benefits that are low cost, unlikely to be over-utilized, diagnostic, or not cost-effective to devote resources to review are included on the Care Oregon non-authorization list. This list is modified occasionally based on complaints, utilization reports, staff resources, quality concerns • (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	guidelines. The HERC include 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 prioritized list of services, developing or identifying evidence-based health care guidelines and conducting comparative effectiveness research. HERC provides outcome evidence and clinical guidelines for certain diagnoses that may be translated into UM requirements. There are fewer guidelines for MH/SUD than for 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	overutilization on a quarterly basis • (1) Benefits that are low cost, unlikely to be over-utilized, diagnostic, or not cost-effective to devote resources to review are included on the Care Oregon non-authorization list. This list is modified occasionally based on complaints, utilization reports, staff resources, quality concerns. • (3) 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. • (4) Applicable federal and State requirements.	MH/SUD because 1) there are more technological procedures (e.g., surgery, devices, procedures and diagnostic tests); and 2) the literature is more robust. • (1) InterQual • (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
• (2, 3) 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) 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. • (3) Members with an eating disorder are placed into the appropriate level-of-care to eliminate risks associated with malnutrition, physical complications due to behaviors, laxative or diuretic misuse, or imminent risk of suicide or serious self-harm. • (4) Applicable federal and State requirements.	robust (e.g., fewer randomized trials, more subjective diagnoses (or the ICD-10-CM diagnoses represent a spectrum) and less standardization in interventions). • (1) InterQual.		

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
4. What are the NQTL procedures?			
Timelines for authorizations: • It is preferred that PA is requested ten days prior to admission but there is not a limit. Urgent requests are expedited and generally completed the same day. • IP stays are reviewed within 1 business day of notification of admission or need for continued stay. • PRTS – every 30 days.	**Timelines for gender reassignment surgery authorizations:** **(OHA)** • 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 three days of receiving complete requests for SCIP, SAIP or subacute. **(Comagine)** • 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 Comagine. **Timelines for adult residential and YAP authorizations:** **(Comagine Health)** • Emergency requests are processed within one business	**Timelines for authorizations:** • It is preferred that PA is requested two weeks prior to admission (consistent with mandated 14 day authorization turnaround time) but there is not a limit. Urgent requests are expedited and generally completed the same day. • IP stays are reviewed within 1 business day of notification of admission or need for continued stay. • Investigational: Standard requests are completed within 14 days; Urgent requests are completed within 3 days.	**Timelines for authorizations:** • All in-state and out-of-state (OOS) emergency admissions, LTAC, and IP rehabilitation require notification. Notification is preferred within 24 hours of admission, but there is no timeline requirement. Notification allows the State to conduct case management and discharge planning, but does not limit the scope or duration of the benefit. • PA is required before admission. • IP stays are reviewed within 1 week of notification of admission or need for continued stay. • OARs require emergency requests be processed within one business day, urgent requests within three business days and standard requests within 14 days.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	day, urgent within two business days, and standard requests within 10 business days.		
Documentation requirements: • PA and CR: The claims or authorization request form is one page. However, hospitals, practitioners, and providers send documentation supporting medical necessity for review and approval.	**Documentation requirements (OHA):** • PA documentation requirements for non-residential MH/SUD benefits 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 PRTF CONS and CR for PRTF, SCIP and SAIP (Comagine):** • PRTS CONS requires documentation that supports the justification for child residential services, including: – A cover sheet detailing relevant provider and recipient	**Documentation requirements:** • Standard forms used for all services, typically one page along with relevant medical records to support requested service.	**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
	– Medicaid numbers; – Requested dates of service; – HCPCS or CPT Procedure code requested; and – Amount of service or units requested; – A behavioral health assessment and service plan meeting the requirements described in OAR 309-019-0135 through 0140; or – Any additional supporting clinical information supporting medical justification for the services requested; – For substance use disorder services (SUD), the Division uses the American Society of Addiction Medicine (ASAM) Patient Placement Criteria second edition-revised (PPC-2R) to determine the appropriate level of SUD treatment of care. • There are no specific documentation requirements for CR of PRTS, SCIP or SAIP.		

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	Documentation requirements (Comagine Health): • Documentation may include assessment, service plan, plan-of-care, Level-of-Care Utilization System (LOCUS), Level of Service Inventory (LSI), PCSP, IBL, or other relevant documentation.		
Method of document submission: • Requests can be made either via provider web portal, EHR, fax., or USPS. • Providers use statewide electronic census tool • (PreManage), which automatically submits notification to CareOregon about inpatient request. • Can conduct CR through EMR.	**Method of document submission (OHA):** • For non-residential MH/SUD services, 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 secure email and has also picked up information. Supplemental information may be obtained by phone. **Method of document submission (Comagine):** • Packets are submitted to Comagine by mail, fax, email or web portal for review for child	**Method of document submission:** • PA: via provider portal along with relevant medical records to support requested service submitted via provider web portal, EHR, fax. • CR: Providers use statewide electronic census tool • (PreManage), which automatically submits notification to CareOregon about inpatient request. • Can conduct CR through EMR when given access.	**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
	residential services. Telephonic clarification may be obtained. • Psychiatrist to psychiatrist review is telephonic. **Method of document submission (Comagine Health):** • Providers submit authorization requests for adult MH residential to Comagine Health by mail, fax, email or via portal, but documentation must still be faxed if the request is through portal. Telephonic clarification may be obtained.		
Qualifications of reviewers: • PA for investigational procedures: If a facility provider or Independent practitioner specifically requests authorization to apply an investigational intervention, request would be reviewed by the CMO for consideration and approval for authorization given only after consent by GOBHI QI Committee. • PA decisions are made by qualified health care professionals with appropriate credentials.	**Qualifications of reviewers (OHA):** • OHA M/S staff conduct PA and CR (if applicable) for gender reassignment surgery. • The OHA designee is a licensed, master's-prepared therapist that reviews psychiatric evaluations to approve or deny the level-of-care requested. Psychiatric consultation is available if needed. **Qualifications of reviewers (Comagine):**	**Qualifications of reviewers:** • Requests for investigational services are made relative to HERC or sent to an IRE (e.g., NCCN) for review. • PA determinations made by RN's and/or MD/DO. • Denials are determined by MD/DO.	**Qualifications of reviewers:** • Nurses may authorize and deny authorization requests relative to OAR, HERC PL guidelines and associated notes, and other industry guidelines (e.g., AIM for radiology).

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Medical director or licensed physician reviewers determine denials.	• Two reviewers with QMHP designation make residential authorization decisions. • Two psychiatrists make CONS determinations. **Qualifications of reviewers (Comagine Health):** • Comagine Health 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, 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 of Oregon;		

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	– 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: • Authorization decisions are made using InterQual, ASAM, HERC PL and guidelines, OAR, internal UM guidelines or other MNC relevant to the situation.	**Criteria (OHA):** • Authorizations for non-residential MH/SUD services are based on the HERC PL and guidelines; Oregon Statute, OAR, and federal regulations; InterQual guidelines; and evidence-based guidelines from private and professional associations. • OHA delegates review requests relative to least restrictive environment requirement.	**Criteria:** • Decisions based on standards defined by InterQual, or as appropriate, other MNC such as HERC/OHP criteria, Oregon Administrative Rule, etc. Processes are in alignment with MH/SUD.	**Criteria:** • Authorizations are based on the HERC PL and guidelines; Oregon Statute, OAR, and federal regulations; InterQual guidelines; and 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
	Criteria (Comagine): • HERC PL, InterQual, and Comagine policy are used for residential CR. **Criteria (Comagine Health):** • QMHPs review information submitted by providers relative to State plan and OAR requirements and develop a PCSP. • The PCSP components are entered into MMIS as an authorization.		
Reconsideration/RR: • RR is offered for providers who fail to PA medically necessary care; no timeframe applied. • Utilization Management Coordinator will review claims request and/or RR request and make determination of whether a benefit limitation or administrative exclusion applies.	**Retrospective Review:** • Retrospective authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why authorization could not have been obtained within the 90 days. **Reconsideration (OHA):** • A provider may request review of an OHA denial decision for nonresidential MH/SUD services. The review occurs in	**Reconsideration/RR:** • RR is offered for providers who fail to PA medically necessary care; no timeframe applied. • Exceptional circumstances can allow for review (e.g. member coverage could not have been known), and/or facility may submit Post Service RR request.	**Retrospective Review:** • Retrospective authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why authorization could not have been obtained within the 90 days. **Reconsideration:** • A provider may request review of a denial decision. The review occurs in weekly MMC meetings.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	weekly Medical Management Committee (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. • If a provider requests review of an OHA delegate level-of-care determination, KEPRO may conduct the second review. **Reconsideration (Comagine):** • If the facility requests a reconsideration of a CONS denial, a second psychiatrist (who did not make the initial decision) will review the documentation and discuss with the facility in a formal meeting. • No policy for CR denials. **Reconsideration (Comagine Health):** • A provider may request review of a denial decision, which occurs in weekly MMC meetings or Comagine Health's own comparable medical management meeting.		• Exception requests for experimental and other non-covered benefits may be granted at the discretion of the MMC, which is led by the OHA's medical director.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Consequences for failure to authorize: • PA & CR: Failure to obtain either a pre- or concurrent authorization can result in no payment for rendered services.	**Consequences for failure to authorize (OHA):** • Failure to obtain authorization for non-residential MH/SUD services can result in non-payment for benefits for which it is required. • Failure to obtain notification for non-residential MH/SUD services does not result in a financial penalty. • For SCIP, SAIP and subacute, if coverage is retroactively denied, general funds will be used to cover the cost of care. **Consequences for failure to authorize (Comagine):** • Non-coverage. **Consequences for failure to authorize (Comagine Health):** • Failure to obtain authorization can result in non-payment for benefits for which it is required.	**Consequences for failure to authorize:** • PA & RR: No payment to provider and/or facility for procedures performed outside of emergent situations without authorization.	**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.
Appeals: • Facility provider has the right to appeal to the Chief Medical Officer if claim or authorization is denied based on a benefit or administrative finding.	**Appeals (OHA):** • Members may request a hearing on any denial decision. **Appeals (Comagine):**	**Appeals:** • Member or provider has the right to appeal.	**Appeals:** • Standard appeal and fair hearing rights apply.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Provider can appeal the decision under a post-authorization decision. If denied at this level, then appealed by provider, payment will be based on the outcome of the appeal process.	• Members may request a hearing on any denial decision. **Appeals (Comagine Health):** • Members may request a hearing on any denial decision.		
5. How frequently or strictly is the NQTL applied?			
Frequency of review (and method of payment): • MH/SUD IP is paid by per diem. • CR for acute IP and IP rehab are guided by InterQual, and are case dependent combined with reviewer judgement. The hospitals do not send re-authorization requests on the weekends, just new cases. So if a case came in on a Thursday we could authorize it for 4 days. • Concurrent review is based on InterQual and as clinically indicated based on estimated LOS. • Services are approved based on the members presenting condition, recommendations of the attending physician, practice guidelines, and GOBHI's Chief	**Frequency of review (and method of payment) (OHA):** • Gender reassignment surgery is authorized as a procedure. • The initial authorization for SCIP, SAIP, and subacute is 30 days. **Frequency of review (and method of payment) (Comagine):** • 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) (Comagine Health):** • Adult residential authorizations are conducted at least once per year. An independent and	**Frequency of review (and method of payment):** • Most M/S is paid by DRG with the exception of Critical Access Hospitals, which are paid a percentage of billed charges and LTAC which is paid via IPPS pricing. • CR: all inpatient events require review by RN staff. All investigational procedures require PA. • Frequency of application: every 1-3 days. • Services are authorized based on InterQual or DRG expected length of stay. Additional review is required if LOS exceeds this initial estimate. Subsequent reviews are performed on a schedule based on clinical judgment of	**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 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 three months.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Medical Officers final determination. • Exceptions are made on a case-by-case basis. Notification requirements are required of the entity and practitioner placing the member into acute care and on the acute care facility. • CR: Exceptions can only be authorized by GOBHIs' Chief Medical Officer (CMO).	qualified agent (IQA) contacts MH provider quarterly for 1915i assessment accuracy. If member's status changes for more than 30 days, provider can contact IQA for a re-assessment.	reviewing clinicians (RN/MD/DO). • The full 20 day benefit is authorized. • Investigational: Exceptions considered when the condition is a covered service and there are no other reasonable alternatives. Exceptions are made on a case by case basis by reviewing physician.	
RR conditions and timelines: • This process is applied when initial or concurrent authorization was not obtained during admission or within 24 to 72 hours post-admission. The facility provider then submits either a claim for payment or authorization for placement and reimbursement. In either circumstance, time frames allowed for either process may have been exceeded, thus requiring a review to determine if payment is allowable. • No timeframe for RR. • In circumstances where a miscommunication between both or either of these	**Retrospective Review:** • Retrospective authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why authorization could not have been obtained within the 90 days. **Reconsideration (OHA):** • A provider may request review of an OHA denial decision for nonresidential MH/SUD services. The review occurs in weekly Medical Management Committee (MMC) meetings. • Exception requests for experimental and other non-	**RR conditions and timelines:** • This process is applied when initial or concurrent authorization was not obtained during admission or within 24 to 72 hours post-admission. The facility provider then submits either a claim for payment or authorization for placement and reimbursement. In either circumstance, time frames allowed for either process may have been exceeded, thus requiring a review to determine if payment is allowable. • No timeframe for RR.	**Retrospective Review:** • Retrospective authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why authorization could not have been obtained within the 90 days. **Reconsideration:** • 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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
entities/parties occurs there might be instances in which authorization for placement will be made beyond the initial notification time period.	covered benefits 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 delegate level-of-care determination, KEPRO may conduct the second review. **Reconsideration (Comagine)**: • If the facility requests a reconsideration of a CONS denial, a second psychiatrist (who did not make the initial decision) will review the documentation and discuss with the facility in a formal meeting. • No policy for CR denials. **Reconsideration (Comagine Health):** • A provider may request review of a denial decision, which occurs in weekly MMC meetings or Comagine Health's own comparable medical management meeting.		MMC, which is led by the OHA's medical director.
Methods to promote consistent application of criteria: • IRR conducted annually. • 80% testing standard.	**Methods to promote consistent application of criteria (OHA):** • Nurses are trained on the application of the HERC PL and guidelines, which is spot-	**Methods to promote consistent application of criteria:** • IRR conducted annually. • 80% testing standard.	**Methods to promote consistent application of criteria:** • Nurses are trained on the application of the HERC PL and guidelines, which is spot-

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	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 non-residential MH/SUD services. • There are only two OHA designee reviewers for level-of-care review for SCIP, SAIP, and subacute and no specific criteria, so N/A. **Methods to promote consistent application of criteria (Comagine):** • Parallel chart reviews for the two reviewers. (No criteria.) **Methods to promote consistent application of criteria (Comagine Health):** • Monthly clinical team meetings in which randomly audited charts are reviewed/discussed by peers using Comagine Health compliance department-approved audit tool.		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.

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	• Results of the audit are compared, shared and discussed by the team and submitted to Compliance Department monthly for review and documentation. • Individual feedback is provided to each clinician during supervision on their authorization as well as plan-of-care reviews.		
6. What standard supports the frequency or rigor with which the NQTL is applied?			
Evidence for UM review frequency: • PA & CR: CCO utilizes the following best practices which determine the frequency in which PA's are performed. InterQual guidelines are utilized first and are diagnostically based (medical necessity only) and can do level-of-care. If the MCG is not sufficient to the situation, then Utilization Management practices developed by the Chief Medical Officer and approved by the Quality Assurance Committee would be utilized to determine length of authorization. Finally,	**Evidence for UM frequency (OHA (and designee for level-of-care review), Comagine and KEPRO):** • PA length and CR frequency are tied to HERC PL and guidelines, OAR, CFRs, InterQual, reviewer expertise and timelines for expectations of improvement.	**Evidence for UM review frequency:** • InterQual. • Clinical/reviewer judgment. • HERC PL and guidelines. • OAR. • DRG expected LOS. • Medical policy.	**Evidence for UM frequency:** • PA length and CR frequency are tied to HERC PL and guidelines, DRGs, OAR, CFRs, InterQual, reviewer expertise and timelines for expectations of improvement.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
general medical necessity criteria will be utilized in establishing the prior authorization, which does include duration of the authorization and next review. Each of these practices establishes authorization requirements and treatment duration, thus the frequency in which reviews will occur. General medical necessity criteria are based upon MCG standards. • RR: 410-141-3420 (1), OHP Contract Exhibit B part 7 (3).			
Data reviewed to determine UM application: • CCO tracks all service authorization requests. The medical management software evaluates the type of authorization and the timeframes in which the authorization was approved. • CCO tracks number of denials and grievances, timeframe for addressing denials and grievances, number of appeals, and timeframe to address	**Data reviewed to determine UM application:** • Denial/appeal overturn rates; number of PA requests; stabilization of cost trends; and number of hearings requested. These data are reviewed in subcontractor reports, on a quarterly basis by the State. (Applicable to non-residential MH/SUD services.) **Data reviewed to determine UM application (Comagine):** • N/A	**Data reviewed to determine UM application:** • Inter-rater reliability measures, denial rates, appeal monitoring and rates through various sources including monthly Appeal Review meeting attended by all Appeals Dept RNs, Medical Directors and Managers of both Benefit Management and Appeals. Results of hearings-members have hearing rights, which can alert plan to need to review denials later overturned by	**Data reviewed to determine UM application:** • A physician led group of clinical professionals conducts an annual review to determine which services receive or retain PA. Items reviewed include: – Utilization. – Approval/denial rates. – Documentation/ justification of services. – Cost data.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
appeals, plus appeal and grievance outcomes. • CCO tracks qualifications of practitioner making authorization determinations by service area, progress of member in care, and costs associated with that service area.	**Data reviewed to determine UM application (Comagine Health):** • N/A	judge. Medical Director reviews all denials.	
IRR standard: • IRR conducted at least annually. • IRR goal is 80%.	**IRR standard (OHA):** • KEPRO has a formal policy including an 80% standard using InterQual criteria, conducting reviews at least annually. **IRR standard (Comagine Health):** • Spot-checks performed through supervision. Formal policy to be developed. **IRR standard (Comagine Health):** • Spot-checks performed through supervision.	**IRR standard:** • IRR conducted at least annually. • IRR goal is 80%.	**IRR standard (OHA):** • KEPRO has a formal policy including an 80% standard using InterQual criteria, conducting reviews at least annually.
Analysis			
CPCCO was responsible for delivering IP MH/SUD and M/S Medicaid benefits to members in all four benefit packages (CCOA, CCOB, CCOE, and CCOG), whereas OHP FFS was fully managing IP M/S benefits for CCOE and CCOG benefit packages. Emergency MH/SUD and M/S IP hospital admissions required notification, with most ongoing IP services requiring subsequent CR. Regarding nonemergent CCO MH/SUD and M/S IP admissions, PA or level-of-care approval was required. PA was also required for extra-contractual coverage requests (including experimental			

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

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. For psychiatric residential treatment services (PRTS) benefits (e.g., Secure Children's Inpatient Treatment Programs [SCIP], Secure Adolescent Inpatient Treatment Programs [SAIP], and adult and youth residential services) delivered under all benefit packages, OHP FFS's subcontractor, Comagine Health, was conducting the certificate of need (CON) and PA processes, with the CCO conducting CR for those services. The CCO was also conducting CR for MH/SUD subacute benefits. For M/S benefits under CCOA and CCOB benefit packages, the CCO was conducting PA and CR for SNF benefits for the first 20 days, with subsequent management being conducted by OHP FFS.

HSAG's analysis of CPCCO's PA data for IP and OP benefits did not reveal any concerns related to MHP due to low denial rates of MH/SUD requests. Of the total 6,360 IP and OP PA requests reported, 8.29 percent were denied. Of the 11 MH/SUD PA requests denied, representing 2.79 percent of the 394 MH/SUD PA requests, none were appealed. The majority of the MH/SUD PA request denials were requests for inpatient benefits, all denied for a "benefit exclusion" categorical reason.

Comparability

UM was assigned to MH/SUD and M/S IP benefits primarily using five rationales: 1) To ensure coverage, medical necessity, and prevent unnecessary overutilization (e.g., in violation of relevant OARs, HERC PL and guidelines, MCG, and other clinical practice guidelines or research); 2) To ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual; 3) To maximize use of in-network (INN) providers to promote cost-effectiveness when appropriate; 4) To comply with federal and State requirements; and 5) To preserve scarce resources as evidenced by documented bed shortages. In addition, the CCO conducted UM for MH/SUD and M/S to preserve limited resources and facilitate safe transitions as supported by recent studies. HSAG determined the rationale and evidence to be comparable.

Emergency MH/SUD and M/S IP hospital admissions required notification within one to three business days, with child emergency residential admissions separately requiring notification within 14 days. Most CCO documentation requirements for MH/SUD included an admission note and records submitted via a provider Web portal, electronic health record (EHR), fax, or United States Postal Service (USPS). OARs required authorization decisions within 24 hours for emergencies, 72 hours for urgent requests, and 14 days for standard requests. Both CPCCO and OHP FFS adhered to these requirements across the benefit packages. Most ongoing IP services required subsequent CR. Most documentation requirements for MH/SUD and M/S IP admissions included information that supports medical necessity such as the admission summary and progress notes. Documentation requirements for child residential PA/level-of-care review included a psychiatric evaluation or a psychiatrist-to-psychiatrist telephonic review. Comagine Health, OHP FFS's subcontractor, accepted information for child residential CR via mail, email, fax, and Web portal. Adult and youth residential required an assessment (i.e., completion of a relevant level-of-care tool [e.g., ASAM, LSI, or LOCUS]) and plan-of-care consistent with State plan requirements. Comagine Health documentation submission could be done using mail, email, fax, or Web portal. Consistent with OARs, federal CON procedures, and due to the potential absence of a psychiatric referral, the PRTS documentation

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
requirements included a cover sheet, a behavioral health assessment, and service plan meeting the requirements described in OAR 309-019-0135 through 0140. **Stringency** Qualified individuals conducted UM applying OARs, HERC, InterQual, national guidelines, and ASAM for CCO SUD. The CCO and OHP FFS subcontractors required all MH/SUD and M/S denials to be made by physicians and professional peers; however, nurses could deny benefits managed by OHP FFS. HSAG determined this difference to be an issue of quality rather than parity. OHP FFS's subcontractor, Comagine Health (a licensed MH professional), made denial determinations for level-of-care review for certain child residential services. HSAG determined the MH/SUD authorization time frames and documentation requirements were compliant and consistent to those applied to M/S authorization requests for all benefit packages. Both the CCO and OHP FFS allowed RR for MH/SUD and M/S when providers failed to obtain authorization. CPCCO did not have a time frame for RR for IP MH/SUD or M/S PA requests, which HSAG determined was less stringent than OHP FFS's 90-day time frame applied to M/S request. For adult and youth residential services, Comagine Health allowed reconsideration of denials with the submission of additional documentation within 10 days of the denial. For OHP FFS and Comagine Health, the review of denial decisions occurred during MMC meetings. MH/SUD and M/S denial decisions could be appealed through appeals and/or State fair hearing processes. Failure to obtain authorization could result in noncoverage, although SCIP, SAIP, and subacute services could be covered by general fund dollars. Regarding IRR, the CCO was conducting reviews at least annually, applying an 80 percent testing standard, which was consistent with OHP FFS IRR processes and standards.			
Outcome			
HSAG's analysis determined that the rationale, documentation requirements, processes, and frequency of UM applied to IP MH/SUD benefits were comparable to and no more stringently applied to IP M/S benefits.			

Category II—Utilization Management Limits Applied to Outpatient Services

NQTL: UM limits including PA, CR, RR, and IRR

Benefit Package: CCOA, CCOB, CCOE, and CCOG for adults and children

Classification: OP

Overview: UM is assigned to OP MH/SUD and M/S benefits to confirm coverage, meet federal requirements in providing benefits in the least restrictive environment, evaluate the safety of certain OP services, and prevent overutilization that has been identified by specific medical necessity criteria or in utilization reports. These rationalizations are identified as indicators 1, 2, and 3 as listed in comparability and stringency Standard #2 below, which cross-reference to indicators used by OHP FFS. HSAG analyzed NQTLs applied to OP benefits based on information provided related to all six comparability and stringency standards as listed below. The benefit packages were analyzed as follows:

- **Benefit packages A and B:** MH/SUD benefits in columns 1 (FFS/home- and community-based services [HCBS] 1915[c][i] MH /SUD) and column 3 (CCO MH/SUD) compared using indicators 1–4 to M/S benefits in columns 2 (FFS/HCBS 1915[c][k][j] M/S) and 4 (CCO M/S), respectively. These benefit packages include MH/SUD IP benefits managed by the CCO and OHA through its subcontractors, Comagine Health and KEPRO.
- **Benefit packages E and G** MH/SUD benefits in columns 1 (FFS/HCBS 1915[c][i] MH/SUD) and column 3 (CCO MH/SUD) compared using indicators 1, 2, and 4 to M/S benefits in columns 2 (FFS/HCBS 1915[c][k][j] M/S) and 5 (FFS M/S), respectively. These benefit packages include MH/SUD IP benefits managed by the CCO and OHP FFS through its subcontractors, Comagine Health and KEPRO.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
1. To which benefit is the NQTL assigned?				
• (2) Applied Behavior Analysis (ABA). • (2) OT, PT, ST for MH conditions are managed	The following services are managed by DHS:	PA: • (2, 4) Applied Behavior Analysis (ABA).	PA: • (2, 3, 4) Specialist visits, elective procedures performed in outpatient	The following services are managed by OHA: • (2, 3) Out of hospital births.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
through RR; PA is not required.	• (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. • (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, 3, 4) Electroconvulsive therapy (ECT). • (2, 3, 4) PHP, IOP and residential treatment of Eating Disorders. • (2, 3, 4, 5) Psychiatric Day Treatment.	hospital setting and/or ASC. • (2, 4) Selected procedures performed in PCP offices. • (2, 4) Rehab services (PT/OT/ST). • (2, 3, 4) Selected imaging and lab studies. • (2, 4) Durable medical equipment (DME), vision services. • (2, 4) Chiropractic care. • (3) Circumcision. • CR & RR: "delegated" UM with RR chart review. • (2, 4, 5) BRS outpatient. • (2, 3,4, 5) Bariatric Evaluation. • (2, 3, 4, 5) Pain Management related to back pain.	• (2) Home health services. • (2) OT, PT, ST for MH conditions are managed through RR; PA is not required. • (2, 3) Imaging. • (2) DME.
2. Why is the NQTL assigned to these benefits?				
• (2) HERC PL. • (2) OAR 410-172-0650 for ABA services.	• (1) The State requires PA of HCBS in order to meet federal requirements regarding	• (2) Reduce overutilization and ensure services adhere to State criteria defined	• (2) Reduce overutilization and ensure services adhere to State criteria defined	• (2) To prevent services being delivered in violation of relevant OARs, associated

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
• (2) PA requests with insufficient documentation to demonstrate MNC or HERC PL guidelines are not being followed.	PCSPs and ensure services are provided in accordance with a participant's PCSP and in the last restrictive setting.	in HERC PL and guidelines • (3) Reduce risk, confirm safety, least intrusive, educate • (4) Comply with State and federal requirements. • (5) OP programs for which the provider is contractually responsible for fidelity standards for the program, thus should be afforded local control over maintaining fidelity.	in HERC PL and guidelines • (3) Reduce risk, confirm safety, least intrusive, educate • (4) Comply with State and federal requirements. • (5) The provider in most of these cases is contractually responsible for fidelity standards for the program, thus should be afforded local control over maintaining fidelity.	HERC PL and guidelines and federal regulations. • (3) Services are associated with increased health or safety risks.
3. What evidence supports the rationale for the assignment?				
• (2) HERC PL • (2) OAR 410-172-0650 for ABA services. • (2) PA requests with insufficient documentation to demonstrate medical necessity is not being met or HERC PL guidelines are not being followed.	• (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	• (2) HERC • (2) UM and encounter reports (90%capitated) are reviewed for trends in overutilization on a quarterly basis by frequent utilizers, procedure code and provider relative to prior year spend. • (2) Those outpatient services with the highest	• (2) At a high level, approximately 30% of medical care in the US is estimated to be "unnecessary"; reviewing for medical appropriateness is the main process to ensure appropriate utilization. • http://www.healthcarefinancenews.com/news	• (2) HERC PL and guidelines, and clinical practice guidelines. • (2) PA requests with insufficient documentation to demonstrate medical necessity are not being met or HERC PL guidelines are not being followed.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
	1915(i) services require that HCBS are provided in the least restrictive setting possible.	potential to be over-utilized in the absence of demonstrated medical necessity are assigned PA. Other services are deemed at risk but the cost associated with reviewing makes that process prohibitive. • (2) Oregon Performance Plan (OPP) requires that all BH services are provided in least restrictive setting possible. • (2, 3, 4) OAR, HERC, MCG • (4) OAR 410-172-0650, 410-172-0770 (3)(a-e), and OHA CCO contract exhibit B part 2 (3). Health Evidence Review Commission (HERC) guidelines 75 and 126. • (4) OAR 410-172-0650, 410-172-0770 (3)(a-e), and OHA CCO contract exhibit B part 2 (3). Health Evidence Review Commission (HERC) guidelines 69.	/unnecessary-medical-tests-treatments-cost- • 200- billion-annually-cause-harm • (2) Those outpatient services with the highest potential to be over-utilized in the absence of demonstrated medical necessity are assigned PA. Other services are deemed at risk but the cost associated with reviewing makes that process prohibitive. • (2) CareOregon website contains list of procedure codes that do not require any authorization-those codes may be billed and will be paid assuming member is eligible. The list includes services that are low cost, unlikely to be over-utilized, diagnostic, or not cost- effective to devote resources to review.	• (3) HERC Guidelines - Recommended limits on services for member safety.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
		• (4) OAR 410-172-0650, 410-172-0770 (3)(a-e), and OHA CCO contract exhibit B part 2 (3). Health Evidence Review Commission (HERC) guideline 127. • OAR 410-172-0650, • 410- 172-0770 (3)(a-e), and OHA CCO contract exhibit B part 2 (3). • (5) OP Program	• (2, 3, 4) OAR, HERC, InterQual • (2) Utilization review reports • (5) OP Program contracts • (4) Bariatric: OAR • 410- 172-0650, 410-172-0770 (3)(a-e), and OHA CCO contract exhibit B part 2 (3). Health Evidence Review Commission (HERC) guideline 8. • (4) Pain management: OAR 410-172-0650, • 410- 172-0770 (3)(a-e), and OHA CCO contract exhibit B part 2 (3). Health Evidence Review Commission (HERC) guidelines 56.	
4. What are the NQTL procedures?				
Timelines for authorizations: • Urgent requests are processed in three business days and immediate requests in	**Timelines for authorizations:** • A PCSP must be approved within 90 days from the date a	**Timelines for authorizations:** • PA requests are desired at least 10 days prior to the start of services, however, there is no cut-	**Timelines for authorizations:** • It is preferred that information is submitted 14 days in advance of service delivery, but	**Timelines for authorizations:** • Urgent requests are processed in three business days and immediate requests in

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
one business day. Routine requests are processed in 14 days. • OT, PT, ST for MH conditions are managed through RR; PA is not required.	completed application is submitted.	off. Providers can request urgent review when meets OAR criteria. • CR is completed per InterQual.	there is no cut off. Providers can request urgent review when meets OAR criteria. Urgent requests are expedited. • CR is completed per InterQual when applicable.	one business day. Routine requests are processed in 14 days. • OT, PT, ST for MH conditions are managed through RR; PA is not required.
Documentation requirements: • Form is one cover page. • Require diagnostic and CPT code and rationale for medical necessity plus any additional supporting documentation. • In addition, as part of the supporting documentation ABA must have an evaluation and referral for treatment from a licensed practitioner described in OAR 410-172-0760 (1)(a-d) and a treatment plan from a licensed health care	**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.	**Documentation requirements:** • Consistent with OARs and HERC, documentation requirements include valid assessment, current service plan. • Specialty services such as ABA, Gender Dysphoria benefits, eating disorders services, require documented evidence that the referral comes from a practitioner qualified in that area.	**Documentation requirements:** • Template on web portal. • Bariatric evaluation requests must come from a hospital certified as a center for bariatric excellence. • Certain procedures require provider to submit requested codes with chart documentation to support requested payment for service, as required by OAR.	**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. • Documentation supporting medical necessity is required at the time of billing for OT, PT, ST services.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
professional described in 410-172-0650(B). • Documentation supporting medical necessity is required at the time of billing for OT, PT, ST services.				
Method of document submission: • Paper (fax) or online PA/POC submitted prior to the delivery of services.	**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:** • Authorization requests can be made either via provider web portal, EHR, fax, or USPS.	**Method of document submission:** • PA & RR: Documentation submission via provider web portal, EHR, fax. • The bariatric evaluation requires GOBHI to establish a SCA with a qualified MHP to conduct the evaluation • Pain Management requests require GOBHI to establish a SCA if the contracted provider or practitioner is not qualified in CBT or pain management.	**Method of document submission:** • Paper (fax) or online PA/POC submitted prior to the delivery of services.
Qualifications of reviewers:	**Qualifications of reviewers:** • A case manager must have at least:	**Qualifications of reviewers:** • MH/SUD professional can review.	**Qualifications of reviewers:**	**Qualifications of reviewers:** • Nurses may authorize and deny services.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
• For ABA services, physicians review services. • For OT, PT, ST services, nurses may authorize and deny services. • Professional peers deny for other OP services.	– 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.	• Only physicians can make denials.	• Non-licensed staff can make some authorization decisions. • Licensed RNs can make many decisions relative to InterQual and HERC criteria, including some cases issuing denials. • Denials are determined by MD/DO.	
Criteria: • Authorizations are based on applicable HERC guidelines, Oregon Statute, Oregon Administrative rules, federal regulations, and evidence-based	**Criteria:** • Qualified case managers approve or deny services in the PCSP consistent with waiver/state plan and OAR requirements.	**Criteria:** • InterQual, HERC, ASAM, OARs. • Gender Dysphoria authorizations use version 7 WPATH and require GOBHI to establish a SCA with a	**Criteria:** • InterQual, HERC, OARs and clinical judgement. • Investigational: Coverage must be made by Medical Director. Exception samples	**Criteria:** • Authorizations are based on applicable HERC PL and guidelines, Oregon Revised Statute, OAR, federal regulations, and evidence-based guidelines from private

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
guidelines from private and professional associations such as the American Psychiatric Association, where no State or federal guidelines exist.	• Once a PCSP is approved, itis entered into the payment management system as authorization by the CME staff.	qualified MHP to conduct the evaluation (due to scarcity of resources). • If a facility provider or Independent practitioner requested authorization to apply an investigational intervention, this request would be reviewed by the CMO for consideration and approval for authorization given only after consent given by a QI Committee.	discussed at RN meetings and Medical Director meetings to attempt consistency among different reviewers. Exceptions are marked in system to allow for analysis patterns.	and professional associations such as the Society of American Gastrointestinal and Endoscopic Surgeons where no State or federal guidelines exist.
Reconsideration/RR: • A provider may request review of a denial decision, which occurs in weekly MMC meetings or Comagine's own comparable MMC meeting. • RR authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why authorization could not	**Reconsideration/RR:** • (c) NA	**Reconsideration/RR:** • Reconsideration is available for facility denials. • Providers may request a reconsideration of a denied service, whether or not a member appeals a denial. • RR is available, no timeframe applied.	**Reconsideration/RR:** • Reconsideration is available for facility denials. • Providers may request a reconsideration of a denied service, whether or not a member appeals a denial. • RR is available, no timeframe applied.	**Reconsideration/RR:** • A review of a denial decision can be requested and is reviewed in weekly MMC meetings. • RR authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why authorization could not

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
have been obtained within the 90 days. • OT, PT, ST are reviewed after the initial service prior to payment. Additionally, denial decisions can be requested and reviewed at weekly MMC meetings.				have been obtained within the 90 days. • OT, PT, ST are reviewed after the initial service prior to payment. Additionally, denial decisions can be requested and reviewed at weekly MCM meetings.
Consequences for failure to authorize: • Failure to obtain authorization may result in non-payment.	**Consequences for failure to authorize:** • Failure to obtain authorization may result in non-payment.	**Consequences for failure to authorize:** • PA & CR: No payment for rendered services; provider can either be paid or appeal the decision under a post-authorization decision. If denied at this level, then appealed, payment will either be made or not, based on the outcome of the appeal process.	**Consequences for failure to authorize:** • PA: No payment to provider and/or facility for procedures performed outside of emergent situations. • CR: Facility does not receive payment for unauthorized days of service. • Investigational: Payment denied when procedure not authorized.	**Consequences for failure to authorize:** • Failure to obtain authorization may result in non-payment.
Appeals: • Notice and fair hearing rights apply.	**Appeals:** • Notice and fair hearing rights apply.	**Appeals:** • Standard appeal processes apply.	**Appeals:** • Standard appeal processes apply.	**Appeals:** • Notice and fair hearing rights apply.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
5. How frequently or strictly is the NQTL applied?				
Frequency of review: • PA is granted for different LOS depending on the service and can be adjusted. PAs for extensive services usually range from 6 months to 1 year. • ABA is usually multiple service codes approved for 6 months. • Exceptions may be made at the discretion of the MMC, which is led by the HSD medical director.	**Frequency of review:** • PCSPs are reviewed and revised as needed, but at least every 12 months.	**Frequency of review:** • Timeframes are adjusted and considered with input from requesting provider's plan of care, MD/DO review, InterQual and other criteria estimated LOS. • General CR/RR conducted during triannual site visits.	**Frequency of review:** • PA: When previously authorized units are exhausted. • PA: Medical Directors have latitude to make clinically appropriate exceptions, or when review is not cost-effective. Some services are covered by exception to avoid other high cost sequelae (cost avoidance). • Pain Management authorizations are for 90 days and reauthorization is dependent on the mental health professionals determination of the impact of CBT on the member's depression and/or anxiety, improved ability to work/function, increased self-sufficiency or other clinically significant objective improvement.	**Frequency of review**: • PA is granted for different authorization periods depending on the service and can be adjusted. PAs for extensive services usually range from 6 months to 1 year. • Exceptions may be made at the discretion of the MMC, which is led by the HSD medical director.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
Reconsideration/RR: • A provider may request review of a denial decision, which occurs in weekly MMC meetings or Comagine's own comparable MMC meeting. • RR authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why authorization could not have been obtained within the 90 days. • OT, PT, ST are reviewed after the initial service prior to payment. Additionally, denial decisions can be requested and reviewed at weekly MMC meetings.	**Reconsideration/RR:** • NA	**RR conditions and timelines:** • RR allowed; no timeframe applied.	**RR conditions and timelines:** • RR allowed; no timeframe applied.	**Reconsideration/RR:** • A review of a denial decision can be requested and is reviewed in weekly MMC meetings. • RR authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why authorization could not have been obtained within the 90 days. • OT, PT, ST are reviewed after the initial service prior to payment. Additionally, denial decisions can be requested and reviewed at weekly MCM meetings.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
Methods to promote consistent application of criteria: • For ABA, a sample of cases are reviewed for ability to address assessed member needs and whether OARs were met.	**Methods to promote consistent application of criteria:** • DHS Quality Assurance Review teams review a representative sample of PCSPs as part of quality assurance and case review activities to assure that PCSPs meet program standards. • Additionally, OHA staff review a percentage of files to assure quality and compliance.	**Methods to promote consistent application of criteria:** • IRR conducted at least annually. • IRR goal is 80%.	**Methods to promote consistent application of criteria:** • IRR conducted at least annually. • IRR goal is 80%.	**Methods to promote consistent application of criteria:** • Nurses are trained on the application of the HERC guidelines, which is spot checked through ongoing supervision.
6. What standard supports the frequency or rigor with which the NQTL is applied?				
Evidence for UM frequency: • HERC guidelines (for ABA and OT, PT, ST) 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); 2) the literature is more robust.	**Evidence for UM frequency:** • Federal requirements regarding PCSPs and 1915(c), 1915(k), and 1915(j) services (e.g., 42 CFR 441.301, 441.468, and 441.540) and the applicable approved 1915(c) waiver application/State plan amendment.	**Evidence for UM frequency:** • ABA: HERC guideline 75. • ECT: HERC guideline 69. • Gender dysphoria: HERC guideline 127. • Eating disorders: MCG	**Evidence for UM frequency:** • HERC, InterQual, OARs and clinical judgment.	**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 diagnostic tests); and 2) the literature is more robust.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
• 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 one 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.				• 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 one 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 conduct an annual review to determine which services receive or retain a PA; items reviewed include: – Utilization – Approval/denial rates	**Data reviewed to determine UM application:** • N/A	**Data reviewed to determine UM application:** • MCG, CCO tracks number of denials and grievances, timeframe for addressing denials and grievances, number of appeals, and timeframe to address appeals, plus appeal and grievance outcomes.	**Data reviewed to determine UM application:** • Appeal/Grievance process; InterQual; Cost trends • Inter-rater reliability measures, denial rates. Appeal monitoring and rates. Results of hearings-members have hearing rights, which can alert plan to need to	**Data reviewed to determine UM application:** • A physician-led group of clinical professionals conduct an annual review to determine which services receive or retain a PA; items reviewed include: – Utilization – Approval/denial rates

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
– Documentation/justification of services – Cost data			review denials later overturned by judge.	– Documentation/justification of services – Cost data
IRR standard (OHA): • KEPRO has a formal policy including an 80% standard using InterQual criteria. **IRR standard (Comagine):** • Spot-checks performed through supervision. Formal policy to be developed. **IRR standard (Comagine Health):** • Spot-checks performed through supervision.	**IRR standard:** • Spot-checks performed through supervision.	**IRR standard:** • IRR conducted at least annually. • IRR goal is 80%.	**IRR standard:** • IRR conducted at least annually. • IRR goal is 80%.	**IRR standard (OHA):** • KEPRO has a formal policy including an 80% standard using InterQual criteria.
Analysis				
UM was applied to FFS MH/SUD and M/S HCBS benefits, and CCO MH/SUD and FFS M/S OP benefits listed in comparability and stringency Standard #1. For HCBS, MH/SUD benefits were administered by the Oregon Department of Human Services (DHS) and OHA's subcontractor, Comagine Health, while HCBS M/S benefits were administered by DHS. Pursuant to the 2020 CCO 2.0 Health Care Services Contract, the CCO did not require PA for MH/SUD benefits with the exception of more intensive care benefits such as ABA and psychiatric day treatment. HSAG's analysis of CPCCO's PA data for IP and OP benefits did not reveal any concerns related to MHP due to low denial rates of MH/SUD requests. Of the total 6,360 IP and OP PA requests reported, 8.29 percent were denied. Of the 11 MH/SUD PA requests denied, representing 2.79 percent of the 394 MH/SUD PA requests, none were appealed. The majority of the MH/SUD PA request denials were requests for inpatient benefits, all denied for a "benefit exclusion" categorical reason.				

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
Comparability UM of MH/SUD and M/S HCBS benefits was required to meet federal HCBS requirements regarding PCSPs, providing benefits in the least restrictive environment, and applicable waiver applications/State plan amendments. Evidence for the application of UM to these benefits included federal requirements regarding PCSPs for 1915(c), 1915(i), 1915(k), and 1915(j) services and applicable approved waiver applications/State plan amendments. UM was applied to non-HCBS CCO MH/SUD, and M/S OP services were assigned UM to confirm coverage relative to the HERC PL and guidelines, State and federal requirements, and national guidelines. Non-HCBS MH/SUD services were also reviewed to ensure services were medically necessary relative to clinical 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 were also assigned UM to assure the individual's safety. Evidence for safety issues included HERC guidelines and MCG. HSAG determined the rationale and evidence to be comparable. CPCCO and OHP FFS made authorization decisions within 24 hours for emergencies, 72 hours for urgent requests, and 14 days for standard requests. Providers were encouraged to submit requests for authorization sufficiently in advance to be consistent with OAR time frames. Most CCO documentation requirements for MH/SUD included an admission note and records submitted via a provider Web portal, EHR, fax, or USPS. **Stringency** The PCSP for both MH/SUD and M/S was based on an assessment and other relevant supporting documentation and developed by the member, the member's team, and the member's case manager. MH/SUD and M/S DHS reviewers were required to have a BA in a related field; a BA in any field plus one year of experience; an AA with two years' experience; or three years' experience. The CCO and Comagine required all MH/SUD and M/S denials to be made by physicians or professional peers; however, nurses could deny M/S benefits managed by OHP FFS. HSAG determined this difference to be an issue of quality rather than a parity concern. HSAG determined that the MH/SUD PA review time frames, documentation requirements, and qualification of reviewers were comparable to those applied to M/S benefits. Both the CCO and OHA allowed RR for MH/SUD and M/S when providers failed to obtain authorization. CPCCO did not have a time frame for RR for IP MH/SUD or M/S PA requests, which HSAG determined was less stringent than OHP FFS's 90-day time frame applied to M/S requests. MH/SUD and M/S denial decisions could be appealed through appeals and/or State fair hearing processes. Failure to obtain authorization could result in noncoverage. Regarding IRR, the CCO was conducting reviews at least annually, applying an 80 percent testing standard, which was consistent with OHP FFS IRR processes and standards.				
Outcome				
HSAG's analysis determined that the rationale, documentation requirements, processes, and frequency of UM applied to OP MH/SUD benefits were comparable to and no more stringently applied to OP M/S benefits.				

Category III—Prior Authorization for Prescription Drug Limits

NQTL: PA for Prescription Drugs

Benefit Package: CCOA and CCOB for adults and children

Classification: Prescription Drugs

Overview: PA is required for certain MH/SUD and M/S prescription drugs, and OHA requires PA of certain MH carve-out drugs. HSAG reviewed the reasons why CCOs and OHP FFS apply PA criteria to certain MH/SUD and M/S prescription drugs, the evidence used to establish PA criteria, and the processes used by the CCOs and OHP FFS to develop and apply PA criteria. HSAG analyzed CPCCO's application of PA for prescription drug benefits based on comparability and stringency standard information provided below.

CCO MH/SUD	FFS MH Carve Out	CCO M/S
1. To which benefit is the NQTL assigned?		
• A, F, P, S drug groups	• A and F drug groups • MH carve out drugs do not have an enforceable preferred drug list. • While certain higher cost-effect agents are listed as "preferred," this is not enforced by PA.	• A, F, P, S drug groups
2. Why is the NQTL assigned to these benefits?		
• Prior authorization is applied to prescription drugs to promote appropriate and safe treatment of funded conditions and to encourage use of preferred agents.	• To promote appropriate and safe treatment of funded conditions.	• Prior authorization is applied to prescription drugs to promote appropriate and safe treatment of funded conditions and to encourage use of preferred agents.

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• Prior authorization is applied to prescription drugs due to cost trends far outpacing revenue and/or other medical cost trends.		• Prior authorization is applied to prescription drugs due to cost trends far outpacing revenue and/or other medical cost trends.
3. What evidence supports the rationale for the assignment?		
• Evidence for applying PA criteria to a drug includes: – FDA prescribing guidelines – Medical literature – Best practices – Professional guidelines – CMS accepted compendia – (Micromedex)	• 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.	• Evidence for applying PA criteria to a drug includes: – FDA prescribing guidelines – Medical literature – Best practices – Professional guidelines – CMS accepted compendia – (Micromedex)
4. What are the NQTL procedures?		
• PA requests can be mailed or faxed • (more typical) to the Pharmacy Call Center. • The standard PA form is one page long. Most PA criteria require 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 a rejected claim/no payment.	• 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.	• PA requests can be mailed or faxed • (more typical) to the Pharmacy Call Center. • The standard PA form is one page long. Most PA criteria require 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 a rejected claim/no payment.

CCO MH/SUD	FFS MH Carve Out	CCO M/S
	• Failure to obtain PA in combination with an absence of medical necessity results in no provider reimbursement. • Notice of Benefit Determination sent to both Recipient and Provider. - Denials letters include information on required criteria, denial reasons, and how the provider can appeal and member hearing rights.	
5. How frequently or strictly is the NQTL applied?		
• Typically, the frequency range is six months to a year, depending on medical appropriateness and safety, as recommended by the P&T Committee. • Approximately 48% of MH/SUD drugs are subject to PA criteria for clinical reasons. • Providers can appeal denials on behalf of a member, and members have appeal and fair hearing rights. • The CCO assesses stringency through review of PA denial/approval and appeal rates.	• The State approves PAs for up to 12 months, depending on medical appropriateness and safety, as recommended by the P&T Committee. • Approximately 19% of MH/SUD drugs are subject to PA criteria for clinical reasons. • 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. • There were 10 client fair hearing requests for denied MH/SUD medications. None were reversed after agency reconsideration or, and none were reversed by hearing. • The State assesses stringency through review of PA denial/approval and appeal rates; number of drugs requiring PA;	• Typically, the frequency range is six months to a year, depending on medical appropriateness and safety, as recommended by the P&T Committee. • Approximately 28% of M/S drugs are subject to PA criteria for clinical reasons. • Providers can appeal denials on behalf of a member, and members have appeal and fair hearing rights. • The CCO assesses stringency through review of PA denial/approval and appeal rates.

CCO MH/SUD	FFS MH Carve Out	CCO M/S
	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.	
6. What standard supports the frequency or rigor with which the NQTL is applied?		
• Evidence for applying PA criteria to a drug includes: – FDA prescribing guidelines – Medical literature – Best practices – Professional guidelines – CMS accepted compendia – (Micromedex)	• 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.	• Evidence for applying PA criteria to a drug includes: – FDA prescribing guidelines – Medical literature – Best practices – Professional guidelines – CMS accepted compendia – (Micromedex)
Analysis		
CPCCO applied PA criteria to MH/SUD and M/S prescription drug benefits and applied PA to certain MH/SUD and M/S drugs to promote appropriate and safe treatment, and cost-effective use of prescription drugs. Since 2018, the CCO made changes to its prescription drug authorization requirements that either added, removed, or adjusted PA criteria to prescription drugs. Prescription drug PA processes were consistent across all benefit packages (CCOA, CCOB, CCOE, and CCOG). HSAG's analysis of CPCCO's counts for prescription drug PA requests identified a high denial rate, which resulted in an inconclusive finding for the CCO in that parity, in operation, could not be determined. Of the total 1,002 prescription drug PA requests reported, 73.45 percent were denied. Less than 1 percent of the 736 prescription drug PA request denials were appealed, with only two PA denials resulting in an overturned decision. The prescription drug PA request denials were primarily due to a "not covered" categorical reason. **Comparability** PA was applied to certain MH FFS carve-out drugs to promote appropriate and safe treatment. Evidence used by the CCO and OHA to determine which MH/SUD and M/S drugs are subject to PA included Food and Drug Administration (FDA) prescribing guidelines, medical evidence, best		

CCO MH/SUD	FFS MH Carve Out	CCO M/S
practices, professional guidelines, and Pharmacy and Therapeutic (P&T) Committee review and recommendations. The PA criteria for both MH/SUD and M/S drugs were developed by pharmacists in consultation with the P&T Committee. PA requests for both MH/SUD and M/S drugs could be submitted by fax, phone, or online. **Stringency** For both MH/SUD and M/S drugs, most PA criteria required clinical documentation such as chart notes. Failure to obtain PA for MH/SUD and M/S drugs subject to PA in combination with an absence of medical necessity resulted in no reimbursement for the drug. Decisions were responded to within 24 hours, with decisions being made within 72 hours. For both MH/SUD and M/S drugs, the length of authorizations was dependent on medical appropriateness and safety, as recommended by the P&T Committee, based on clinical evidence such as FDA prescribing guidelines, best practices, and clinical practice guidelines. Both the CCO and OHA allowed exceptions to the formulary and preferred drug list based on medical necessity. For carve-out drugs covered by OHA, the CCO stated that it works with pharmacies and providers to redirect PA requests and claims to OHA. While CPCCO's high denial rate did not result in a parity concern due to the inability to separately analyze prescription drugs by benefit type, the CCO must evaluate PA request denials to determine whether barriers or opportunities for improvement exist in the CCO's UM process or formulary. High denial rates for prescription drugs should be reviewed and can be due to a variety of reasons such as exclusions, medical necessity criteria, and dosage limits.		
Outcome		
HSAG determined CPCCO's processes, strategies, and evidentiary standards for PA of MH/SUD prescription drugs to be comparable and no more stringently applied, in writing and in operation, to M/S prescription drugs, with the exception of the following finding: **Inconclusive Finding #1:** Although not a parity concern due to the inability to separately analyze prescription drugs by benefit type, CPCCO's reported data revealed a high denial rate (73.45 percent) for prescription drug PA requests. This resulted in an inconclusive finding, in operation. **Required Action:** CPCCO must evaluate PA request denials by benefit type to determine whether there are parity concerns or whether barriers or opportunities for improvement exist in the CCO's UM process or formulary.		

Category IV—Provider Admission—Closed Network

NQTL: Provider Admission

Benefit Package: CCOA, CCOB, CCOE, and CCOG for adults and children

Classification: IP and OP

Overview: CCOs require providers of MH/SUD and M/S services to successfully meet credentialing and recredentialing requirements in order to be admitted to and continue to participate in the CCO's network. HSAG analyzed CPCCO's provider admission processes based on comparability and stringency standard information related to network closures provided below. Since Medicaid provider enrollment for OHP FFS did not include a provider credentialing component, HSAG deemed provider admission processes not applicable for OHP FFS and did not include that classification in the provider admission analysis.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
1. To which benefit is the NQTL assigned?			
• CCO may close its network for new MH/SUD providers of inpatient services. • CCO may close its network for new MH/SUD providers of outpatient services.	• The State does not restrict new providers of inpatient or outpatient MH/SUD services from enrollment.	• CCO may close its network for new M/S providers of inpatient services. • CCO may close its network for new M/S providers of outpatient services.	• The State does not restrict new providers of inpatient or outpatient MH/SUD services from enrollment.
2. Why is the NQTL assigned to these benefits?			
• CCO closes its network to additional MH/SUD providers when it determines there is no need for additional providers. • When CCO closes its network to new providers, it is done to enhance efficiency, promote	• N/A	• CCO closes its network to additional M/S providers when it determines there is no need for additional providers. • When CCO closes its network to new providers, it is done to enhance efficiency, promote	• N/A

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
efficient provider monitoring, and improve provider relations.		efficient provider monitoring, and improve provider relations.	
3. What evidence supports the rationale for the assignment?			
• 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. What are the NQTL procedures?			
• Providers that are denied admission into the network due to network closure may not be able to participate as an in-network provider and receive in-network rates.	• N/A	• Providers that are denied admission into the network due to network closure may not be able to participate as an in-network provider and receive in-network rates.	• N/A

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Provider requests for network inclusion are reviewed for need based on current provider network. Provider requests for network inclusion are tracked and assessed annually. In operation, to date, the CCO has not closed the network to new providers of MH/SUD services; however, the CCO at a policy level has the tools to do so. • CCO considers: capacity reports, access complaints, time to appointments, inpatient rates, complaints and grievances, internal reports on unmet needs, number of requests for OON, membership profile (cultural, racial, ethnic, linguistic, and demographic makeup), and any other data that indicate a need in making the determination to close the network. • CCO evaluates need for providers to support decisions to close the network. Provider need is determined by evaluating network adequacy using both OHA and CMS time and distance standards and evaluating access through		• Provider Relations tracks open and closed specialties using a spreadsheet. When certain specialties or provider types are closed, requests to join the CCO's network are declined. The spreadsheet is maintained and updated periodically, and available to all PR staff who might field requests for inclusion in the panel. • CCO evaluates need for providers to support decisions to close the network. Provider need is determined by evaluating network adequacy using both OHA and CMS time and distance standards and evaluating access through review of member grievances and complaints, requests for OON providers, member demographics and PCP capacity reporting. • Providers that are denied the opportunity to participate in CCO's network may appeal the CCO's decision. • Exceptions might occur when an OP provider in a specialty	

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
review of member grievances and complaints, requests for OON providers, member demographics and PCP capacity reporting. • Network decisions made by CareOregon Behavioral Health Network, Quality and Compliance Committee. • Providers that are denied the opportunity to participate in CCO's network may appeal the CCO's decision. • Exceptions are made for providers who demonstrate specialized services that fill a need.		not otherwise needed joins the large IPA in the region.	
5. How frequently or strictly is the NQTL applied?			
• When the CCO decides to close the network to particular specialties/provider types, all new providers applying for those particular • specialties/provider types are subject to this NQTL.	• N/A	• When the CCO decides to close the network to particular specialties/provider types, all new providers applying for those particular • specialties/provider types are subject to this NQTL.	• N/A
6. What standard supports the frequency or rigor with which the NQTL is applied?			
• The CCO reviews the following data/information at least annually to determine how	• N/A	• The CCO reviews the following data/information to determine how strictly to apply the	• N/A

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
strictly to apply the criteria/considerations to close the CCO network to new providers: – Capacity reports. – Access complaints. – Time to appointments. – Inpatient rates. – Complaints and grievances. – Internal reports on unmet needs. – Number of requests for OON. – Membership profile (cultural, racial, ethnic, linguistic, demographic makeup). – Other data that indicate a need.		criteria/considerations to close the CCO network to new providers: – Capacity reports. – Access complaints. – Time to appointments. – Inpatient rates. – Complaints and grievances. – Multiple SCA requests from a single provider. – Membership profile. – Other data that indicate a need.	
Analysis			
CPCCO may close its network to providers of MH/SUD and M/S services when the CCO determines there is no community need for new providers to meet service capacity and access standards. Developing a network based on network adequacy and sufficiency standards is supported by federal regulation, including the ability of an MCO (CCO) to limit contracting beyond the needs of its members 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. In addition, 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 §438.12. Accordingly, parity was not analyzed. **Comparability** Closure of the CCO's network to new MH/SUD and M/S providers would be enacted 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. The CCO evaluated the need for providers to support decisions to close the network. Provider need was determined by evaluating network			

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
adequacy using both OHA and CMS time and distance standards and evaluating access through review of member grievances and complaints, requests for OON providers, member demographics, and PCP capacity reporting. Network decisions were made by CareOregon Behavioral Health Network, Quality and Compliance Committee. Based on HSAG's analysis, the CCO's strategy and evidence for closing the network to OP providers when the CCO determines that it has met network adequacy and sufficiency standards were comparable for providers of MH/SUD and M/S services. **Stringency** When the CCO closes its network to particular specialties/provider types, all new MH/SUD and M/S providers applying for those particular specialties/provider types would be subject to the NQTL. The CCO reported that it was unknown exactly how many providers were impacted by the CCO's decision to close all or part of its network to new providers in the last contract year as denied requests were not formally tracked, which HSAG determined to be a question of stringency applied to network closure operations. The CCO monitored metrics related to decisions to close the network across MH/SUD and M/S, reviewing information such as capacity reports, access complaints, time to appointments, inpatient rates, complaints and grievances, number of requests for OON services/SCAs, and the overall existing membership profile (cultural, racial, ethnic, linguistic, demographic makeup). Additionally, other MH/SUD data reviewed include internal reports on unmet needs. Based on this information, the strategies and evidentiary standards for network closure were comparable and no more stringently applied to MH/SUD providers than to M/S providers.			
Outcome			
HSAG's analysis of CPCCOCPCCO's reported information resulted in the determination that the CCO's network closure processes and decisions for MH/SUD providers were comparable to that applied to M/S providers. However, the inability of the CCO to provide information on how many providers were impacted by the CCO's decision to close all or part of its network to new providers in the last contract year was a parity concern that was inconclusive as to the impact of the stringency applied to network closures, in operation, as documented in the following finding: **Inconclusive Finding #2:** While CPCCO documented and described comparable processes and evidentiary standards for decisions to close its network to MH/SUD and M/S providers, the CCO was unable to provide information on how many providers were impacted by the CCO's decision to close all or part of its network to new providers in the last contract year as denied requests were not formally tracked. This resulted in an inconclusive finding. **Required Action:** CPCCO must develop a mechanism to document and track network closures for MH/SUD and M/S providers to determine whether parity concerns exist in operation.			

Category V—Provider Admission—Network Credentialing

NQTL: Provider Admission

Benefit Package: CCOA, CCOB, CCOE, and CCOG for adults and children

Classification: IP and OP

Overview: CCOs require providers of MH/SUD and M/S services to successfully meet credentialing and recredentialing requirements in order to be admitted to and continue to participate in the CCO's network. HSAG analyzed CPCCO's provider admission processes based on comparability and stringency standard information related to credentialing and recredentialing provided below. Since Medicaid provider enrollment for OHP FFS did not include a provider credentialing component, HSAG deemed provider admission processes not applicable for OHP FFS and did not include that classification in the provider admission analysis.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
1. To which benefit is the NQTL assigned?			
• 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. Why is the NQTL assigned to these benefits?			
• CCO applies credentialing and re-credentialing requirements to: – Meet State and Federal requirements	• 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	• CCO applies credentialing and re-credentialing requirements to: – Meet State and Federal requirements	• 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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
– Ensure capabilities of provider to deliver high quality of care – Ensure provider meets minimum competency standards – Ensure members receive safe, medically necessary care	safety and to reduce Medicaid provider fraud, waste, and abuse.	– Ensure capabilities of provider to deliver high quality of care – Ensure provider meets minimum competency standards – Ensure members receive safe, medically necessary care	safety and to reduce Medicaid provider fraud, waste, and abuse.
3. What evidence supports the rationale for the assignment?			
• Credentialing/ re-credentialing requirements are supported by the following evidence: – State law and Federal regulations, including 42 CFR 438.214 – State contract requirements – Accreditation guidelines (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 supported by the following evidence: – State law and Federal regulations, including 42 CFR 438.214 – State contract requirements – Accreditation guidelines (NCQA)	• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E-Provider Screening and Enrollment.
4. What are the NQTL procedures?			
• All providers must meet credentialing and re-credentialing requirements. • Providers must complete and provide the following documentation: Oregon Practitioner Credentialing	• All providers are eligible to enroll as a provider and receive reimbursement provided they meet all relevant Federal and State licensing and other rules and are not on an exclusionary list. Providers must complete	• All providers must meet credentialing and re-credentialing requirements. • Providers must complete and provide the uniform Oregon Practitioner Credentialing and Re-credentialing application, an	• 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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Application (20 pages), admission plan, a copy of their professional license, verification of Drug Enforcement Administration or pending registration (physicians and non-physician practitioners with prescribing ability in Oregon only), verification of Controlled Dangerous Substance certificate registration (physicians and non-physician practitioners with prescribing ability in Oregon only), verification of the highest level of education and training, verification of Board certification for physicians or verification of successful completion of residency for physicians who are not Board certified, verification of Board certification for non-physicians, verification of at least five years of work history in the field (work experience is not required for network admission, but requested), review of professional liability claims history, review of any sanctions/restrictions/or limitations on professional	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 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	Admission plan, S&R policy, whether or not they perform deliveries, a copy of their professional license, verification of Drug Enforcement Administration or pending registration (physicians and non-physician practitioners with prescribing ability in Oregon only), verification of the highest level of education and training, verification of Board certification for physicians or verification of successful completion of residency for physicians who are not Board certified, verification of Board certification for non-physicians, review of professional liability claims history, review of any sanctions/restrictions/or limitations on professional license, verification of professional liability insurance coverage, attestation of good standing with clinical privileges in primary facility. • Providers may submit supporting documentation by	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 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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
license, verification of professional liability insurance coverage, attestation of good standing with clinical privileges in primary facility. • Providers may submit supporting documentation by fax, email, USPS, courier and/or in person. • CCO's credentialing process involves staff review of required information, the submission of complete package to Credentialing Committee for final decision to deny or approve. • CCO's Accreditation Manager is responsible for reviewing required information and the Credentialing Committee for making provider credentialing decisions. • CCO performs re-credentialing at a minimum of every three years. • Providers who do not meet credentialing/re-credentialing cannot contract with the CCO, cannot participate in network	reviewing information and making provider enrollment decisions	email, mail, fax, courier, hand delivery • CCO's requires that the credentialing process may not exceed 90 days upon receipt of all information from applicant. • CCO's credentialing process involves staff review, Medical Director review and Credentialing Committee review. • CCO's Credentialing Committee is responsible for reviewing required information and Network and Quality Committee of the Board of Directors is responsible making ultimate provider credentialing decisions. • CCO performs re-credentialing every three years at minimum. • Providers who do not meet credentialing/re-credentialing cannot contract with the CCO, cannot participate in network and do not receive the CCO's contracted rate, which is typically more than what is paid to an OON provider (DMAP fee schedule).	reviewing information and making provider enrollment decisions

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
and do not receive the CCO's contracted rate. • Providers who are adversely affected by credentialing or re-credentialing decisions may challenge the decision by requesting a hearing with the credentialing committee, being present at the hearing, be represented by an attorney or another person of her or his choice, call, examine and cross-examine witnesses, present relevant information, submit a written statement at the close of the hearing.		• Providers who are adversely affected by credentialing or re-credentialing decisions may challenge the decision through a fair hearing process.	
5. How frequently or strictly is the NQTL applied?			
• All providers/provider types must be credentialed. • There are no exceptions to meeting these requirements for admission into the CCO's network; however a provider may deliver services and be paid DMAP rates as an OON provider.	• 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 must be credentialed. • There are no exceptions to meeting these requirements for admission into the CCO's network; however, if any individual provider wishes to be OON, they do not have to be credentialed. They can deliver services and be paid DMAP rates	• 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
6. What standard supports the frequency or rigor with which the NQTL is applied?			
• 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 Exhibit B Part 4 (3)(b) – National accreditation standards (NCQA) • CCO monitors the following data/information to determine how strictly to apply credentialing/re-credentialing criteria: – Denial/Termination rates for providers as a result of credentialing/re-credentialing reviews. – Provider appeals/disputes. – Network adequacy data, such as access to care, provider specialties.	• 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) • CCO monitors the following data/information to determine how strictly to apply credentialing/re-credentialing criteria: – Denial/Termination rates for providers as a result of credentialing/re-credentialing reviews. – Provider appeals/disputes. – Network adequacy data, such as access to care, provider specialties.	• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E Provider Screening and Enrollment. The frequency with which the State re-enrolls providers is based on State law and Federal regulations.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Analysis			

All IP and OP providers of MH/SUD and M/S services were subject to CCO credentialing and recredentialing requirements. CPCCO conducted credentialing and recredentialing for both providers of MH/SUD and M/S services to meet State and federal requirements, ensure providers are capable of delivering high-quality care, and ensure providers meet minimum competency standards. The CCO's parent company, CareOregon, was responsible for credentialing and recredentialing MH/SUD and M/S providers. The CCO's processes were the same across all benefit packages (CCOA, CCOB, CCOE, and CCOG).

HSAG's analysis of CPCCO's provider credentialing data did not reveal any parity concerns due to low denial rates for both MH/SUD and M/S providers seeking credentialing during the reporting period. CPCCO shared the same network of providers with JCC, which was equally managed by CareOregon as its parent company. Of the 13,292 reported average number of providers credentialed during the reporting period, 7.36 percent were MH/SUD providers. There were no reported denials for any MH/SUD providers seeking credentialing during the reporting period.

Comparability

CPCCO requires providers of MH/SUD and M/S services to successfully meet credentialing and recredentialing requirements in order to be admitted to and continue to participate in the CCO's network. Providers were required to complete and submit a credentialing application and provide supporting documentation as part of the credentialing process. Both MH/SUD and M/S providers had several methods of submitting their application and supporting documentation, including by fax, by mail, or electronically. Nonlicensed MH care providers (e.g., qualified mental health providers/assistants and traditional health care works) were reviewed according to qualifications and certifications related to specific provider type and checked for exclusion.

The CCO's credentialing process for MH/SUD providers included 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 six months. The process for M/S providers involved a similar review of each application to determine whether standards are met.

Stringency

The credentialing process for both MH/SUD and M/S providers averaged 60 days depending on the completeness of the application and timeliness of primary source verification documents. The CCO's credentialing committee was responsible for reviewing required information and making provider credentialing decisions for both MH/SUD and M/S providers. Recredentialing for both MH/SUD and M/S providers was conducted every three years, or as needed based on self-disclosure of certain kinds of incidents or background checks. Failure for MH/SUD and M/S providers to meet credentialing and recredentialing requirements resulted in exclusion from the CCO's network. MH/SUD and M/S providers who are adversely affected by credentialing or recredentialing decisions may challenge the decision through an appeal process. The CCO monitored similar metrics

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
related to applying credentialing and recredentialing requirements for MH/SUD and M/S providers, including reviewing denial/termination provider rates resulting from credentialing/recredentialing reviews, provider appeals/disputes, and network adequacy data (access to care and provider specialties).			
Outcome			
HSAG's analysis found CPCCO's credentialing processes and data for MH/SUD providers to be comparable and no more stringently applied to, in writing and in operation, than those for M/S providers.			

Category VI—Out-of-Network/Out-of-State Limits

NQTL: OON and OOS limits

Benefit Package: CCOA, CCOB, CCOE, and CCOG for adults and children

Classification: IP and OP

Overview: OON/OOS services were required to provide coverage for needed MH/SUD and M/S benefits when they were not available INN or in-state. Similarly, for MH/SUD FFS benefits, OHP FFS provided OOS coverage to provide needed benefits when they were not available in-state. HSAG analyzed CPCCO's application of limits applied to OON/OOS limits based on comparability and stringency standard information provided below.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
1. To which benefit is the NQTL assigned?			
• Out of Network (OON) and Out of State (OOS) Benefits	• OOS Benefits	• Out of Network (OON) and Out of State (OOS) Benefits	• OOS Benefits
2. Why is the NQTL assigned to these benefits?			
• To ensure that members have access to appropriate quality care. • The purpose of providing OOS coverage is to provide needed services when they are not available in-State.	• The State seeks to maximize use of in-State providers because the State has determined that they meet applicable requirements, and they have a provider agreement with the State, which includes agreement to comply with Oregon Medicaid requirements and accept DMAP rates. • The purpose of providing OOS coverage is to provide needed	• To ensure that members have access to appropriate quality care. • The purpose of providing OOS coverage is to provide needed services when they are not available in-State. • The purpose of prior authorizing non-emergency OOS benefits is to determine the medical necessity of the requested benefit and the	• 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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	services when the service is not available in the State of Oregon or the client is OOS and requires covered services. • The purpose of PA for non-emergency OOS services is to ensure the criteria in OAR 410-120-1180 are met.	availability of an in-State provider.	services when the service is not available in the State of Oregon or the client is OOS and requires covered services. • The purpose of PA for non-emergency OOS services is to ensure the criteria in OAR 410-120-1180 are met.
3. What evidence supports the rationale for the assignment?			
• 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 OARs.	• 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 OARs.
4. What are the NQTL procedures?			
• A member has the right to request care from an OON/OOS provider. • CCO has an open network so any service delivered by OON Medicaid providers is treated identically to network providers from a coverage standpoint. In other words, if the benefit is covered and properly delivered, billed and authorized, the provider will be paid for those services at the DMAP rate.	• 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 through the State PA process. • The timeframe for approving or denying a non-emergency OOS	• A member has the right to request care from an OON/OOS provider. • CCO has an open network so any service delivered by in-State OON Medicaid providers is treated identically to network providers from a coverage standpoint. In other words, if the benefit is covered and properly delivered, billed and authorized, the provider will be paid for those services at the DMAP rate.	• 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 through the State PA process. • The timeframe for approving or denying a non-emergency OOS

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• No PA is required for a member to seek services from an OON/OOS provider. However, in order to pay the claims, the CCO will require (if this information is not already in CCO possession) verification that the OON/OOS provider does not have any sanctions against license, is not excluded from participation in Medicaid, has a current DMAP number, and is willing to accept Medicaid FFS rates. • The CCO establishes a single case agreement (SCA) with an OON/OOS provider if the provider will not accept DMAP rates. • The CCO's process for establishing a SCA includes contacting the OON/OOS provider to collect information and negotiating the terms of the SCA. • SCAs can be established within 24 hours of request. • The CCO pays OON/OOS providers the Medicaid FFS rate or a negotiated rate.	request is the same as for other PAs (14 days for standard and three business days for urgent). • OOS providers must enroll with Oregon Medicaid. • The State pays OOS providers the Medicaid FFS rate.	• No PA is required for a member to seek services from an OON provider. However, in order to pay the claims, the CCO will require (if this information is not already in CCO possession) verification that the OON provider does not have any sanctions against license, is not excluded from participation in Medicaid, has a current DMAP number, and is willing to accept Medicaid FFS rates. • For most services, OOS providers are not covered unless they are contracted as part of a contiguous network area close to service area borders. • Non-emergency OOS services by non-contracted providers (OOS services) are not covered unless medically necessary services are not available in-State. • Requests for non-emergency OOS services are made through the prior authorization process. • The timeframe for approving or denying a non-emergency OOS request is the same as for other	request is the same as for other PAs (14 days for standard and three business days for urgent). • OOS providers must enroll with Oregon Medicaid. • The State pays OOS providers the Medicaid FFS rate.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
		prior authorizations (14 days for standard requests). • The CCO establishes a single case agreement (SCA) with an OON/OOS provider if the provider will not accept DMAP rates. • The CCO's process for establishing a SCA includes contacting the OON/OOS provider to collect information and negotiating the terms of the SCA. • The average length of time to negotiate a SCA is 2–3 days. • The rate the CCO pays OON/OOS providers includes the Medicaid FFS rate, a percentage of the Medicaid FFS rate, and a negotiated rate.	
5. How frequently or strictly is the NQTL applied?			
• If a non-emergency OON/OOS benefit is not medically necessary or is delivered by a provider not-qualified to provide Medicaid services in Oregon, the service will not be covered and payment for the service will be denied.	• If a request for a non-emergency OOS benefit does not meet the OAR criteria, it will not be authorized. • If a non-emergency OOS benefit is not authorized, the service will not be covered, and	• If a request for a non-emergency OOS benefit does not meet the CCO's OOS criteria (service is medically necessary and not available in-State), it will not be prior authorized. • If a non-emergency OOS benefit is not prior authorized,	• If a request for a non-emergency OOS benefit does not meet the OAR criteria, it will not be authorized. • If a non-emergency OOS benefit is not authorized, the service will not be covered, and

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• OON/OOS providers may appeal the denial of payment for an OON/OOS service. • The CCO evaluates the number of SCAs twice a year, the types of referrals made, whether they were initiated by the CCO or in-network provider, outcomes of care, complaints/grievances, notices of action, and whether an OON/OOS provider should be a network provider.	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.	the service will not be covered, and payment for the service will be denied. • Members/providers may appeal the denial of an OOS request or non-payment of an OON/OOS claim. • The CCO evaluates the number of SCAs on an ad hoc basis to determine whether the network should be expanded or a particular OON/OOS should be recruited to be a network provider.	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.
6. What standard supports the frequency or rigor with which the NQTL is applied?			
• Federal and State requirements, including OAR and the CCO contract.	• The State covers OOS benefits in accordance with OAR.	• Federal and State requirements, including OAR and the CCO contract.	• The State covers OOS benefits in accordance with OAR.
Analysis			
CPCCO ensured OON/OOS coverage to provide needed MH/SUD and M/S benefits when they were not available INN or in-state. Similarly, for MH/SUD FFS benefits, the State provided OOS coverage to provide needed benefits when they were not available in-state. The same PA processes and evidentiary standards described in NQTL categories I, II, and III were applied to OOS coverage of MH/SUD and M/S benefits across all benefit packages (CCOA, CCOB, CCOE, and CCOG). CPCCO established SCAs with OON providers in the absence of INN providers to ensure the provision of appropriate quality care for members, while OHP FFS ensured OON providers were enrolled with Medicaid. **Comparability** For both nonemergency 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 INN/in-state providers are available to provide the benefit. The same PA processes and evidentiary standards described in NQTL categories I, II, and III were applied to OOS coverage of MH/SUD and M/S requests. For OON			

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
coverage requests, the CCO would determine if an INN provider was available or work with the OON provider to establish a SCA with payment of applicable Medicaid FFS rates. This process was applied equitably to both MH/SUD and M/S providers across all benefit packages. **Stringency** Requests for nonemergency OON/OOS CCO MH/SUD and M/S benefits were made through the CCO's PA process and reviewed for medical necessity and INN/in-state coverage. The PA time frames (14 days for standard requests and 72 hours for urgent requests) applied. Similarly, the State reviewed requests for nonemergency OOS MH/SUD services through its PA process, adhering to its PA time frames identified at 14 days for standard requests and 72 hours for urgent requests. The CCO described a process for handling a complex OON/OOS MH/SUD member case, identifying how it would appropriately apply the PA and SCA process to ensure benefits were provided in relation to the member's needs. CPCCO also provided an SCA template for review that identified compliant agreement information and confirmed the CCO's processes related to its use of OON providers. For both MH/SUD and M/S benefits, CPCCO and OHP FFS would not authorize payment for services denied.			
Outcome			
HSAG determined CPCCO's processes, strategies, and evidentiary standards for OON/OOS limits applied to MH/SUD to be comparable and no more stringently applied, in writing and in operation, to M/S OON/OOS limits across all benefit packages.			

Appendix C. Improvement Plan Template

Columbia Pacific CCO, LLC MHP Improvement Plan					
Year	**Finding #**	**Report Reference**	**Finding**	**Required Action**	
2020	1	Page. #			
CCO Intervention/Action Plan				**Individual(s) Responsible**	**Proposed Completion Date**
HSAG Assessment of CCO Intervention/Action					
CCO Post-Implementation Status Update					
Documentation Submitted as Evidence of Implemented Intervention/Action					
HSAG Assessment of Intervention/Action Implementation					