HEALTH WEALTH CAREER

COLUMBIA PACIFIC CCO (COLUMBIA)

NQTL ANALYSIS

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INTRODUCTION

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

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

OHA analyzed the following four NQTLs for each CCO:

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

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

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

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

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

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

INPATIENT UTILIZATION MANAGEMENT

NQTL: Utilization Management (PA, CR, Retrospective Review)
Benefit Package: A, B, E, and G for Adults and Children
Classification: Inpatient (IP)
CCO: Columbia

Benefit package A and B: MH/SUD benefits in columns 1 (CCO MH/SUD) and 2 (FFS MH/SUD) compared using strategies1-4 to M/S benefits in column 3 (CCO M/S). These benefit packages include MH/SUD IP benefits managed by the CCO (by GOBHI), OHA, HIA and KEPRO, compared to M/S IP benefits in column 3 managed by the CCO (by CareOregon).

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

1. To which benefits is the NQTL assigned?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• (1, 2, 3, 4) PA and CR are required for planned non-emergency admissions to acute IP (in and out-of-network (OON)), PRTS, subacute). • (1, 2, 3, 4) Emergency and urgent admissions require notification within 24-72 hours of admission. • (1, 4) Extra-contractual and experimental/investigational/ unproven benefit requests (i.e., exceptions) are	• (1, 4) PA (only) for MH/SUD procedures performed in a medical facility (e.g., gender reassignment surgery authorizations for benefit packages E and G), experimental/investigational, and extra-contractual benefits are conducted by OHA consistent with the information in column 4 for benefit packages E and G. • (2, 4, 5) A level-of-care review is required for SCIP, SAIP and subacute care that is conducted by an OHA	• (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 48 hours of admission and subsequent CR. • (1, 2, 3, 4) Skilled nursing facility benefits (first 20 days) require PA.	• (1, 2, 4) PA and CR are required for in-state and OOS planned surgical procedures (including transplants) and associated imaging, rehabilitation and professional surgical services delivered in an IP setting and listed in OAR 410-130-0200, Table 130-0200-1; rehabilitation, and long term acute care (LTAC). (Notification is required for all IP admissions.) • (1, 2, 4) PA, CR and RR for Behavior Rehabilitation

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• (1) These processes are meant to eliminate or reduce	• (1) UM is assigned to ensure medical necessity of	• (1) These processes are meant to eliminate or reduce	• (1) PA and CR are assigned to prevent overutilization

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
overutilization of higher levels of care through medical necessity and HERC[1] 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.	services/prevent overutilization of these high cost services. • (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual (e.g., matching the level of need to the least restrictive setting using the LOCUS – Level-of-care Utilization System and LSI – Level of Service Inventory). • (4) To comply with federal and State requirements. • (5) Most MH residential services were excluded from the capitated arrangements with the CCOs due to the high cost and unpredictability of services and associated risk.	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.	(e.g., requests for care that are not medically necessary in violation of relevant OARs, the Health Evidence Review Commission (HERC) PL and guidelines). • (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. • (4) To comply with federal and State requirements.

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• (1-4) HERC PL and guidelines. • (1) UM and claims reports are reviewed for trends in 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 • (1) Medical literature demonstrates high cost of unnecessary medical care (i.e. 30% of medical costs). (Institute of Medicine Report, (2012). Also see Fisher, Elliott S., MD, MPH,	• (1, 2, and 4) HERC PL and guidelines. (HERC provides outcome evidence and clinical indications for certain diagnoses that may be translated into UM requirements.) • (1) Medical literature demonstrates high cost of unnecessary medical care (i.e., 30% of medical costs). (Institute of Medicine Report, (2012). Also see Fisher, Elliott S., MD, MPH, Wennberg, David E., MD,	• (1-4) HERC PL and guidelines. • (1) UM and claims reports are reviewed for trends in 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. • (1) Medical literature demonstrates high cost of unnecessary medical care (i.e. 30% of medical costs). (Institute of Medicine Report, (2012)). Also see Fisher, Elliott S., MD, MPH, Wennberg, David E., MD,	• (1, 2, and 4) The HERC PL and guidelines. • (1) PA staff reports. If the UM team identifies any services for which utilization appears to be increasing (e.g., number of requests) or it appears that the State is paying for medically unnecessary care, the UM team consults with the health analytics team to analyze and evaluate adjustments to PA or CR. • (1) Health analytics reports. The health analytics team and policy analysts refer services that have been identified to have increasing utilization to the UM team for evaluation.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Wennberg, David E., MD, MPH, Stukel, Therese A., PhD et al., The Implications of Regional Variations in Medicare Spending: Part 2. Health Outcomes and Satisfaction with Care, Center for the Evaluative Clinical Sciences, Dartmouth Medical School, VA Outcomes Group, White River Junction VT, Center for Outcomes Research and Evaluation, Maine Medical Center, & Institute for the Evaluative Clinical Sciences, Toronto, Canada, Financial support was provided by grants from the Robert, Wood Johnson Foundation, the National Institutes of Health (Grant Number CA52192) and the National Institute of Aging (Grant Number 1PO1AG19783-01), 2002, pp 1-32. • (2) Oregon Performance Plan (OPP) requires that BH services be provided in least restrictive setting possible.	MPH, Stukel, Therese A., PhD et al., The Implications of Regional Variations in Medicare Spending: Part 2. Health Outcomes and Satisfaction with Care, Center for the Evaluative Clinical Sciences, Dartmouth Medical School, VA Outcomes Group, White River Junction VT, Center for Outcomes Research and Evaluation, Maine Medical Center, & Institute for the Evaluative Clinical Sciences, Toronto, Canada, Financial support was provided by grants from the Robert, Wood Johnson Foundation, the National Institutes of Health (Grant Number CA52192) and the National Institute of Aging (Grant Number 1PO1AG19783-01), 2002, pp 1-32. • (2) The Oregon Performance Plan (OPP) requires that BH services be provided in the least restrictive setting possible. The OPP is a DOJ-	MPH, Stukel, Therese A., PhD et al., The Implications of Regional Variations in Medicare Spending: Part 2. Health Outcomes and Satisfaction with Care, Center for the Evaluative Clinical Sciences, Dartmouth Medical School, VA Outcomes Group, White River Junction VT, Center for Outcomes Research and Evaluation, Maine Medical Center, & Institute for the Evaluative Clinical Sciences, Toronto, Canada, Financial support was provided by grants from the Robert, Wood Johnson Foundation, the National Institutes of Health (Grant Number CA52192) and the National Institute of Aging (Grant Number 1PO1AG19783-01), 2002, pp 1-32.	

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
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 • (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.	negotiated Olmsted settlement.	• (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.	

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• (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.	• (4) PRTS CONS: OAR 410-172-0690 and 42 CFR 441.156. • (4) OARs and other applicable federal and State requirements. • (5) Cost and utilization reports	• (4) Applicable federal and State requirements.	• (4) Applicable federal and State requirements.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Timelines for authorizations: • 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. • CR requests must be submitted the same day or	**Timelines for gender reassignment surgery authorizations (for benefit packages E and G):** **(OHA)** • Standard requests are to be processed within 14 days. **Timelines for child residential authorizations**:	**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	**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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
within 24-72 hours of the initiation of services, or the day following the weekend, including allowances for holidays, if services are initiated on a weekend. • Authorizations (in response to PA requests) for acute hospitalization and OON requests are made within the following timelines: 1. Concurrent (within 1 calendar day) 2. Urgent Pre-service (2 calendar days) 3. Non urgent pre-service (14 calendar days) 4. Post-service (within 30 days) **Documentation requirements:** • PA and CR: The claims or authorization request form is	**(OHA)** • OHA provides the initial authorization (level-of-care review) within 3 days of requests for SCIP, SAIP or subacute. **(HIA)** • Authorization requests for PRTS are submitted prior to admission or within 14 days of an emergency admission. An emergency admission is acceptable only under unusual and extreme circumstances, subject to RR by HIA. **Timelines for adult residential and YAP authorizations**: **(KEPRO)** • OARs require emergency requests are processed within 24 hours, urgent within 72 hours, and standard requests within 14 days. **Documentation requirements (OHA):**	expedited and generally completed the same day. • Notification of emergency admission is required as soon as is reasonably possible (e.g., within 2 days) without a cutoff. • PA & RR: Response to PA and RR requests are completed within regulatory timelines, in practice within 5-10 days. • CR: Due to nature of emergent IP stays, reviews are necessarily retrospective, usually within 24-72 hours of admission • Investigational: Standard requests are completed within 14 days; Urgent requests are completed within 3 days. **Documentation requirements:** • Standard forms used for all services, typically one page	to conduct case management and discharge planning, but does not limit the scope or duration of the benefit. • PA is required before admission. • OARs require emergency requests are processed within 24 hours, urgent requests within 72 hours and standard requests within 14 days; although a backlog may develop. **Documentation requirements**: • PA documentation requirements include a form that consists of a cover page.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
one page. However, hospitals, practitioners, and providers send documentation supporting medical necessity for review and approval.	• PA documentation requirements for non-residential MH/SUD benefits in benefit packages E and G include a form that consists of a cover page. Diagnostic and CPT code information and a rationale for medical necessity must be provided, plus any additional supporting documentation. • The documentation requirement for level-of-care assessment for SCIP, SAIP and subacute is a psychiatric evaluation. Other information may be reviewed when available. **Documentation requirements for PRTS CONS and CR for SCIP and SAIP (HIA)**: • PRTS CONS requires documentation that supports the justification for child residential services including: (a) A cover sheet detailing relevant provider and recipient Medicaid numbers;	along with relevant medical records to support requested service.	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
	(b) Requested dates of service; (c) HCPCS or CPT Procedure code requested; and (d) Amount of service or units requested; (e) A behavioral health assessment and service plan meeting the requirements described in OAR 309-019-0135 through 0140; or (f) Any additional supporting clinical information supporting medical justification for the services requested; (g) For substance use disorder services (SUD), the Division uses the American Society of Addiction Medicine (ASAM) Patient Placement Criteria second edition-revised (PPC-2R) to determine the appropriate level of SUD treatment of care. • There were no reported specific documentation requirements for CR of SCIP or SAIP.		

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Method of document submission: • Requests can be made either telephonically, by fax, email, or USPS. • Providers use statewide electronic census tool (PreManage), which automatically submits notification to CareOregon about inpatient request. • Can conduct CR through EMR.	**Documentation requirements (KEPRO)**: • Documentation may include assessment, service plan, plan-of-care, Level-of-care Utilization System (LOCUS), Level of Service Inventory (LSI) or other relevant documentation. **Method of document submission (OHA):** • For non-residential MH/SUD services in benefit packages E and G, paper (fax) or online PA requests are submitted prior to the delivery of services for which PA is required. • For SCIP, SAIP and subacute level-of-care review, the OHA designee may accept information via fax, mail or email and has also picked up information. Supplemental information may be obtained by phone. **Method of document submission (HIA):**	**Method of document submission:** • PA: via provider portal along with relevant medical records to support requested service submitted via fax or electronically. • 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
	• Packets are submitted to HIA by mail, fax, email or web portal for review for child residential services. Telephonic clarification may be obtained. • Psychiatrist to psychiatrist review is telephonic. **Method of document submission (KEPRO):** • Providers submit authorization requests for adult MH residential to KEPRO by mail, fax, e-mail or via portal, but documentation must still be faxed if the request is through the portal. Telephonic clarification may be obtained.		
Qualifications of reviewers: • 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	**Qualifications of reviewers (OHA)**: • OHA M/S staff conduct PA and CR (if applicable) for gender reassignment surgery (for benefit packages E and G). (See processes, strategies and evidentiary standards in column 4.)	**Qualifications of reviewers:** • Requests for investigational services are made relative to HERC or sent to an IRE (e.g., NCCN) for review. • CR. In most cases, RN staff have access to hospital EMR to conduct authorization review, and issue	**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
consideration and approval for authorization given only after consent by GOBHI QI Committee. • PA decisions are made by licensed health care professionals with appropriate credentials. • Medical director or licensed physician reviewers determine denials.	• The OHA designee is a licensed, masters'-prepared therapist that reviews psychiatric evaluations to approve or deny the level-of-care requested. Psychiatric consultation is available if needed. **Qualifications of reviewers (HIA)**: • Two LCSWs with QMHP designation make residential authorization decisions. • Two psychiatrists make CONS determinations. **Qualifications of reviewers (KEPRO)**: • KEPRO QMHPs must meet minimum qualifications (see below) and demonstrate the ability to conduct and review an assessment, including identifying precipitating events, gathering histories of mental and physical health, substance use, past mental health services and criminal justice contacts, assessing family, cultural, social and	determination of approval or denial relative to InterQual. • All denials require a Medical Director review.	

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Reconsideration/RR: • RR is offered for providers who fail to PA medically necessary care. • Utilization Management Coordinator will review claims request and/or RR request and make determination of whether a benefit limitation or administrative exclusion applies.	**Reconsideration/RR (OHA)**: • A provider may request review of an OHA denial decision. The review occurs in weekly Medical Management Committee (MMC) meetings. (Applies to non-residential MH/SUD services in benefit packages E and G.) • Exception requests for experimental and other non-covered benefits (for benefit packages E and G) may be granted at the discretion of the MMC, which is led by the HSD medical director. • If a provider requests review of an OHA designee level-of-care determination, HIA may conduct the second review. **Reconsideration/RR (HIA)**: • If the facility requests a reconsideration of a CONS denial, a second psychiatrist (who did not make the initial decision) will review the documentation and discuss	**Reconsideration/RR:** • RR is offered for providers who fail to PA medically necessary care. • Exceptional circumstances can allow for review (e.g. member coverage could not have been known), and/or facility may submit Post Service RR request.	**Reconsideration/RR**: • A provider may request review of a denial decision. The review occurs in weekly MMC meetings. • Exception requests for experimental and other non-covered benefits may be granted at the discretion of the MMC, which is led by the HSD medical director.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	with the facility in a formal meeting. • No policy for CR denials. **Reconsideration/RR (KEPRO)**: • Within 10 days of a denial, the provider may send additional documentation to KEPRO for reconsideration. • A provider may request review of a denial decision, which occurs in weekly MMC meetings or KEPRO's comparable MM meeting.		
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 in benefit packages E and G can result in non-payment for benefits for which it is required. • Failure to obtain notification for non-residential MH/SUD services in benefit packages E and G does not result in a financial penalty.	**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.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Appeals: • Member or 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. • 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.	• For SCIP, SAIP and subacute, if coverage is retroactively denied, general funds may be used to cover the cost of care. **Consequences for failure to authorize (HIA)**: • Non-coverage. **Consequences for failure to authorize (KEPRO)**: • Failure to obtain authorization can result in non-payment for benefits for which it is required. **Appeals (OHA)**: • Members may request a hearing on any denial decision. **Appeals (HIA)**: • Documentation has not included the fair hearing process. **Appeals (KEPRO)**: • Members may request a hearing on any denial decision.	**Appeals:** • Member or provider has the right to appeal.	**Appeals**: • Members may request a hearing on any denial decision.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Frequency of review (and method of payment): • MH/SUP IP is paid by per diem. • CR for acute IP and IP rehab are guided by MCG, 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. • Authorizations for acute care are a maximum of 3 days. • Detox-anywhere from 4-10 days. • Eating Disorder Residential is continually reauthorized until minimum discharge standards are met per MCG. • PRTS 30 days at a time • Subacute up to 3 days at a time • SUD residential is every 30-90 days.	**Frequency of review (and method of payment) (OHA)**: • Gender reassignment surgery (for benefit packages E and G) is authorized as a procedure. • The initial authorization for SCIP, SAIP and subacute is 30 days. **Frequency of review (and method of payment) (HIA)**: • Child residential services are paid by per diem. • Child residential services authorizations are conducted every 30-90 days. **Frequency of review (and method of payment) (KEPRO)**: • Adult residential and YAP authorizations are conducted at least once per year. In practice reviews average every 6 months.	**Frequency of review (and method of payment):** • 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 reviewing clinicians (RN/MD/DO). • The full 20 day benefit is authorized. • Investigational: Exceptions considered when the	**Frequency of review (and method of payment)**: • Most IP claims are paid DRG; as a result, CR is infrequently used. • CR is conducted monthly for LTAC and rehabilitation. • The State conducts CR for SNF after the first 20 days (which are managed by the CCO) at a frequency that is determined by the care manager, but not less than one time a year. • Authorization lengths are individualized by condition and are valid for up to a year. • Procedural authorizations are valid for 3 months.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Services are approved based on the members presenting condition, recommendations of the attending physician, practice guidelines, and GOBHI's Chief 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).		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	**RR conditions and timelines (OHA)**: • RR for non-residential MH/SUD services in benefit packages E and G is only available for retro eligibility situations (e.g., the person became eligible during the stay).	**RR conditions and timelines:** • 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	**RR conditions and timelines**: • RR is only available for retro eligibility situations (e.g., the person became eligible during the stay).

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
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. • RR can be submitted at least 30 days post-service. • In circumstances where a miscommunication between both or either of these entities/parties occurs there might be instances in which authorization for placement will be made beyond the initial notification time period.	**RR conditions and timelines (HIA):** • No policy **RR conditions and timelines (KEPRO)**: • The request for authorization is received within 30 days of the date of service. • Any requests for authorization after 30 days from date of service require documentation from the provider that authorization could not have been obtained within 30 days of the date of service.	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. • RR can be submitted at least 30 days post-service.	
Methods to promote consistent application of criteria: • IRR conducted quarterly (biannually for physicians)	**Methods to promote consistent application of criteria (OHA)**: • Nurses are trained on the application of the HERC PL and guidelines, which is spot-checked through ongoing supervision. Whenever possible, practice guidelines from clinical professional	**Methods to promote consistent application of criteria:** • IRR conducted quarterly (biannually for physicians)	**Methods to promote consistent application of criteria**: • Nurses are trained on the application of the HERC PL and guidelines, which is spot-checked through ongoing supervision. Whenever possible, practice guidelines from clinical professional

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	organizations such as the American Medical Association or the American Psychiatric Association, are used to establish PA frequency for services in the FFS system. (Applicable to non-residential MH/SUD services in benefit packages E and G.) • There is only one OHA designee reviewer for level-of-care review for SCIP, SAIP, and subacute and no specific criteria, so N/A. **Methods to promote consistent application of criteria (HIA):** • Parallel chart reviews for the two reviewers. (No criteria.) **Methods to promote consistent application of criteria (KEPRO)**: • Monthly clinical team meetings in which randomly audited charts are reviewed/discussed by peers using the KEPRO compliance department-approved audit tool.		organizations such as the American Medical Association or the American Psychiatric Association, are used to establish PA frequency for services in the FFS system.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	• Results of the audit are compared, shared and discussed by the team and submitted to the Compliance Department monthly for review and documentation. • Individual feedback is provided to each clinician during supervision on their authorization as well as plan-of-care reviews.		

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Evidence for UM review frequency: • PA & CR: GOBHI utilizes the following best practices which determine the frequency in which PA's are performed. Milliman Care 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	**Evidence for UM frequency (OHA (and designee for level-of-care review), HIA and KEPRO)**: • PA length and CR frequency are tied to HERC PL and guidelines, OAR, CFRs, reviewer expertise and timelines for expectations of improvement. • The Commission that develops HERC consists of 13 appointed members, which include five physicians, a dentist, a public health	**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, reviewer expertise and timelines for expectations of improvement. • The Commission that develops HERC consists of 13 appointed members, which include five physicians, a dentist, a public health nurse, a pharmacist and an insurance industry representative, a provider of

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
approved by GOBHIs' Quality Assurance Committee would be utilized to determine length of authorization. Finally, 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).	nurse, a pharmacist and an insurance industry representative, a provider of complementary and alternative medicine, a behavioral health representative and two consumer representatives. The Commission is charged with maintaining a priority list of services, developing or identifying evidence-based health care guidelines and conducting comparative effectiveness research. • HERC guidelines of which there are fewer for MH/SUD than M/S. This is because 1) there are fewer technological procedures for MH/SUD (e.g., cognitive behavioral therapy and psychodynamic therapy are billed using the same codes, no surgeries, few devices); 2) the MH/SUD literature is not as robust (e.g., fewer randomized trials, more subjective diagnoses (or the ICD-10-CM diagnoses represent a spectrum) and		complementary and alternative medicine, a behavioral health representative and two consumer representatives. The Commission is charged with maintaining a priority list of services, developing or identifying evidence-based health care guidelines and conducting comparative effectiveness research. • HERC guidelines of which there are more M/S than MH/SUD because 1) there are more technological procedures (e.g., surgery, devices, procedures and diagnostic tests); and 2) the literature is more robust.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Data reviewed to determine UM application: • GOBHI tracks all service authorization requests. The medical management software evaluates the type of authorization and the timeframes in which the authorization was approved. GOBHI 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. GOBHI tracks qualifications of practitioner making authorization determinations by service area, progress of member in care, and costs associated with that service area.	less standardization in interventions). **Data reviewed to determine UM application (OHA)**: • Denial/appeal overturn rates; number of PA requests; stabilization of cost trends; and number of hearings requested. These data are reviewed in contractor reports, on a quarterly basis by the State. (Applicable to non-residential MH/SUD services in benefit packages E and G.) **Data reviewed to determine UM application (HIA)**: N/A **Data reviewed to determine UM application (KEPRO):** N/A	**Data reviewed to determine UM application:** • 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 judge. Medical Director reviews all denials.	**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
IRR standard: • IRR goal is 80%.	**IRR standard:** • OHA: N/A • HIA: N/A • KEPRO: N/A	**IRR standard:** • IRR goal is 80%.	**IRR Standard**: • N/A
Results of criteria application: • 0% appeal overturn rate	**Results of criteria application**: • OHA: 0 appeal overturns • HIA: 0 appeal overturns • KEPRO: 0 appeal overturns	**Results of criteria application:** • 36% appeal overturn rate combined IP and OP.	**Results of criteria application**: • 0 appeal overturns

7. Compliance Determination for Benefit Packages CCO A and B

IP Benefits: All non-emergent CCO MH/SUD and M/S IP admissions require PA or a level-of-care approval. Emergency CCO MH/SUD requires notification within 24-72 hours and M/S CCO IP is 1-3 days. Most ongoing IP services require subsequent CR. Emergency child residential admissions require notification within 14 days. The CCO conducts PA and CR for MH/SUD and M/S IP hospital benefits. An OHA designee conducts level-of-care review for SCIP, SAIP and subacute. CR for SCIP and SAIP child residential benefits is conducted by HIA. HIA conducts the CONS procedure and PA for PRTS. KEPRO conducts PA and CR for adult residential and YAP. The CCO conducts CR for subacute and PRTS. SNF CR is conducted by the CCO for the first 20 days (after which the State conducts CR).

Comparability of Strategy and Evidence: UM is assigned to MH/SUD and M/S IP benefits primarily using four strategies: 1) To ensure coverage, medical necessity and prevent unnecessary overutilization (e.g., in violation of relevant OARs, the HERC PL and guidelines). Evidence of MH/SUD overutilization includes HERC, research demonstrating 30% of IP costs are unnecessary; and for MH/SUD and M/S benefits administered by the CCO and utilization reports. 2) To ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. Although strategy (2) primarily applies to MH/SUD benefits, it is permissible because it is a requirement resulting from a DOJ-negotiated Olmstead settlement agreement. 3) To promote the health and safety of members, for which safety issues are identified by MCG, InterQual and HERC. 4) To comply with federal and State requirements. As a result, the strategies and evidence are comparable.

Comparability and Stringency of Processes: OARs require authorization decisions within 24 hours for emergencies, 72 hours for urgent requests and 14 days for standard requests. Providers are encouraged to submit requests for authorization sufficiently in advance to be consistent with OAR time frames. Most documentation requirements for MH/SUD and M/S IP admissions include a form and information that

supports medical necessity. PreManage notifies the CCO when admissions occur. CR can be conducted for some facilities via the EHR. Documentation for CCO MH/SUD and M/S may also be submitted by phone, email, fax or web portal. Documentation requirements for child residential PA/level-of-care review include a psychiatric evaluation or a psychiatrist-to-psychiatrist telephonic review. HIA accepts information for child residential CR via mail, email, fax and web portal. Adult residential and YAP require an assessment (i.e., completion of a relevant level-of-care tool (e.g., ASAM, LSI, LOCUS)) and plan-of-care consistent with State plan requirements. KEPRO documentation submission is via mail, email, fax, and web portal. Consistent with OARs, federal CONS procedures, and due to the potential absence of a psychiatric referral, the PRTS documentation requirements include a cover sheet, a behavioral health assessment and service plan meeting the requirements described in OAR 309-019-0135 through 0140. These documentation requirements appear comparable.

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

Stringency of Strategy and Evidence: Concurrent review is conducted every 1-4 days for MH/SUD IP hospital, while M/S acute IP hospital services are reviewed every 1-3 days. CCO MH/SUD residential (e.g., SUD, and PRTS) frequency of review ranges from every 30 to 90 days. FFS child residential is reviewed every 30-90 days while FFS adult residential and YAP are reviewed no less than annually, but in practice averages 6 months. The CCO authorizes the full 20 day SNF benefit. Evidence for the frequency of CCO MH/SUD review includes ASAM and MCG and CCO M/S references InterQual*. OHA plans to task the FFS residential subcontractors with review of CR frequencies relative to the most recent research to confirm MH/SUD review frequency is directly tied to evidence rather than historical standard practice*. CCO MH/SUD and M/S offer RR. KEPRO makes RR available for 30 days post-admission. The OHA designee and HIA do not have standard policies

describing when RR is available. In addition, it was discovered that there are conflicting State rules regarding RR timelines. *OHA plans to standardize the availability of RR, including the conditions under which it is permissible and the timeframes. OHA will align OAR requirements and RR offerings by contractors.* The CCO and State review utilization data to determine if PA or CR should be added or adjusted for MH/SUD and M/S IP benefits. For both MH/SUD and M/S, the CCO conducts IRR testing to a standard of 80% on a quarterly basis. HIA conducts parallel chart reviews for its two reviewers and KEPRO team meetings include random chart audits using a compliance tool followed by team discussion. There is no formal oversight of criteria application for the OHA designee level-of-care review process for certain child residential services. OHA plans to institute a more formalized measurement of criteria application for FFS when feasible. The CCO reported a 36% appeal overturn rate for M/S while MH/SUD (FFS and CCO) had 0 appeal overturns in 2017. Inclusive of OHA action plans, the strategy and evidence are no more stringently applied to MH/SUD than to M/S in writing or in operation.

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

Below are the OHA action plans:

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

8. Compliance Determination for Benefit Packages CCO E and G

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

Comparability of Strategy and Evidence: UM is assigned to MH/SUD and M/S IP benefits primarily using three strategies: 1) To ensure coverage, medical necessity and prevent unnecessary overutilization (e.g., in violation of relevant OARs, HERC PL or guidelines). Evidence of MH/SUD overutilization includes HERC, research demonstrating 30% of IP costs are unnecessary; and for MH/SUD benefits administered by the CCO, utilization reports. 2) To ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. Although strategy (2) primarily applies to MH/SUD benefits, it is permissible because it is a requirement resulting from a DOJ-negotiated Olmstead settlement agreement. M/S safety issues are supported by HERC. 3) To comply with federal and State requirements. As a result, the strategy and evidence are comparable.

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

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

benefit packages, OHA intends to standardize RR processes when feasible. Providers may appeal a MH/SUD denial decision by the CCO to the CCO. OHA FFS reviews denials through the fair hearing process, but HIA and the OHA designee have not encouraged use of this process. *OHA plans to confirm all notices, appeals and fair hearing processes are consistent with federal requirements*. Failure to obtain authorization may result in non-coverage. Inclusive of OHA action plans, the MH/SUD and M/S processes are comparable and no more stringently applied to MH/SUD benefits.

Stringency of Strategy and Evidence: Concurrent review is conducted every 1-4 days for MH/SUD IP hospital (which is paid by per diem), while FFS M/S rarely conducts CR because most IP services are paid by DRG. CCO MH/SUD residential (e.g., SUD, subacute and PRTS) frequency of review ranges from every 3 to 30 days. FFS child residential is reviewed every 1-3 months while FFS adult residential and YAP are reviewed no less than annually but in practice average 6 month reviews. SNF is also reviewed no less than annually after the first 20 days. LTAC and rehab hospital (M/S IP) are reviewed monthly. Evidence for the frequency of review for CCO MH/SUD is MCG. *OHA plans to task FFS residential subcontractors with review of CR frequencies relative to the most recent research to confirm MH/SUD review frequency is directly tied to evidence rather than historical standard practice*. CCO MH/SUD offers RR without significant restrictions reported. KEPRO makes RR available for 30 days post-admission. FFS MH/SUD only allows RR for retro-eligibility circumstances. The OHA designee and HIA do not have standard policies describing when RR is available. In addition, it was discovered that there are conflicting State rules regarding RR timelines. *Although not a parity concern for these benefit packages, OHA plans to standardize the availability of RR, including the conditions under which it is permissible and the timeframes. OHA will align OAR requirements and RR offerings by contractors*. The CCO and State review utilization data to determine if PA or CR should be added or adjusted for MH/SUD and M/S IP benefits. For MH/SUD the CCO conducts IRR testing to a standard of 80%. HIA conducts IRR and parallel chart reviews for its two reviewers and KEPRO team meetings include random chart audits using a compliance tool followed by team discussion. HIA and the OHA designee do not have specific criteria against which decisions are made. FFS M/S conducts spot-checks through supervision to assess criteria application. *Although not a parity issue for these benefit packages, OHA plans to institute a more formalized measurement of criteria application when feasible even though this is not a parity issue in these benefit packages.* MH/SUD reported 0 appeal overturns in 2017. FFS and M/S's appeal overturn rate was also 0. Inclusive of OHA action plans, the strategy and evidence are no more stringently applied to MH/SUD than to M/S in writing or in operation.

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

OUTPATIENT UTILIZATION MANAGEMENT

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

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

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

1. To which benefits is the NQTL assigned?

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
• (1) 1915(c) Comprehensive DD waiver (operated/managed by DHS) • (1) 1915(c) Support Services DD waiver (operated/managed by DHS) • (1) 1915(c) Behavioral DD Model waiver (operated/managed by DHS)	The following services are managed by DHS: • (1) 1915(c) Comprehensive DD waiver • (1) 1915(c) Support Services DD waiver • (1) 1915(c) Behavioral DD Model waiver • (1) 1915(c) Aged & Physically Disabled waiver • (1) 1915(c) Hospital Model waiver	PA: • (2, 4) Applied Behavior Analysis (ABA) • (2, 3, 4) Electroconvulsive therapy (ECT) • (2, 3) Gender Dysphoria assessment • (2, 3, 4) PHP, IOP and residential treatment of Eating Disorders • (2, 3, 4) MAT	PA: • (2, 3, 4) Specialist visits, elective procedures performed in outpatient 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	The following services are managed by OHA: • (2, 3) Out of hospital births • (2) Home health services • (2) OT, PT, ST, and audiology for M/S conditions (and autistic disorder, which is also managed according to the processes, strategies and

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
• (1)1915(i)(HK) services for adults (home-based habilitation, behavioral habilitation and psychosocial rehab for persons with CMI) (managed by KEPRO under contract with OHA)	• (1) 1915(c) Medically Involved Children's NF waiver • (1) 1915(k) Community First Choice State Plan option • (1) 1915(j): Self-directed personal assistance	CR & RR: "delegated" UM with RR chart review • (2, 3, 4, 5) Assertive Community Treatment (ACT) • (2, 4, 5) Supportive Employment (SE) • (2, 4, 5) Children's IOP • (2, 3, 4, 5) SUD IOP • (2, 3, 4, 5) Wrap around • (2, 3, 4, 5) Psychiatric Day Treatment	• (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	evidentiary standards described for FFS/M/S OP) • (2, 3) Imaging • (2) DME

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
• (1) The State requires PA of HCBS in order to meet federal requirements regarding PCSPs and ensure services are provided in accordance with a participant's PCSP	• (1) The State requires PA of HCBS in order to meet federal requirements regarding PCSPs and ensure services are provided in accordance with a participant's PCSP	• (2) Reduce overutilization and ensure services adhere to State criteria defined in HERC PL and guidelines	• (2) Reduce overutilization and ensure services adhere to State criteria defined in HERC PL and guidelines	• (2) To prevent services being delivered in violation of relevant OARs, associated HERC PL and guidelines and federal regulations. • (3) Services are associated with

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
and in the least restrictive setting.	and in the least restrictive setting.	• (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.	• (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.	increased health or safety risks.

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
• (1) Federal requirements regarding PCSPs for 1915(c) and 1915(i) services (e.g., 42 CFR 441.301 and 441.725) and the applicable approved 1915(c) waiver application/1915(i) State plan amendment. • (1) Oregon Performance Plan (OPP) requires that all BH services are provided in the least restrictive setting possible as do federal requirements regarding 1915(c) and 1915(i) services.	• (1) Federal requirements regarding PCSPs for 1915(c), 1915(k), and 1915(j) services (e.g., 42 CFR 441.301, 441.468, and 441.540) and the applicable approved 1915(c) waiver application/State plan amendment. • (1) Federal requirements regarding 1915(c) and 1915(i) services require that HCBS are provided in the least restrictive setting possible.	• (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 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	• (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/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	• (2) HERC PL • (2) PA requests with insufficient documentation demonstrate MNC are not being met or HERC PL guidelines are not being followed. • (3) HERC Guidelines - Recommended limits on services for member safety.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
		provided in 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. • (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.	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. • (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	

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
		• OAR 410-172-0650, 410-172-0770 (3)(a-e), and OHA CCO contract exhibit B part 2 (3). • (5) OP Program contracts	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. Comparability and Stringency of Processes: Describe the NQTL procedures (e.g., steps, timelines and requirements from the CCO, member, and provider perspectives).

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Timelines for authorizations: • A PCSP must be approved within 90 days from the date a completed application is submitted.	**Timelines for authorizations**: • A PCSP must be approved within 90 days from the date a completed application is submitted.	**Timelines for authorizations:** • PA requests are desired at least 10 days prior to the start of services, however, there is no cut-off. • CR: No authorization from GOBHI is required. These services are assessed by local multi-disciplinary teams and/or qualified	**Timelines for authorizations:** • It is preferred that information is submitted 14 days in advance of service delivery, but there is no cut off. Urgent requests are expedited. • CR: No authorization is required for pain management programs. These	**Timelines for authorizations**: • Urgent requests are processed in 72 hours and immediate requests in 24 hours. Routine requests are processed in 14 days.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Documentation requirements: • (c)The PCSP is based on a functional needs assessment and other supporting documentation. It is developed by the individual, the individual's team and	**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	clinical staff for determination of medical necessity. Facility providers and independent practitioners are contractually required to adhere to eligibility standards established either under OAR, OHP Contract, program standards, or HERC guidelines. Site visits conducted every 3 years confirm compliance. **Documentation requirements:** • Consistent with OARs and HERC, documentation requirements include valid (no older than 30 days) assessment, current service plan.	services are assessed by local multi-disciplinary teams and/or qualified clinical staff for determination of medical necessity. Facility providers and independent practitioners are contractually required to adhere to eligibility standards established either under OAR, OHP Contract, program standards, or HERC guidelines. Site visits conducted every 3 years confirm compliance. **Documentation requirements:** • Template on web portal • Bariatric evaluation requests must come from a hospital certified as a center	**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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
the individual's case manager. • (i)The PCSP is based on an assessment, service plan, plan-of-care, Level-of-care Utilization System (LOCUS), Level of Service Inventory (LSI) or other relevant documentation. The PCSP is developed by the member's treatment team in consultation with the member. **Method of document submission**: • All 1915(c) services must be included in a participant's PCSP and approved by a qualified case manager at the local case management entity (CME) prior to service delivery.	the individual's case manager. **Method of document submission**: • All 1915(c), 1915(k), and 1915(j) services must be included in a participant's PCSP and approved by a qualified case manager at the local case management	To review relative to MCG, GOBHI also reviews progress notes and a medication list. • 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. **Method of document submission:** • Authorization requests can be made either telephonically, fax, email, or USPS.	for bariatric excellence. • Certain procedures require provider to submit requested codes with chart documentation to support requested payment for service, as required by OAR. **Method of document submission:** • PA & RR: Electronic submission on web portal that mirrors paper submission previously used that comprised one page of requested information. • The bariatric evaluation requires	documentation are required. **Method of document submission**: • Paper (fax) or online PA/POC submitted prior to the delivery of services.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
• Information is obtained during a face-to-face meeting, often at the individual's location. • (i) Providers submit authorization requests to KEPRO by mail, fax email or via portal, but documentation must still be faxed if the request is submitted via portal. **Qualifications of reviewers**: • (c) A case manager must have at least: – A bachelor's degree (BA) in behavioral science, social science, or a closely related field; or – A BA in any field AND one year of human services	entity (CME) prior to service delivery. • Information is obtained during a face-to-face meeting, often at the individual's location. **Qualifications of reviewers**: • A case manager must have at least: – A BA in behavioral science, social science, or a closely related field; or – A BA in any field AND one year of human services related experience; or	**Qualifications of reviewers:** • Licensed healthcare professional with a minimum of 5 years' experience in community behavioral health work or quality assurance review authorization requests relative to MCG. • Only physicians can make denials	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. **Qualifications of reviewers:** • 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. • Most denials are reviewed by Medical Directors to ensure an	**Qualifications of reviewers:** • Nurses may authorize and deny services.

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

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
– Graduate degree in social work; – Graduate degree in recreational, art, or music therapy; – Graduate degree in a behavioral science field; or – A qualified Mental Health Intern, as defined in 309-019-0105(61).				
Criteria: • (c) Qualified case managers approve or deny services in the PCSP consistent with waiver and OAR requirements. • Once a PCSP is approved, services in the PCSP are entered into the payment management system by the CME staff as authorizations.	**Criteria**: • Qualified case managers approve or deny services in the PCSP consistent with waiver/state plan and OAR requirements. • Once a PCSP is approved, it is entered into the payment management system as authorization by the CME staff.	**Criteria:** • MCG, HERC, ASAM, OARs • Gender Dysphoria authorizations use version 7 WPATH and require GOBHI to establish a SCA with a qualified MHP to conduct the evaluation (due to scarcity of resources). • If a facility provider or Independent practitioner requested	**Criteria:** • InterQual, HERC, OARs and clinical judgement • Investigational: Coverage must be made by Medical Director. Exception samples discussed at RN meetings and Medical Director meetings to attempt consistency among different reviewers. Exceptions are	**Criteria:** • Authorizations are based on the HERC PL and guidelines, Oregon Statute, Oregon Administrative rules, federal regulations, and evidence-based guidelines from private and professional associations such as the Society of American Gastrointestinal and Endoscopic Surgeons

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
• (i) QMHPs approve or deny services in the PCSP consistent with State plan and OAR requirements. • QMHPs enter prior authorizations into the MMIS based on the member's PCSP. **Reconsideration/RR**: • (c) N/A • (i) Within 10 days of a denial, the provider may send additional documentation to KEPRO for reconsideration. • (i) A provider may request review of a denial decision, which occurs in weekly MMC meetings or KEPRO's own comparable MMC meeting.	**Reconsideration/RR**: • N/A	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 GOBHI QI Committee. **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.	marked in system to allow for analysis patterns. **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.	where no State or federal guidelines exist. **Reconsideration/RR**: • A review of a denial decision can be requested and is reviewed in weekly MMC meetings.

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

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Frequency of review: • PCSPs are reviewed and revised as needed, but at least every 12 months.	**Frequency of review:** • PCSPs are reviewed and revised as needed, but at least every 12 months.	**Frequency of review:** • ABA: Authorizations are dependent upon the recommendations of the treating BCBA as established in the service plan. However, no authorization shall exceed six months in duration. At this point, all services need to be re-authorized per HERC guidelines. • ECT: The number of treatments authorized is based on the clinical determination of the attending physician and GOBHI Chief Medical Officer - or their qualified proxy. • Subsequent re-authorizations require that the attending physician and GOBHIs' Chief Medical Officer review	**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,	**Frequency of review**: • PA is granted for different authorization periods depending on the service and can be adjusted. Authorizations for extensive services usually range from 6 months to 1 year. • PT, ST, OT authorizations are usually for one year (i.e., 30 visits). • Exceptions may be made at the discretion of the MMC which is led by the HSD medical director.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
		the case as if an initial authorization was being requested. The CMO has the authority to make exceptions. • Gender Dysphoria: authorization requests are compared to version 7 WPATH. • Eating Disorders: PHO, IOP and residential are continually reauthorized every 30 days until minimum discharge standards are met per MCG. • General CR/RR conducted during triannual site visits.	increased self-sufficiency or other clinically significant objective improvement.	
RR conditions and timelines: • (c) N/A • (i) Within 10 days of a denial, the provider may send additional documentation to	**RR conditions and timelines:** • N/A	**RR conditions and timelines:** • Facilities only	**RR conditions and timelines:** • Facilities only	**RR conditions and timelines:** • RR available for retro eligibility circumstances.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
KEPRO for reconsideration • (i) A provider may request review of a denial decision, which occurs in weekly Medical Management meetings or KEPRO's own comparable MM meeting. **Methods to promote consistent application of criteria:** • For 1915(c), DHS Quality Assurance Review teams review a representative sample of PCSPs as part of quality assurance and case review activities to assure that PCSPs meet program standards. • Additionally, OHA staff review a percentage of 1915(c) participant	**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 with a standard of 80%.	**Methods to promote consistent application of criteria:** • IRR with a standard of 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.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
files to assure quality and compliance. • For 1915(i), monthly clinical team meetings in which randomly audited charts are reviewed/discussed by peers using the KEPRO compliance department-approved audit tool. • Results of the audit are compared, shared and discussed by the team and submitted to Compliance Department monthly for review and documentation. • Individual feedback is provided to each clinician during supervision on their PA. • For 1915(i), on a quarterly basis a representative sample of cases are reviewed for ability to address				

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
assessed member needs, whether the PCSPs are updated annually, whether OARs are met, and whether member's choices regarding services and providers were documented.				

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Evidence for UM frequency: • Federal requirements regarding PCSPs and 1915(c) and 1915(i) services (e.g., 42 CFR 441.301 and 441.725) and the applicable approved 1915(c) waiver application/1915(i) State plan amendment.	**Evidence for UM frequency**: • Federal requirements regarding PCSPs and 1915(c), 1915(k), and 1915(j) services (e.g., 42 CFR 441.301, 441.468, and 441.540) and the applicable approved 1915(c) waiver application/State plan amendment.	**Evidence for UM frequency:** • 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. • The amount of time a PA covers for services is limited by OAR 410-120-1320(7) which

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
				states that PAs can be approved and renewed up to 1 year at a time. • Whenever possible, practice guidelines from clinical professional organizations such as the American Medical Association or the American Psychiatric Association, are used to establish PA frequency.
Data reviewed to determine UM application: • N/A	**Data reviewed to determine UM application**: • N/A	**Data reviewed to determine UM application:** • MCG, GOBHI tracks number of denials and grievances, timeframe for addressing denials and grievances, number of appeals, and timeframe to address appeals, plus	**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	**Data reviewed to determine UM application**: • A physician-led group of clinical professionals conducts an annual review to determine which services receive or retain a PA; items reviewed include: – Utilization

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
IRR standard: • N/A **Results of criteria application (appeal overturn rates)**: • (c): 0 appeal overturns • (i) (KEPRO) 11% appeal overturn rate (1 out of 9 hearings)	**IRR standard:** • N/A **Results of criteria application (appeal overturn rates):** • (c) for I/DD: 0 appeal overturns • (c) for APD plus (k) and (j): 0.8% appeal overturn rate	appeal and grievance outcomes. **IRR standard:** • IRR standard of 80% **Results of criteria application (appeal overturn rates):** • 0 appeal overturns	hearing rights, which can alert plan to need to review denials later overturned by judge. **IRR standard:** • IRR standard of 80% **Results of criteria application (appeal overturn rates):** • 42% appeal overturn rate	– Approval/denial rates – Documentation/ justification of services – Cost data **IRR standard:** • N/A **Results of criteria application (appeal overturn rates):** • 0 appeal overturns

7. Compliance Determination for Benefit Packages CCO A and B

OP Benefits: UM applies to the FFS MH/SUD and M/S HCBS benefits and the CCO MH/SUD and M/S OP benefits listed in Section 1.

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

Some non-HCBS CCO MH/SUD and M/S OP services are assigned UM to confirm coverage relative to the HERC PL and guidelines. Non-HCBS MH/SUD services are also reviewed to ensure services are medically necessary relative to MCG and offered in the least restrictive environment, as required by the OPP Olmstead settlement for MH/SUD. A subset of CCO MH/SUD and M/S OP services are also assigned UM to assure the individual's safety. Evidence for safety issues includes HERC guidelines. Programmatic MH/SUD and M/S services for which providers are contractually required to operate in fidelity with applicable requirements (e.g., OARs, HERC, CCO contract) are managed through triannual site visits during which RR of charts is conducted. These strategies and evidence are comparable.

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

Non-HCBS CCO MH/SUD and M/S OP benefit reviews are conducted by qualified clinicians who evaluate clinical information that is submitted via mail, email, or fax relative to MCG, InterQual, ASAM, HERC, or OARs. Providers who deliver certain programmatic MH/SUD services are contracted to comply with HERC and OARs, so UM is conducted in a less stringent manner through triannual site visits. Timelines for authorization decisions are the same for MH/SUD and M/S and defined in OARs. MH/SUD documentation requirements include an assessment, current service plan, 30 days (or available) service notes, medication list and in some cases, evidence that the provider is qualified to provide a specialty service. The CCO M/S requires documentation that supports medical necessity and in certain circumstances that a provider is a center

of excellence for certain specialty services. Failure to obtain authorization may result in non-payment for MH/SUD and M/S services; although an exception process allows RR for CCO MH/SUD and M/S benefits and standard appeal processes apply. There are no differences in processes for children and adults that are not tied to practice guidelines. UM processes are comparable to, and no more stringently applied, to non-HCBS CCO MH/SUD benefits than to M/S benefits.

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

In general, non-HCBS CCO MH/SUD and M/S service authorizations are based on provider request, service type, clinical judgement, HERC, MCG and InterQual. MH/SUD OP may be authorized for a procedure, 30 days up to 6 months. M/S OP may be authorized for a procedure, 3 months or longer. CCO offers reconsideration to MH/SUD and M/S facilities. CCO MH/SUD and M/S MNC application is evaluated through IRR and a concordance standard of 80%. The CCO reviews utilization and other data to determine if UM requires adjustment. MH/SUD and M/S reported appeal overturn rates of 0 and 42% respectively. As a result, the UM strategy and evidence are no more stringently applied to MH/SUD than to M/S OP benefits in operation or in writing.

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

8. Compliance Determination for Benefit Packages CCO E and G

OP Benefits: UM applies to the FFS MH/SUD and M/S HCBS benefits, and the CCO MH/SUD and FFS M/S OP benefits listed in Section 1.

Comparability of Strategy and Evidence: UM of MH/SUD and M/S HCBS benefits is required to meet federal requirements regarding HCBS, including requirements regarding PCSPs, providing benefits in the least restrictive environment, and applicable waiver applications/State plan amendments. Evidence includes the federal requirements regarding PCSPs for 1915(c), 1915(i), 1915(k), and 1915(j) services and applicable approved waiver applications/State plan amendments[2]. These strategies and evidence are comparable.

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

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

Non-HCBS CCO MH/SUD benefit reviews are conducted by qualified clinicians who evaluate clinical information that is submitted via mail, email, or fax relative to MCG and ASAM, HERC, and OARs. MH/SUD documentation requirements include an assessment, current service plan, 30 days (or available) service notes, medication list and in some cases, evidence that the provider is qualified to provide a specialty service. FFS M/S benefit reviews are also conducted by qualified clinicians that evaluate clinical information that supports medical necessity

[2] Programmatic strategies do not apply to benefit packages E and G.

(which may include POCs) submitted via paper (fax) or online relative to OARs and HERC. Timelines for authorization decisions are the same for MH/SUD and M/S and defined in OARs. Failure to obtain authorization may result in non-payment for MH/SUD and M/S services; although an exception process allows RR for CCO MH/SUD and FFS M/S benefits. Appeal processes apply for both CCO MH/SUD and FFS M/S. There are no differences in processes for children and adults that are not tied to practice guidelines. Accordingly, UM processes are comparable to, and no more stringently applied, to non-HCBS MH/SUD benefits than to M/S benefits.

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

In general, non-HCBS CCO MH/SUD service authorizations are based on provider request, service type, clinical judgement, HERC and MCG. MH/SUD OP may be authorized for a procedure, 30 days to 6 months. FFS M/S authorization lengths range from 6 months to one year. The FFS M/S lengths are tied to HERC. CCO offers reconsideration to MH/SUD facilities. CCO MH/SUD MNC application is evaluated through quarterly IRR testing. FFS M/S application is spot-checked through supervision and chart review. *Although not a parity issue, OHA plans to institute a more formalized measurement of criteria application when feasible*. At a minimum, the CCO and State review utilization and other data to determine if UM requires adjustment. MH/SUD and M/S reported OP appeal overturn rates of 0. As a result, the UM strategy and evidence are no more stringently applied to MH/SUD than to M/S OP benefits in operation or in writing.

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

PRIOR AUTHORIZATION FOR PRESCRIPTION DRUGS

NQTL: Prior Authorization for Prescription Drugs
Benefit Package: A and B for Adults and Children
Classification: Prescription Drugs
CCO: Columbia

1. To which benefits is the NQTL assigned?

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• A, F, P, S drug groups	• A and F drug groups	• A, F, P, S drug groups

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• Prior authorization is applied to prescription drugs to promote appropriate and safe treatment of funded conditions and to encourage use of preferred agents. • Prior authorization is applied to prescription drugs due to cost trends far outpacing revenue and/or other medical cost trends.	• 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. • Prior authorization is applied to prescription drugs due to cost trends far outpacing revenue and/or other medical cost trends.

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• Evidence for applying PA criteria to a drug includes: – FDA prescribing guidelines – Medical literature – Best practices – Professional guidelines	• 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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
– CMS accepted compendia (Micromedex)		– CMS accepted compendia (Micromedex)

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• 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. • Failure to obtain PA in combination with an absence of medical necessity results in no provider reimbursement.	• 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.

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• Typically, the frequency range is six months to a year, depending on medical appropriateness and safety, as recommended by the P&T Committee.	• The State approves PAs for up to 12 months, depending on medical appropriateness and safety, as recommended by the P&T Committee.	• Typically, the frequency range is six months to a year, depending on medical appropriateness and safety, as recommended by the P&T Committee.

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• 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 appeal overturn rate for CY 2017 was 24%. • The CCO assesses stringency through review of PA denial/approval and appeal rates.	• Approximately 17% of MH drugs are subject to PA criteria for clinical reasons. • The State allows providers to submit additional information for reconsideration of a denial. • Providers can appeal denials on behalf of a member, and members have fair hearing rights. • The appeal overturn rates for MH carve out drugs was 8:2 (25%). • The State assesses stringency through review of PA denial/approval and appeal rates; number of drugs requiring PA; number of PA requests; and pharmacy utilization data/reports. • PA criteria are reviewed as needed due to clinical developments, literature, studies, and FDA medication approvals.	• 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 appeal overturn rate for CY 2017 was 25%. • The CCO assesses stringency through review of PA denial/approval and appeal rates.

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• Evidence for applying PA criteria to a drug includes: – FDA prescribing guidelines – Medical literature – Best practices – Professional guidelines	• 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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
– CMS accepted compendia (Micromedex)		– CMS accepted compendia (Micromedex)

7. Compliance Determination for Benefit Packages CCO A and B

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

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

Stringency of Strategy and Evidence: PAs for both MH/SUD and M/S drugs are approved for up to 12 months, depending on medical appropriateness and safety, as recommended by the applicable P&T Committee based on evidence such as FDA prescribing guidelines, best practices, and professional guidelines. The CCO and the State assess the stringency of strategy through review of PA denial/approval and appeal rates. The percent of MH/SUD drugs subject to PA requirements is comparable to M/S drugs. In addition, the appeal overturn rates are comparable. As a result, the strategies and evidentiary standards for prior authorization of prescription drugs are applied no more stringently to MH/SUD drugs than to M/S drugs.

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

PROVIDER ADMISSION — CLOSED NETWORK

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• 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. Comparability of Strategy: Why is the NQTL assigned to these provider type(s)?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• CCO 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 efficient provider monitoring, and improve provider relations.	• 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 efficient provider monitoring, and improve provider relations.	• N/A

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Network sufficiency standards are required by 42 CFR 438.206. • Requirements related to the selection and retention of providers are specified in 42 CFR 438.214. • Requirements in 42 CFR 438.12 for the non-discrimination of provider participation states that this does not require an MCO (CCO) to contract beyond the needs of its enrollees to maintain quality and control costs. • State rule related to network sufficiency standards, OAR 410-141-0220.	• N/A	• Network sufficiency standards are required by 42 CFR 438.206. • Requirements related to the selection and retention of providers are specified in 42 CFR 438.214. • Requirements in 42 CFR 438.12 for the non-discrimination of provider participation states that this does not require an MCO (CCO) to contract beyond the needs of its enrollees to maintain quality and control costs. • State rule related to network sufficiency standards, OAR 410-141-0220.	• N/A

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• 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. • 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. • All requests are reviewed by the Credentialing Committee, which is responsible for recommendations to maintain the current network or solicit new providers. • CCO Credentialing Physician, Accreditation Manager, Director of Health Systems Integration, and Contracts	• 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. • 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 CMS time and distance standards and evaluating access through review of member grievances and complaints, requests for OON	• N/A

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Manager are responsible for the decision-making process to close the network. • 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. • 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.		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 not otherwise needed joins the large IPA in the region.	

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• When the CCO decides to close the network to particular specialties/provider types, all new providers applying for those particular specialties/provider types are subject to this NQTL. • No providers were impacted by CCO's decision to close all or part of its network to new providers in the last contract year.	• 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. • Twelve providers were impacted (no contract offered) by CCO's decision to close all or part of its network to new providers in the last contract year.	• N/A

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• The CCO reviews the following data/information at least annually to determine how strictly to apply the criteria/considerations to close the CCO network to new providers: – Capacity reports – Access complaints – Time to appointments – Inpatient rates	• N/A	• The CCO reviews the following data/information to determine how strictly to apply the criteria/considerations to close the CCO network to new providers: – Capacity reports – Access complaints – Time to appointments – Inpatient rates	• N/A

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
– 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		– Complaints and grievances – Multiple SCA requests from a single provider – Membership profile – Other data that indicate a need	

7. Compliance Determination for Benefit Packages CCO A and B

Comparability of Strategy and Evidence: The CCO may close its network to new providers of MH/SUD and M/S inpatient and outpatient services. When the CCO closes its network to new MH/SUD and M/S providers, it is done based upon an assessment of network adequacy, to enhance efficient provider monitoring, and to improve provider relations.

Developing a network based upon network adequacy and sufficiency standards is supported by Federal regulation, including the ability of a MCO (CCO) to limit contracting beyond the needs of its enrollees to maintain quality and control costs (42 CFR 438.12). OAR 410-141-0220 also requires the CCO to meet network sufficiency standards, which impacts the application of this NQTL. Based upon these findings, the CCO's strategy and evidence for closing the network to inpatient and outpatient providers when the CCO determines that it has met network adequacy and sufficiency standards are comparable for providers of MH/SUD and M/S services.

Comparability and Stringency of Processes: The CCO reviews all requests for network admission of providers of MH/SUD and M/S services for need based on the network adequacy of the current provider network. Providers who 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. For MH/SUD providers, the CCO's Credentialing Physician, Accreditation Manager, Director of Health Systems Integration, and Contracts Manager are responsible for the decision-making process to close the network; requests for network inclusion are tracked and assessed annually by the Credentialing Committee. For M/S providers, the CCO's provider relations department is responsible for the decision-making process to close the network, and maintains and

monitors network closure by using a spreadsheet of open and closed provider types. Additionally, for MH/SUD providers, monitoring includes reviewing 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. For M/S providers, monitoring includes network adequacy review using CMS time and distance standards as well as reviews of member grievances and complaints, requests for OON providers, member demographics and PCP capacity reporting. MH/SUD and M/S providers that are denied the opportunity to participate in CCO's network may appeal the CCO's decision. The CCO applies limited exceptions for MH/SUD and M/S providers when a determination has been made to close the network: exceptions are made for MH/SUD providers who demonstrate specialized services that fill a need; and, exceptions are made for M/S providers who join a large IPA/specialty care group. Based upon these findings, the CCO's network closure processes for providers of MH/SUD services are comparable and applied no more stringently than to providers of M/S services.

Stringency of Strategy and Evidence: When the CCO decides to close the network to particular specialties/provider types, all new MH/SUD and M/S providers applying for those particular specialties/provider types are subject to the NQTL. In operation, MH/SUD providers have not been impacted by the application of a closed network; no MH/SUD providers were denied within the last contract year as a result of the CCO closing the network. In contrast, the CCO's decision to close all or part of its network has impacted 12 M/S providers within that same period of time.

The CCO monitors similar 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 upon this information, the strategies and evidentiary standards for network closure are comparable and no more stringently applied to MH/SUD providers than to M/S providers.

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

8. Compliance Determination for Benefit Packages CCO E and G

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

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

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

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

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

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
– Ensure members receive safe, medically necessary care		– Ensure members receive safe, medically necessary care	

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Credentialing/ re-credentialing requirements are 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. Comparability and Stringency of Processes: Describe the NQTL procedures (e.g., steps, timelines and requirements from the CCO and Provider perspectives).

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• All providers must meet credentialing and re-credentialing requirements. • Providers must complete and provide the following documentation: Oregon Practitioner Credentialing Application (20 pages),	• 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.	• All providers must meet credentialing and re-credentialing requirements. • Providers must complete and provide the uniform Oregon Practitioner Credentialing and Re-credentialing application, an Admission plan, S&R	• 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.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
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	• Providers must complete forms and documentation required for their provider type. This includes information demonstrating the provider meets provider enrollment requirements such as NPI, tax ID, disclosures, and licensure/certification. • The provider enrollment forms vary from 1 to 19 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	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	• Providers must complete forms and documentation required for their provider type. This includes information demonstrating the provider meets provider enrollment requirements, such as NPI, tax ID, disclosures, and licensure/certification. • The provider enrollment forms vary from 1 to 19 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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
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 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	exclusion databases, and verifying any licenses, certifications or equivalents. • The State's enrollment process averages 7 to 14 days. • State staff in the provider enrollment unit are responsible for reviewing information and making provider enrollment decisions. • The State reviews all provider enrollment every three years, as required by Federal regulations. • Providers who are not enrolled/re-enrolled are not eligible for Medicaid reimbursement. • Providers who are denied enrollment or re-enrollment may appeal the decision to the State.	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,	provider name against exclusion databases, and verifying any licenses, certifications or equivalents. • The State's enrollment process averages 7 to 14 days. • State staff in the provider enrollment unit are responsible for reviewing information and making provider enrollment decisions. • The State reviews all provider enrollment every three years, as required by Federal regulations. • Providers who are not enrolled/re-enrolled are not eligible for Medicaid reimbursement. • Providers who are denied enrollment or re-enrollment may appeal the decision to the State.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
cannot contract with the CCO, cannot participate in network 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.		which is typically more than what is paid to an OON provider (DMAP fee schedule). • Providers who are adversely affected by credentialing or re-credentialing decisions may challenge the decision through a fair hearing process.	

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• All providers/provider types must be credentialed. • There are no exceptions to meeting these requirements for admission into the CCO's network; however a provider may deliver services and be	• 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	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
paid DMAP rates as an OON provider. • One provider was denied admission or terminated from the network in the last contract year as a result of credentialing and re-credentialing.	• Less than 1% of providers were denied admission, and .005% of providers were terminated last CY for failure to meet enrollment/re-enrollment requirements.	be credentialed. They can deliver services and be paid DMAP rates • Far less than 1% of providers were denied admission or terminated from the network in the last contract year as a result of credentialing and re-credentialing.	• Less than 1% of providers were denied admission, and .005% of providers were terminated last CY for failure to meet enrollment/re-enrollment requirements.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Requirement to conduct credentialing for all new providers is established by State law and Federal regulations. • The frequency with which CCO performs re-credentialing is based upon: – State law and Federal regulations – State contract requirements Exhibit B Part 4 (3)(b) – National accreditation standards (NCQA)	• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E — Provider Screening and Enrollment. • The frequency with which the State re-enrolls providers is based on State law and Federal regulations.	• 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)	• 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 monitors the following data/information to determine		• CCO monitors the following data/information to determine	

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

7. Compliance Determination for Benefit Packages CCO A and B

Comparability of Strategy and Evidence: All IP and OP providers of MH/SUD and M/S services are subject to CCO credentialing and re-credentialing requirements. Credentialing and re-credentialing is conducted for both providers of MH/SUD and M/S services to meet State and Federal requirements, ensure capabilities of provider to deliver high quality of care, ensure provider meets minimum competency standards and ensure members receive care that is safe and medically necessary. Credentialing and re-credentialing of providers is supported by State law and Federal regulations, the CCO's contract with the State, and national accreditation guidelines (NCQA). M/S providers also consider provider performance based upon grievance rates for re-credentialing frequency. Based upon these findings, the CCO's strategy and evidence for conducting credentialing and re-credentialing are comparable for providers of MH/SUD and M/S services.

Comparability and Stringency of Processes: All providers of MH/SUD and M/S services must successfully meet credentialing and re-credentialing requirements in order to be admitted to and continue to participate in the CCO's network. The information and documentation new providers are required to complete and submit as part of the credentialing process is substantially the same. Providers complete the Oregon Practitioner Credentialing and Re-credentialing application and supporting documents that include proof of professional liability insurance coverage, a copy of their license, DEA or pending registration, verification of the highest level of education and training, Board/residency certification, review of professional liability claims history, review of any sanctions/restrictions/or limitations on professional license, and attestation of good standing with clinical privileges in primary facility. Additionally, MH/SUD review includes verification of Controlled Dangerous Substance certificate registration and at least five years of relevant work history (which may be waived on a case-by-case basis). M/S provider

review also includes S&R policy and whether or not they perform deliveries. Both MH/SUD and M/S providers are given several methods of submitting their application and supporting documentation, including by email, mail, fax, courier or hand delivery.

The CCO's credentialing process involves Accreditation Manager review of required information (for MH/SUD) and Credentialing Committee review (for M/S). The Credentialing Committee makes credentialing decisions for MH/SUD and the Network and Quality Committee of the Board of Directors makes decisions for M/S. The credentialing process for MH/SUD takes less than 60 days; credentialing for M/S providers takes less than 90 days. Re-credentialing for both MH/SUD and M/S providers is conducted every three years, as required by OAR and the national accreditation standards used by the CCO (NQCA). Failure for MH/SUD and M/S providers to meet credentialing and re-credentialing requirements means that providers cannot contract with the CCO, cannot participate in the CCO's network and do not receive the CCO's contracted rate for services provided. Both MH/SUD and M/S providers challenge a credentialing/re-credentialing decision through the Fair Hearing process.

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

Stringency of Strategy and Evidence: All MH/SUD and M/S providers are subject to meeting credentialing and re-credentialing requirements; there are no exceptions to meeting requirements for admission into the network. However, depending upon need, on a case-by-case basis, requirements for MH/SUD providers may be waived, such as five years' work experience. Both MH/SUD and M/S providers may also provide services as OON providers and be reimbursed at a reduced DMAP rate. In operation, MH/SUD and M/S providers have been comparably impacted by the application of credentialing and re-credentialing requirements, with only one MH/SUD provider and fewer than 1% of M/S providers terminated from the network or denied admission in the last contract year as a result of credentialing/re-credentialing requirements.

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

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

8. Compliance Determination for Benefit Packages CCO E and G

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

PROVIDER ADMISSION — PROVIDER EXCLUSIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Compliance Determination for Benefit Packages CCO A and B

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

8. Compliance Determination for Benefit Packages CCO E and G

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

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

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

1. To which benefits is the NQTL assigned?

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• The purpose of having an open network is 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 services when the service is not available in the State of Oregon or the client is OOS and requires covered services.	• The purpose of having an open network is 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 availability of an in-State provider.	• The State seeks to maximize use of in-State providers because the State has determined that they meet applicable requirements, and they have a provider agreement with the State, which includes agreement to comply with Oregon Medicaid requirements and accept DMAP rates. • The purpose of providing OOS coverage is to provide needed services when the service is not available in the State of Oregon or the client is OOS and requires covered services.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	• The purpose of prior authorizing non-emergency OOS services is to ensure the criteria in OAR 410-120-1180 are met.		• The purpose of prior authorizing non-emergency OOS services is to ensure the criteria in OAR 410-120-1180 are met.

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

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• 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	• 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	• 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	• Non-emergency OOS services are not covered unless the service meets the OAR criteria. • The OAR criteria for OOS coverage of non-emergency services include the service is not available in the State of Oregon or the client is OOS and requires covered services. • Requests for non-emergency OOS services are made

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
be paid for those services at the DMAP rate. • 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.	through the State prior authorization process. • The timeframe for approving or denying a non-emergency OOS request is the same as for other prior authorizations (14 days for standard and 72 hours for urgent). • OOS providers must enroll with Oregon Medicaid. • The State pays OOS providers the Medicaid FFS rate.	be paid for those services at the DMAP 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.	through the State prior authorization process. • The average length of time to receive timeframe for approving or denying a non-emergency OOS request is the same as for other prior authorizations (14 days for standard and 72 hours for urgent). • OOS providers must enroll with Oregon Medicaid. • The State pays OOS providers the Medicaid FFS rate.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• The CCO 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.		• 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 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. Stringency of Strategy: How frequently or strictly is the NQTL applied?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• If a 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. • OON/OOS providers may appeal the denial of payment for an OON/OOS service. • In CY 2017 the CCO received 38 non-emergency OON/OOS requests for payment; 19 (50%) of these requests were denied; and one of the denied requests was overturned on appeal (5.3%). • 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,	• If a request for a non-emergency OOS benefit does not meet the OAR criteria, it will not be prior authorized. • If a non-emergency OOS benefit is not prior authorized, the service will not be covered, and payment for the service will be denied. • Members/providers may appeal the denial of an OOS request. • The State measures the stringency of the application of OOS requirements by reviewing OOS denial/appeal rates.	• If a request for a non-emergency 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, 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 was unable to determine the number of OOS requests that were received, denied, appealed, or overturned on appeal for CY 2017. • 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	• If a request for a non-emergency OOS benefit does not meet the OAR criteria, it will not be prior authorized. • If a non-emergency OOS benefit is not prior authorized, the service will not be covered, and payment for the service will be denied. • Members/providers may appeal the denial of an OOS request. • The State measures the stringency of the application of OOS requirements by reviewing OOS denial/appeal rates.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
notices of action, and whether an OON/OOS provider should be a network provider.		recruited to be a network provider.	

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

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

7. Compliance Determination for Benefit Packages CCO A and B

Comparability of Strategy and Evidence: The CCO has an open network for both MH/SUD and M/S. This means that any service delivered by an OON Medicaid provider 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. The purpose of having an open network is to ensure that members have access to appropriate quality care. The CCO's purpose for providing OOS coverage is to provide needed MH/SUD and M/S benefits when they are not available in-State. Similarly, for MH/SUD FFS benefits, the State provides OOS coverage to provide needed benefits when they are not available in-State. While the CCO does not require prior authorization for non-emergency OOS MH/SUD benefits, it does require prior authorization for non-emergency OOS M/S benefits. For both non-emergency FFS MH/SUD and CCO M/S OOS benefits, the State/CCO requires prior authorization to determine medical necessity and to ensure no in-State providers are available to provide the benefit. OOS coverage requirements are based on Federal and State requirements, including OAR (for both the State and the CCO) and the CCO contract (for the CCO). As a result, the strategy and evidence for OON/OOS coverage of non-emergency inpatient and outpatient benefits are comparable for MH/SUD and M/S benefits.

Comparability and Stringency of Processes: Requests for non-emergency OOS CCO M/S benefits are made through the CCO's prior authorization process and are reviewed for medical necessity and in-State coverage. The prior authorization timeframes (14 days for standard requests and 72 hours for urgent requests) apply. Similarly, the State reviews requests for non-emergency OOS MH/SUD services through its prior authorization process, and the prior authorization timeframes (14 days for standard requests and 72 hours for urgent requests) apply. OOS providers are reimbursed the Medicaid FFS rate. If the OOS MH/SUD provider is not enrolled in Oregon Medicaid, the provider must enroll in Oregon Medicaid. Similarly, the CCO requires both MH/SUD and M/S OON/OOS providers to be enrolled with Oregon Medicaid. If the OON/OOS MH/SUD or M/S provider does not agree to the DMAP rate, then the CCO will establish a single case agreement (SCA). The CCO's process for establishing a SCA is the same for MH/SUD and M/S providers and includes collecting information necessary to complete the SCA

and negotiating the terms of the SCA. SCAs can be established within 24 hours for MH/SUD and two to three days for M/S. The CCO pays MH/SUD OON/OOS providers the Medicaid FFS rate or a negotiated rate, and the rate paid to M/S OON/OOS providers includes the Medicaid FFS rate, a percentage of the Medicaid FFS rate, or a negotiated rate. While the CCO indicated that M/S providers have more rate options, both MH/SUD and M/S OON/OOS providers may be reimbursed at a rate higher than the DMAP rate. Based on this, the processes for MH/SUD and M/S non-emergency OON/OOS benefits are comparable and applied no more stringently to MH/SUD non-emergency OON/OOS benefits.

Stringency of Strategy and Evidence: For both FFS MH/SUD and CCO M/S, if a request for a non-emergency OOS benefit does not meet applicable criteria, which are based on Federal and State requirements, it will not be authorized, and payment for the service will be denied by the CCO/State. Similarly, if a payment request to the CCO for a non-emergency MH/SUD OOS request or a MH/SUD or M/S non-emergency OON request does not meet applicable criteria, which are based on Federal and State requirements, payment for the service will be denied. Members and providers may appeal the denial of OON/OOS authorization/payment requests to the CCO/State as applicable. While the State does not have statistics regarding OOS requests, the CCO states that in CY 2017 approximately 54% of MH/SUD OON/OOS payment requests were denied, and one denial was overturned on appeal (a 5% overturn rate). The CCO was not able to provide statistics for M/S OON/OOS. However, 5% is not a high appeal overturn rate and therefore does not raise a parity concern. As a result, the strategies and evidentiary standards for OON/OOS are no more stringently applied to MH/SUD benefits than to M/S benefits.

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

8. Compliance Determination for Benefit Packages CCO E and G

Comparability of Strategy and Evidence: The State provides OOS coverage to provide needed MH/SUD and M/S benefits when they are not available in-State. Similarly, the CCO provides OOS coverage to provide needed MH/SUD benefits when they are not available in-State. For both non-emergency MH/SUD and M/S OOS benefits, the State requires prior authorization to determine medical necessity and to ensure no in-State are available to provide the benefit. The CCO does not require prior authorization for OOS MH/SUD benefits. The State's OOS coverage requirements are based on OAR. The CCO's OON/OOS coverage requirements are based on OAR and the CCO contract. As a result, the strategy and evidence for OON/OOS coverage of non-emergency inpatient and outpatient benefits are comparable for MH/SUD and M/S benefits.

Comparability and Stringency of Processes: Requests for non-emergency OOS FFS MH/SUD and M/S benefits are made through the State's prior authorization process and are reviewed for medical necessity and in-State coverage. The prior authorization timeframes (14 days for standard requests and 72 hours for urgent requests) apply. The CCO does not require prior approval of OON/OOS MH/SUD services. OOS

FFS MH/SUD and M/S providers are reimbursed the Medicaid FFS rate. If the OOS provider is not enrolled in Oregon Medicaid, the provider must enroll in Oregon Medicaid. The CCO also requires OON/OOS MH/SUD providers to be enrolled with Oregon Medicaid. If the OON/OOS MH/SUD provider does not agree to the DMAP rate, then the CCO will establish a single case agreement (SCA). While requiring a SCA is an additional step for CCO MH/SUD providers, it is the provider's choice to not accept the DMAP rate, and this option is not available to M/S providers in FFS. The CCO pays OON/OOS MH/SUD providers either the Medicaid FFS rate or a negotiated rate. Based on this, the processes for MH/SUD non-emergency OON/OOS services are comparable and applied no more stringently to non-emergency MH/SUD OON/OOS benefits than to M/S benefits.

Stringency of Strategy and Evidence: For both MH/SUD and M/S FFS, if a request for a non-emergency OOS benefit does not meet applicable criteria, which are based on OAR, it will not be authorized, and payment for the service will be denied by the State. Similarly, if a request for payment of a non-emergency MH/SUD OON/OOS claim does not meet the CCO's criteria, which are based on OAR and the CCO contract, payment for the service will be denied by the CCO. For both MH/SUD and M/S, members and providers may appeal the denial of OON/OOS request. While the State does not have statistics regarding OOS requests, the CCO states that in CY 2017 approximately 54% of MH/SUD OON/OOS payment requests were denied, with a 5% appeal overturn rate. This appeal overturn rate for MH/SUD is a parity concern. As a result, the strategies and evidentiary standards for OON/OOS are no more stringently applied to MH/SUD benefits than to M/S benefits.

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