Oregon Health Authority

2020 Mental Health Parity Analysis Report

for

Eastern Oregon CCO, LLC

February 2021

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Introduction

Overview of Oregon's Mental Health Parity Analysis

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

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

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

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

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

Components of the 2020 MHP Analysis

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

Figure 1-1—MHP: Four Prescribed Classifications

OHP Benefit Packages

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

Table 1-1—OHP Benefit Packages

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

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

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

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

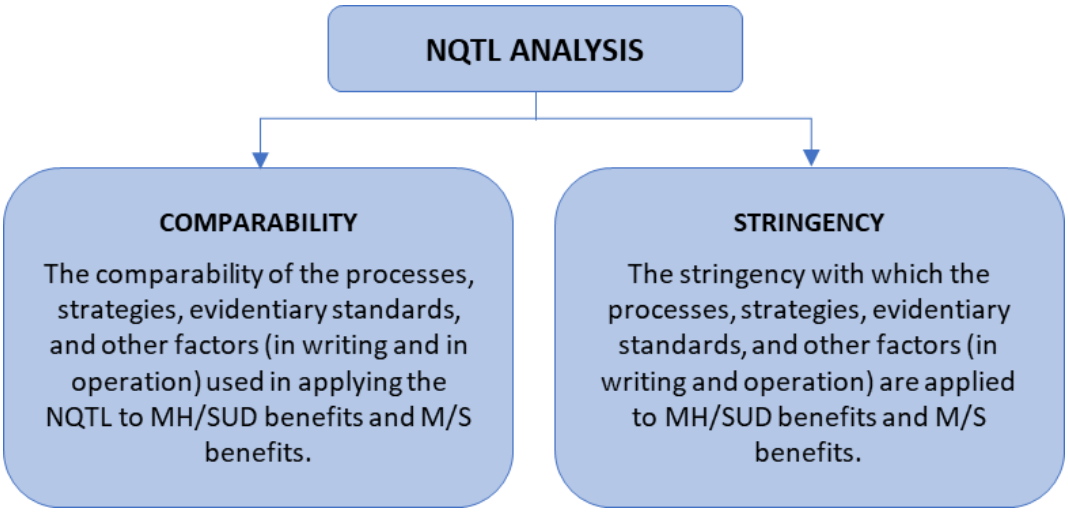
Non-Quantitative Treatment Limitations

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

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

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

Figure 1-2—MHP Analysis Comparability and Stringency



NQTL Categories

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

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

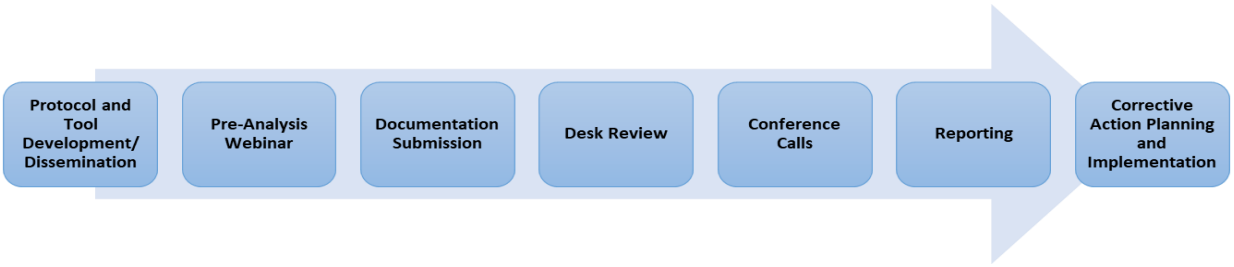
2. Process and Methodology

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

Analysis Activities for 2020

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

Figure 2-1—2020 MHP Analysis Activities



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

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

MHP Analysis Methodology

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

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

Table 2-1—Comparability and Stringency Standards

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

Analysis Results for 2020

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

3. MHP Analysis Results

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

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

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

Overall Assessment

EOCCO was responsible for delivering MH/SUD and M/S Medicaid benefits to members in all four benefit packages (CCOA, CCOB, CCOE, and CCOG), whereas OHP FFS was fully managing M/S benefits for CCOE and CCOG benefit packages. EOCCO was providing MH/SUD benefits prescribed by OHA and had delegation agreements with community mental health programs (CMHPs) for the management of some of these benefits, including PA and credentialing. Most of EOCCO's procedures were standardized across both MH/SUD and M/S benefits, and the CCO did not have segregated policies for the management of benefits based on benefit package. HSAG evaluated EOCCO's application of NQTLs to MH/SUD and M/S benefits in terms of comparability and stringency across the six NQTL categories.

For limits applied to IP and OP health benefits, EOCCO and its affiliate Greater Oregon Behavioral Health, Inc. used UM processes to manage MH/SUD and M/S benefits. The purpose of the CCO's UM processes was to ensure coverage, medical necessity, appropriate treatment in the least restrictive environment that maintains the safety of the individual, compliance with federal and State requirements, and the prevention of unnecessary overutilization. EOCCO reported that the evidence used to apply UM to MH/SUD and M/S included Oregon Administrative Rules (OARs), Health Evidence Review Commission (HERC) Prioritized List (PL) and guidelines, and Milliman Care Guidelines (MCG). Both EOCCO and FFS applied the required time frames for urgent and standard PA requests and made determinations based on medical necessity. Regarding interrater reliability (IRR), the CCO had a MH/SUD and M/S case review standard of 80 percent, which was consistent with OHP FFS's 80 percent standard for cases reviewed. HSAG's analysis determined that the rationale, documentation requirements, processes, and frequency of UM applied to IP and OP MH/SUD benefits were comparable

to those applied to IP and OP M/S benefits across all benefit packages with the exception of a parity concern related to PA data reported. Of the total 14,317 IP and OP PA requests reported, 21.54 percent of MH/SUD requests were denied, whereas only 5.76 percent of M/S requests were denied. The majority of the MH/SUD request denials were for OP benefit requests, resulting in HSAG identifying the concern of higher MH/SUD denial and overturn rates within the OP NQTL Category II. HSAG recommends that EOCCO review OP PA requests for opportunities for improvement in the UM process.

HSAG's analysis of EOCCO's processes and operations did not reveal any MHP concerns for the authorization of prescription drugs across the benefit packages. The application of PA for MH/SUD prescription drugs was comparable to PA for M/S prescription drugs. Prescription drug authorization requirements, guidelines, procedures, and 24-hour responses were determined to be no more stringently applied to MH/SUD benefit requests when compared to M/S requests.

HSAG's analysis of the processes, strategies, and evidentiary standards for OON/OOS limits applied to MH/SUD were determined to be comparable and no more stringently applied, in writing and in operation, to M/S OON/OOS limits across all benefit packages. OHP FFS's PA process for OOS requests was comparable across the two benefit types; however, the State did not use single case agreements (SCAs) for OON providers but instead enrolled the providers. This also did not present a parity concern.

Table 3-1 presents HSAG's overall assessment of EOCCO's compliance based on the analysis of the comparability of NQTL strategies and the stringency applied by EOCCO when implementing NQTLs.

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

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

Findings and Required Actions

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

Table 3-2 presents specific findings of non-parity organized by NQTL category. HSAG's analysis for EOCCO resulted in only one inconclusive finding within NQTL Category II.

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

#	NQTL Category	Finding	Required Action
1.	Category II—UM Limits Applied to Outpatient Services	EOCCO's 21.54 percent denial rate for MH/SUD authorization requests was significantly greater than the 5.76 percent denial rate for M/S. The rate of overturns for MH/SUD authorization denials was also significantly greater than the rate for M/S authorizations, 16.08 percent versus 1.56 percent, respectively. The higher rates of MH/SUD denials and overturns indicate a parity concern in how the CCO makes authorization decisions across the benefit types.	EOCCO should review its application of UM to OP PA requests to determine the basis for the higher rate of denials and to identify any parity concerns and opportunities for improvement to ensure that the process and decisions applied to MH/SUD authorizations are comparable to and no more stringent than the process and decisions applied to M/S authorizations.

Data Analysis Results

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

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

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

Utilization Management for Inpatient/Outpatient Services

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

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

Prior Authorizations by Benefit Type							
Benefit Type	# of PA Requests	# of PA Requests Denied	% of PA Requests Denied	# of PA Denials Appealed	% of PA Denials Appealed	# of PA Denials Overturned	% of PA Denials Overturned
MH/SUD	924	199	21.54%	33	16.58%	32	16.08%
M/S	13,393	771	5.76%	26	3.37%	12	1.56%
Total	**14,317**	**970**	**6.78%**	**59**	**6.08%**	**44**	**4.54%**

Observations

HSAG's analysis of EOCCO's PA data for IP and OP benefits revealed a parity concern related to a higher denial rates for MH/SUD PA requests as compared to M/S denials. The following data points were observed:

- Of the total 14,317 IP and OP PA requests reported, 21.54 percent of MH/SUD requests were denied, whereas only 5.76 percent of M/S requests were denied.
- The majority of the MH/SUD request denials were for OP benefit requests.

Based on the data, HSAG determined the larger number of MH/SUD denials and overturns as a parity concern that should be reviewed by EOCCO for opportunities for improvement. This concern was documented as a finding under NQTL Category II.

Utilization Management for Prescription Drugs

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

Table 3-4—Prior Authorization Counts for Prescription Drugs

Prior Authorization Counts (Formulary and Non-Formulary)						
# of PA Requests	# of PA Requests Denied	% of PA Requests Denied	# of PA Denials Appealed	% of PA Denials Appealed	# of PA Denials Overturned	% of PA Denials Overturned
2,416	1,118	46.27%	22	1.97%	12	1.07%

Observations

HSAG's analysis of EOCCO's counts for prescription drug PA requests did not reveal any concerns related to parity. The following data points were observed:

- Of the total 2,416 prescription drug PA requests reported, 46.27 percent were denied.
- Less than 2 percent of the 1,118 prescription drug PA request denials were appealed, with 12 PA denials resulting in an overturned decision.
- The majority of denied prescription drug PA requests were denied for "Medical Necessity" categorical reasons.

Enrollment/Credentialing

EOCCO provided requested data pertaining to provider enrollment requests and outcomes. Table 3-5 presents EOCCO's enrollment/credentialing counts by provider type, identifying the number of terminations and denials.

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

Enrollment/Credentialing Counts by Provider Type						
Provider Type	**Avg. # Enrolled Providers**	**# Providers Terminated**	**% Terminated**	**# of Cred. Requests**	**# of Cred. Requests Denied**	**% of Cred. Requests Denied**
MH/SUD	1,247	3	0.24%	51	0	0.00%
M/S	7,020	5	0.07%	137	0	0.00%
Total	**8,267**	**8**	**0.10%**	**188**	**0**	**0.00%**

Observations

HSAG's analysis of EOCCO's provider credentialing data did not reveal any parity concerns due to no denials reported and a low rate of terminations, which were primarily due to the providers leaving their practice group or lack of response for recredentialing. The following data points were observed:

- Of the 8,267 reported average number of providers enrolled during the reporting period, 15.08 percent were MH/SUD providers.
- For the 188 MH/SUD and M/S providers that were seeking credentialing during the reporting period, no denials were reported.

Additional Requirement Results

HSAG requested information from EOCCO on the required availability of medical necessity determinations regarding MH/SUD benefits to members, potential members, and contracting providers upon request, and how reasons for denial of reimbursement or payment for MH/SUD benefits were made available to members. EOCCO described its policies on notices of adverse benefit determination (NOABDs) and how the notices describe denial reasons for members. The CCO additionally provided an NOABD example representing MH/SUD denials, confirming that denial reasons inclusive of medical necessity determinations were made available to members. A review of EOCCO's website showed that the CCO had resources available on its website for members that included information on MH benefits available, a prescription drug formulary, and clinical practice guidelines. HSAG determined that EOCCO was compliant with the additional administrative MHP requirements.

4. Improvement Plan Process

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

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

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

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

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

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

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

Barb McConnell, Executive Director
bmcconnell@hsag.com
303.717.2105

Appendix A. MHP Evaluation Questionnaire

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

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

5.	Did the CCO change documentation requirements for UM requests for MH/SUD or M/S benefits (e.g., evidence of medical necessity, documentation submission requirements)?	☐ Yes ☒ No
6.	Did the CCO change qualifications for reviewers that can authorize or deny requests?	☐ Yes ☒ No
7.	Did the CCO develop or add medical necessity/level of care criteria for MH/SUD or M/S benefits?	☐ Yes ☒ No
8.	Did the CCO change the method for monitoring consistency of MNC application for MH/SUD or M/S benefits (e.g., standards for consistency of MNC, reliability adherence criteria)?	☐ Yes ☒ No
9.	Did the CCO change/modify penalties for failure to request/receive authorization for MH/SUD or M/S benefits (e.g., payment reductions, exceptions or waivers of penalties)?	☐ Yes ☒ No
10.	Did the CCO change frequency, time frames, or conditions of utilization review for MH/SUD or M/S benefits (e.g., RR or CR time frames or conditions)?	☒Yes ☐No
11.	What is the number of coverage requests, denials, appeals, appeal overturns, hearings, and hearing overturns experienced during the last full calendar year separately for MH/SUD and M/S for each classification (IP, OP, and Rx)? ***Documentation Required:*** *Provide lists that identify the number of coverage requests, denials, appeals, appeal overturns, hearings, and hearing overturns for the last full calendar year separately for MH/SUD and M/S for each classification (i.e., IP, OP, and Rx). For Rx, include a list identifying the number of drugs subject to PA.*	☐ Yes ☐ No

Provider Network Admission Changes in CCO—MH Parity Analysis Sections IV and V

Question		**Yes/No**
1.	Did the CCO change its network status from open (accepting new provider applications) to closed (not accepting new provider applications for certain provider types) or from closed to open?	☐ Yes ☒ No
2.	Did the CCO add, remove, or change provider admission requirements (e.g., special training, education, experience), including as a result of State licensing changes, for any MH/SUD or M/S providers?	☐ Yes ☒ No
3.	Were any of the CCO's providers denied credentialing due to network closure (if applicable) or based on credentialing requirements?	☐ Yes

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

Appendix B. Finalized MHP NQTL Reporting Tables

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

Category I—Utilization Management Limits Applied to Inpatient Services

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

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

Classification: IP and emergency care

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
1. To which benefit is the NQTL assigned?			
• (1, 2, 3) PA is required for acute, subacute, respite, residential (SUD, eating disorder) and SUD detox IP stays, including PRTS. PA may be requested concurrently and retrospectively. • (1, 2, 3) Emergency admissions require notification within 1-3 days of admission and subsequent CR. • (1, 3) Extra-contractual and experimental/investigational/ unproven benefit requests (i.e., exceptions) are submitted through a PA-like process.	• (1, 4) PA (only) for MH/SUD procedures performed in a medical facility (e.g., gender reassignment surgery authorizations, experimental/ investigational, and extra-contractual benefits are conducted by OHA consistent with the information in column 2). • (2, 4) A level-of-care review is required for SCIP, SAIP and subacute care that is conducted by an OHA designee. • (1, 4) PA for SCIP, SAIP and subacute admission is obtained through a peer-to-peer review between a Comagine psychiatrist and the referring psychiatrist. • (1, 2, 4) CR Comagine RR for SCIP and SAIP are performed by Comagine. • (1, 2, 4) CR and RR for subacute care are conducted by Comagine. • (1, 2, 4) PA, inclusive of a Certificate of Need (CONS)	• (1, 2, 3) PA and CR are required for planned non-emergency admissions to acute IP (in and out-of-network (OON). • (1, 2, 3) Emergency admissions require notification within 1-3 days of admission and subsequent CR. • (1, 2, 3) Skilled nursing facility benefits (first 20 days) require PA. • (1, 3) Extra-contractual and experimental/investigational/ unproven benefit requests (i.e., exceptions) are submitted through a PA-like process.	• (1, 2, 4) PA and CR are required for in-state and OOS planned surgical procedures (including transplants) and associated imaging, rehabilitation and professional surgical services delivered in an inpatient setting and listed in OAR 410-130-0200, Table 130-0200-1; rehabilitation, and long term acute care (LTAC). (Notification is required for all IP admissions.) • (1, 2, 4) PA, CR and RR for Behavior Rehabilitation Services (BRS) are performed by OHA, DHS or OYA designee. • (1, 2, 4) PA and CR of skilled nursing facility (SNF) services. • (1, 4) Requests for extra-contractual and experimental/investigational /unproven benefits (i.e., exceptions) are submitted through a PA-like process.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	process, and CR, is conducted by Comagine for PRTS. • (1, 2, 4) PA, CR for AFH, SRTF, SRTH, YAP, RTF, and RTH are performed by Comagine.		
2. Why is the NQTL assigned to these benefits?			
• To ensure coverage, medical necessity and prevent unnecessary overutilization (e.g., in violation of relevant OARs and associated Health Evidence Review Commission (HERC) guidelines2). • (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. • (3) To comply with federal and State requirements	• (1) UM is assigned to ensure medical necessity of services and prevent overutilization. • (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual (e.g., matching the level of need to the least restrictive setting using the LOCUS – Level-of-Care Utilization System and LSI – Level of Service Inventory or PCSP – Person Centered Service Plan and IBL – Individually-Based Limitations). • (4) To comply with federal and State requirements.	• To ensure coverage, medical necessity and prevent unnecessary overutilization (e.g., in violation of relevant OARs and associated Health Evidence Review Commission (HERC) guidelines). • 2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. • (3) To comply with federal and State requirements	• (1) PA and CR are assigned to ensure medical necessity of services and prevent overutilization (e.g., requests for care that are not medically necessary or in violation of relevant OARs, the Health Evidence Review Commission (HERC) PL and guidelines). • (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. • (4) To comply with federal and State requirements.
3. What evidence supports the rationale for the assignment?			
• (1, 2 and 3) HERC PL and guidelines.	• (1, 2, and 4) Health Evidence Review Commission (HERC) Prioritized List (PL) and	• (1, 2 and 3) HERC PL and guidelines.	• (1, 2 and 4) The HERC PL and guidelines. There are more guidelines for M/S than

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• (1) Capitation, claim, and encounter reports are reviewed for trends in overutilization on a monthly basis, reviewing a six-month window. Reviews compare provider to provider utilization and procure code utilization. • (1) Annual cost and utilization reports that confirm IP as a cost driver based on percentage of spend. • • (2) Oregon Performance Plan (OPP) requires that BH services be provided in least restrictive setting possible. The OPP is a DOJ-negotiated Olmsted settlement. Also see Roberts, E., Cumming, J & Nelson, K., A Review of Economic Evaluations of Community Mental Health Care, Sage Journals, Oct. 1, 2005, 1-13. Accessed May 25, 2018. http://journals.sagepub.com/doi/10.1177/1077558705279307.	guidelines. The HERC include 13 appointed members which include five physicians, a dentist, a public health nurse, a pharmacist and an insurance industry representative, a provider of complementary and alternative medicine, a behavioral health representative and two consumer representatives. The Commission is charged with maintaining a prioritized list of services, developing or identifying evidence-based health care guidelines and conducting comparative effectiveness research. HERC provides outcome evidence and clinical guidelines for certain diagnoses that may be translated into UM requirements. There are fewer guidelines for MH/SUD than for M/S. This is because 1) there are fewer technological procedures for MH/SUD (e.g., cognitive behavioral therapy and psychodynamic therapy are billed using the same codes, no surgeries, few	• (1) UM and claims reports are reviewed for trends in overutilization on a quarterly basis. • (1) Annual cost and utilization reports that confirm IP as a cost driver based on percentage of spend. • • (2) Medical errors in the hospital is the third leading cause of death in the US. Makary, M. & Daniel, M. Medical Error -The Third Leading Cause of Death in the US, BMJ, 2016;353:i2139. • (3) Applicable State and federal requirements.	for MH/SUD because 1) there are more technological procedures (e.g., surgery, devices, procedures and diagnostic tests); and 2) the literature is more robust. • (1) InterQual • (1) PA staff reports. If the UM team identifies any services for which utilization appears to be increasing (e.g., number of requests) or it appears that the State is paying for medically unnecessary care, the UM team consults with the health analytics team to analyze and evaluate adjustments to PA or CR. • (1) Health analytics reports. The health analytics team and policy analysts refer services that have been identified to have increasing utilization to the UM team for evaluation.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• (2) 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) Applicable State and federal requirements.	devices); 2) the MH/SUD literature is not as robust (e.g., fewer randomized trials, more subjective diagnoses (or the ICD-10-CM diagnoses represent a spectrum) and less standardization in interventions). • (1) InterQual.(		
4. What are the NQTL procedures?			
Timelines for authorizations: • Expedited IP stays are made within 72 hours. • Urgent Pre-Service IP stays are made in 2 working days. • Standard/Retrospective IP stays are made within 14 days. • PA requests for IP Head in Bed LOC admissions are expedited decisions. (Head in Bed=Acute, Subacute, Respite, Residential, PRTS) • PA requests for prior and concurrent SUD IP stays are urgent pre-service decisions	**Timelines for gender reassignment surgery authorizations:** **(OHA)** • Standard requests are to be processed within 14 days. **Timelines for child residential authorizations**: **(OHA)** • OHA provides the initial authorization (level-of-care review) within three days of receiving complete requests for SCIP, SAIP or subacute. **(Comagine)** • Authorization requests for PRTS are submitted prior to	**Timelines for authorizations:** • PA must be obtained prior to IP admission, preferably 14 days prior to admission, except in the case of emergencies, when notification is required 1–3 days following the admission. • The full 20-day SNF benefit is authorized during PA. • Authorization decisions for acute hospitalization and OON requests are made within the following timeline submissions: – Concurrent (within 1 calendar day)	**Timelines for authorizations:** • All in-state and out-of-state (OOS) emergency admissions, LTAC, and IP rehabilitation require notification. Notification is preferred within 24 hours of admission, but there is no timeline requirement. Notification allows the State to conduct case management and discharge planning, but does not limit the scope or duration of the benefit. • PA is required before admission. • OARs require emergency requests be processed within

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• PA must be obtained prior to IP admission, preferably 14 days prior to admission, except in the case of emergencies, when notification is required 1–3 days following the admission. • Authorization requests for sub-acute admissions must be made within 1 calendar day of admission. • PRTS IP admission is driven by the CONS process and PA. • PRTS referrals originate with a provider. The CMHP submits documentation to the CCO, and a CONs is completed by the CCO for approval/denial by an independent psychiatrist. • For youth residential (PRTS and subacute), most referrals originate with CCO and require a Certificate of Need (CON) be completed by HIA (usually takes 1 week to complete). • Authorization decisions for acute hospitalization, acute non-hospitalization, PRTS, residential and OON requests	admission or within 14 days of an emergency admission. An emergency admission is acceptable only under unusual and extreme circumstances, subject to RR by Comagine. **Timelines for adult residential and YAP authorizations**: **(Comagine Health)** • Emergency requests are processed within one business day, urgent within two business days, and standard requests within 10 business days.	– Urgent pre-service (2 calendar days) – Non urgent pre-service (14 calendar days – Post-service (within 30 days)	one business day, urgent requests within three business days and standard requests within 14 days.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
are made within the following timelines: – Concurrent (within 1 calendar day) – Urgent pre-service (2 calendar days) – Non urgent pre-service (14 calendar days) – Post-service (within 30 days)			
Documentation requirements: • PA form is one page long and requires supporting documentation to be submitted.	**Documentation requirements (OHA):** • PA documentation requirements for non-residential MH/SUD benefits include a form that consists of a cover page. Diagnostic and CPT code information and a rationale for medical necessity must be provided, plus any additional supporting documentation. • The documentation requirement for level-of-care assessment for SCIP, SAIP and subacute is a psychiatric evaluation. Other information may be reviewed when available.	**Documentation requirements:** • PA form is one page long and requires supporting documentation to be submitted. Some requests may require additional forms or treatment plans.	**Documentation requirements:** • PA documentation requirements include a form that consists of a cover page. Diagnostic and CPT code information and a rationale for medical necessity must be provided, plus any additional supporting documentation.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	Documentation requirements for PRTF CONS and CR for PRTF, SCIP and SAIP (Comagine): • PRTS CONS requires documentation that supports the justification for child residential services, including: – A cover sheet detailing relevant provider and recipient – Medicaid numbers; – Requested dates of service; – HCPCS or CPT Procedure code requested; and – Amount of service or units requested; – A behavioral health assessment and service plan meeting the requirements described in OAR 309-019-0135 through 0140; or – Any additional supporting clinical information supporting medical justification for the services requested;		

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	– For substance use disorder services (SUD), the Division uses the American Society of Addiction Medicine (ASAM) Patient Placement Criteria second edition-revised (PPC-2R) to determine the appropriate level of SUD treatment of care. • There are no specific documentation requirements for CR of PRTS, SCIP or SAIP. **Documentation requirements (Comagine Health)**: • Documentation may include assessment, service plan, plan-of-care, Level-of-Care Utilization System (LOCUS), Level of Service Inventory (LSI), PCSP, IBL, or other relevant documentation.		
Method of document submission: • Authorization requests can be made by phone, fax, email or US mail.	**Method of document submission (OHA):** • For non-residential MH/SUD services, paper (fax) or online PA requests are submitted prior to the delivery of	**Method of document submission:** • Notification for urgent/emergent admissions can be by faxed admission form or by phone.	**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
	services for which PA is required. • For SCIP, SAIP and subacute level-of-care review, the OHA designee may accept information via fax, mail or secure email and has also picked up information. Supplemental information may be obtained by phone. **Method of document submission (Comagine):** • Packets are submitted to Comagine by mail, fax, email or web portal for review for child residential services. Telephonic clarification may be obtained. • Psychiatrist to psychiatrist review is telephonic. **Method of document submission (Comagine Health):** • Providers submit authorization requests for adult MH residential to Comagine Health by mail, fax, email or via portal, but documentation must still be faxed if the request is through portal. Telephonic clarification may be obtained.		

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Qualifications of reviewers: • PA decisions are made by licensed healthcare professionals with appropriate credentials. • Medical director or licensed physician reviewers determine denials.	**Qualifications of reviewers (OHA)**: • OHA M/S staff conduct PA and CR (if applicable) for gender reassignment surgery. • The OHA designee is a licensed, master's-prepared therapist that reviews psychiatric evaluations to approve or deny the level-of-care requested. Psychiatric consultation is available if needed. **Qualifications of reviewers (Comagine)**: • Two reviewers with QMHP designation make residential authorization decisions. • Two psychiatrists make CONS determinations. **Qualifications of reviewers (Comagine Health)**: • Comagine Health QMHPs must meet minimum qualifications (see below) and demonstrate the ability to conduct and review an assessment, including identifying precipitating events, gathering histories of	**Qualifications of reviewers:** • PA decisions are made by a nurse. • Medical director determines denials.	**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
	mental and physical health, substance use, past mental health services and criminal justice contacts, assessing family, cultural, social and work relationships, and conducting/reviewing a mental status examination, complete a DSM diagnosis, and write and supervise the implementation of a PCSP. • A QMHP must meet one of the follow conditions: – Bachelor's degree in nursing and licensed by the State of Oregon; – Bachelor's degree in occupational therapy and licensed by the State of Oregon; – Graduate degree in psychology; – Graduate degree in social work; – Graduate degree in recreational, art, or music therapy; – Graduate degree in a behavioral science field; or		

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	– A qualified Mental Health Intern, as defined in 309-019-0105(61).		
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 are based on the HERC PL and guidelines; Oregon Statute, OAR, and federal regulations; InterQual guidelines; and evidence-based guidelines from private and professional associations. • OHA delegates review requests relative to least restrictive environment requirement. **Criteria (Comagine)**: • HERC PL, InterQual, and Comagine policy are used for residential CR. **Criteria (Comagine Health)**: • QMHPs review information submitted by providers relative to State plan and OAR requirements and develop a PCSP. • The PCSP components are entered into MMIS as an authorization.	**Criteria:** • Authorizations decisions are made using MCG, InterQual, HERC PL and guidelines, OAR.	**Retrospective Review:** • Retrospective authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why authorization could not have been obtained within the 90 days. **Reconsideration:** • A provider may request review of a denial decision. The review occurs in weekly MMC meetings. • Exception requests for experimental and other non-covered benefits may be granted at the discretion of the MMC, which is led by the OHA's medical director.

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; 90-timeframe limit on RR PA requests.	**Retrospective Review:** • Retrospective authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why authorization could not have been obtained within the 90 days. **Reconsideration (OHA)**: • A provider may request review of an OHA denial decision for nonresidential MH/SUD services. The review occurs in weekly Medical Management Committee (MMC) meetings. • Exception requests for experimental and other non-covered benefits may be granted at the discretion of the MMC, which is led by the HSD medical director. • If a provider requests review of an OHA delegate level-of-care determination, KEPRO may conduct the second review. **Reconsideration (Comagine)**: • If the facility requests a reconsideration of a CONS	**Reconsideration/RR:** • RR is offered for providers who fail to PA medically necessary care; 90-timeframe limit on RR PA requests.	

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	denial, a second psychiatrist (who did not make the initial decision) will review the documentation and discuss with the facility in a formal meeting. • No policy for CR denials. **Reconsideration (Comagine Health)**: • Within 10 days of a denial, the provider may send additional documentation to Comagine Health for reconsideration. • A provider may request review of a denial decision, which occurs in weekly MMC meetings or Comagine Health's own comparable medical management meeting.		
Appeals: • Providers/members have appeal rights. • The only procedural difference for children (relative to adults) is the parental guardian procedures.	**Appeals (OHA)**: • Members may request a hearing on any denial decision. **Appeals (Comagine)**: • Members may request a hearing on any denial decision. **Appeals (Comagine Health)**:	**Appeals:** • Providers/members have appeal rights	**Appeals:** • Standard appeal and fair hearing rights apply.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	• Members may request a hearing on any denial decision.		
Consequences for failure to authorize: • Failure to obtain authorization can result in no payment	**Consequences for failure to authorize (OHA)**: • Failure to obtain authorization for non-residential MH/SUD services can result in non-payment for benefits for which it is required. • Failure to obtain notification for non-residential MH/SUD services does not result in a financial penalty. • For SCIP, SAIP and subacute, if coverage is retroactively denied, general funds will be used to cover the cost of care. **Consequences for failure to authorize (Comagine)**: • Non-coverage. **Consequences for failure to authorize (Comagine Health)**: • Failure to obtain authorization can result in non-payment for benefits for which it is required.	**Consequences for failure to authorize:** • Failure to notify of urgent or emergent admission can result in delay or no payment	**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
5. How frequently or strictly is the NQTL applied?			
Frequency of review (and method of payment): • Authorizations for IP acute care are reviewed daily by the UM Coordinator and reviewed as determined by the medical reviewer and documented by UM Coordinator using MCG. • Subacute is reviewed every 7 days • PRTS is reviewed every 30 days. • SUD residential is reviewed based on member need and guidance (i.e., check documentation for progress every 30 days and make authorization determination every 90 days).	**Frequency of review (and method of payment) (OHA)**: • Gender reassignment surgery is authorized as a procedure. • The initial authorization for SCIP, SAIP, and subacute is 30 days. **Frequency of review (and method of payment) (Comagine)**: • Child residential services are paid by per diem. • Child residential services authorizations are conducted every 30-90 days. **Frequency of review (and method of payment) (Comagine Health)**: • Adult residential authorizations are conducted at least once per year. An independent and qualified agent (IQA) contacts MH provider quarterly for 1915i assessment accuracy. If member's status changes for more than 30 days, provider can contact IQA for a re-assessment.	**Frequency of review (and method of payment):** • Notifications are given a 2-day authorization and chart notes are required for continued stay • Concurrent review timeframes are case dependent and average 3 days. • SNF /swing bed post-hospital extended care services are approved for a maximum of 20 days per the benefit allowance • Standard authorizations are valid for a date span of 90 days. If a provider is unable to perform the services within the time span, the provider can call and request an extension.	**Frequency of review (and method of payment):** • Most IP claims are paid DRG; as a result, CR is infrequently used. • CR is conducted monthly for LTAC and rehabilitation. • The State conducts CR for SNF at a frequency that is determined by the care manager, but not less than one time a year. • Authorization lengths are individualized by condition and are valid for up to a year. • Procedural authorizations are valid for three months.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
RR conditions and timelines: • RR is offered for providers who fail to PA medically necessary care; 90-timeframe limit on RR PA requests.	**Retrospective Review:** • Retrospective authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why authorization could not have been obtained within the 90 days. **Reconsideration (OHA)**: • A provider may request review of an OHA denial decision for nonresidential MH/SUD services. The review occurs in weekly Medical Management Committee (MMC) meetings. • Exception requests for experimental and other non-covered benefits may be granted at the discretion of the MMC, which is led by the HSD medical director. • If a provider requests review of an OHA delegate level-of-care determination, KEPRO may conduct the second review. **Reconsideration (Comagine)**:	**RR conditions and timelines:** • RR is offered for providers who fail to PA medically necessary care; 90-timeframe limit on RR PA requests.	**Retrospective Review:** • Retrospective authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why authorization could not have been obtained within the 90 days. **Reconsideration:** • A provider may request review of a denial decision. The review occurs in weekly MMC meetings. • Exception requests for experimental and other non-covered benefits may be granted at the discretion of the MMC, which is led by the OHA's medical director.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	• If the facility requests a reconsideration of a CONS denial, a second psychiatrist (who did not make the initial decision) will review the documentation and discuss with the facility in a formal meeting. • No policy for CR denials. **Reconsideration (Comagine Health)**: • Within 10 days of a denial, the provider may send additional documentation to Comagine Health for reconsideration. • A provider may request review of a denial decision, which occurs in weekly MMC meetings or Comagine Health's own comparable medical management meeting.		
Methods to promote consistent application of criteria: • IRR testing is conducted semiannually.	**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	**Methods to promote consistent application of criteria:** • IRR testing is conducted semiannually.	**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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	submitted to Compliance Department monthly for review and documentation. • Individual feedback is provided to each clinician during supervision on their authorization as well as plan-of-care reviews.		
6. What standard supports the frequency or rigor with which the NQTL is applied?			
Evidence for UM frequency: • Concurrent review for acute IP and IP rehabilitation are guided by MCG and are case dependent. • MCG is set up for daily IP review. MCG provides the evidence-based goal for each day by diagnosis. If goal is met, MCG moves to the next phase of treatment. If treatment is not progressing consistent with daily MCG goals, then identify variance and address why (which extends expected length of stay). • ASAM criteria are integrated into MCG.	**Evidence for UM frequency (OHA (and designee for level-of-care review), Comagine and KEPRO)**: • PA length and CR frequency are tied to HERC PL and guidelines, OAR, CFRs, InterQual, reviewer expertise and timelines for expectations of improvement.	**Evidence for UM frequency:** • Concurrent review for acute IP and IP rehabilitation and are guided by MCG and are case dependent.	**Evidence for UM frequency:** • PA length and CR frequency are tied to HERC PL and guidelines, DRGs, OAR, CFRs, InterQual, reviewer expertise and timelines for expectations of improvement.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Data reviewed to determine UM application: • EOCCO/GOBHI tracks all service authorization requests and evaluates the types of authorizations and denials, tracks number of denials, grievances and appeals and the outcomes.	**Data reviewed to determine UM application**: • Denial/appeal overturn rates; number of PA requests; stabilization of cost trends; and number of hearings requested. These data are reviewed in subcontractor reports, on a quarterly basis by the State. (Applicable to non-residential MH/SUD services.) **Data reviewed to determine UM application (Comagine)**: • N/A **Data reviewed to determine UM application (Comagine Health):** • N/A	**Data reviewed to determine UM application:** • EOCCO/Moda tracks all service authorization requests for authorizations and denials, tracks number of denials, grievances and appeals and outcomes.	**Data reviewed to determine UM application:** • A physician led group of clinical professionals conducts an annual review to determine which services receive or retain PA. Items reviewed include: – Utilization. Approval/denial rates. – Documentation/ justification of services. – Cost data.
IRR standard: • IRR testing is conducted to a standard of 80%.	**IRR standard:** • KEPRO has a formal policy including an 80% standard using InterQual criteria.	**IRR standard:** • IRR testing is conducted to a standard of 80%.	**IRR standard:** • KEPRO has a formal policy including an 80% standard using InterQual criteria.
Analysis			
EOCCO was responsible for delivering IP MH/SUD and M/S Medicaid benefits to members in all four benefit packages (CCOA, CCOB, CCOE, and CCOG), whereas OHP FFS was fully managing IP M/S benefits for CCOE and CCOG benefit packages. Emergency MH/SUD and M/S IP hospital admissions required notification, with most ongoing IP services requiring subsequent CR. Regarding nonemergent CCO MH/SUD and M/S IP admissions, PA or level-of-care approval was required. PA was also required for extra-contractual coverage requests (including experimental services); planned surgical procedures (including transplants); and associated imaging, rehabilitation, and professional surgical services delivered in an IP setting and listed in OAR 410-130-0200, Table 130-0200-1. For psychiatric residential treatment services			

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

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

Of the total 14,317 IP and OP PA requests reported, 21.54 percent of MH/SUD requests were denied, whereas only 5.76 percent of M/S requests were denied. The majority of the MH/SUD request denials were for OP benefit requests, resulting in HSAG identifying the concern of higher MH/SUD denial and overturn rates within NQTL Category #2.

Comparability

UM was assigned to MH/SUD and M/S IP benefits primarily using four rationales: 1) To ensure coverage, medical necessity, and prevent unnecessary overutilization (e.g., in violation of relevant OARs, HERC PL and guidelines, or clinical practice guidelines or research); 2) To ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual; 3) To maximize use of in-network (INN) providers to promote cost-effectiveness when appropriate; and 4) To comply with federal and State requirements. HSAG determined the rationales and evidence to be comparable.

Emergency MH/SUD and M/S IP hospital admissions required notification within 24 to 72 hours, with child emergency residential admissions separately requiring notification within 14 days. Most CCO documentation requirements for MH/SUD include an admission note and records submitted via telephone, fax, or electronically. OARs required authorization decisions within 24 hours for emergencies, 72 hours for urgent requests, and 14 days for standard requests. Both EOCCO and OHP FFS adhered to these requirements across the benefit packages. Most ongoing IP services required subsequent CR. Documentation requirements for child residential PA/level-of-care review included a psychiatric evaluation or a psychiatrist-to-psychiatrist telephonic review. Comagine Health, OHP FFS's subcontractor, accepted information for child residential CR via mail, email, fax, and Web portal. Adult and youth residential required an assessment (i.e., completion of a relevant level-of-care tool [e.g., ASAM, LSI, or LOCUS]) and plan-of-care consistent with State plan requirements. Comagine Health documentation submission could be done using mail, email, fax, or Web portal. Consistent with OARs, federal CON procedures, and due to the potential absence of a psychiatric referral, the PRTS documentation requirements included a cover sheet, a behavioral health assessment, and service plan meeting the requirements described in OAR 309-019-0135 through 0140. HSAG determined the MH/SUD authorization time frames and documentation requirements were comparable to those applied to M/S benefits across all benefit categories.

Stringency

Qualified individuals conducted UM applying OARs, HERC, MCG, and other nationally and CCO-established guidelines for CCO MH/SUD and M/S benefits, and also ASAM for CCO SUD. The CCO and OHP FFS subcontractors required all MH/SUD and M/S denials to be made by

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
professional peers; however, nurses were able to deny benefits managed by OHP FFS. HSAG determined this difference to be an issue of quality rather than parity. OHP FFS's subcontractor, Comagine Health (a licensed MH professional), made denial determinations for level-of-care review for certain child residential services. Both the CCO and OHP allowed for 90-day RRs for MH/SUD and M/S when providers failed to obtain authorization and allowed exceptions to these time frames based on medical necessity and provider request. For adult and youth residential services, Comagine Health allowed reconsideration of denials with the submission of additional documentation within 10 days of the denial. For OHP FFS and Comagine Health, the review of denial decisions occurred during MMC meetings. MH/SUD and M/S denial decisions could be appealed through appeals and/or State fair hearing processes. Failure to obtain authorization could result in noncoverage, although SCIP, SAIP, and subacute services could be covered by general fund dollars. Regarding IRR, the CCO had a MH/SUD and M/S case review standard of 80 percent, which was consistent with OHP FFS's 80 percent standard for cases reviewed. HSAG determined the frequency and rigor of UM applied to MH/SUD benefits was no more stringent than the frequency and rigor applied to M/S benefits. While the high rates of MH/SUD authorization request denials and overturns reported were primarily associated with outpatient authorizations, HSAG recommends that EOCCO also review IP PA requests to determine whether opportunities for improvement in the UM process exists			
Outcome			
HSAG's analysis determined that the rationale, documentation requirements, processes, and frequency of UM applied to IP MH/SUD benefits were comparable to those applied to IP M/S benefits across all benefit packages.			

Category II—Utilization Management Limits Applied to Outpatient Services

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

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

Classification: OP

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

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

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
1. To which benefit is the NQTL assigned?				
• (2) Applied Behavior Analysis (ABA). • (2) OT, PT, ST for MH conditions are	The following services are managed by DHS: • (1) 1915(c) Comprehensive DD waiver.	• (2) ABA (including PT/ST/OT) • (3) ECT	• (2) PT/OT/ST • (3) Bariatric evaluation • (2) Acupuncture	The following services are managed by OHA: • (2, 3) Out of hospital births.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
managed through RR; PA is not required.	• (1) 1915(c) Support Services DD waiver. • (1) 1915(c) Behavioral DD Model waiver. • (1) 1915(c) Aged & Physically Disabled waiver. • (1) 1915(c) Hospital Model waiver. • (1) 1915(c) Medically Involved Children's NF waiver. • (1) 1915(k) Community First Choice State Plan option. • (1) 1915(j): Self-directed personal assistance.	• (3) SUD MAT (for OON providers only, after first 30 days) • OP Eating Disorder Treatment. • Psych/Nueropsych, • Transcranial Magnetic Stimulation. • (2, 3) OON OP - requires notification followed by a medical necessity review and qualifications check.	• (2) Chiropractic services (2) OMT and CMT, habilitative or rehabilitative (2) DME • (2, 3) Imaging • (2) Elective surgical procedures • (3) Pain management related to back pain (only if practitioner is not qualified in CBT or pain management, requiring a SCA)	• (2) Home health services. • (2) OT, PT, ST for MH conditions are managed through RR; PA is not required. • (2, 3) Imaging. • (2) DME.
2. Why is the NQTL assigned to these benefits?				
• (2) HERC PL. • (2) OAR 410-172-0650 for ABA services. • (2) PA requests with insufficient documentation to demonstrate MNC or HERC PL guidelines are not being followed.	• (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 and in the last restrictive setting.	• (2) To ensure coverage, medical necessity and prevent unnecessary overutilization. • (3) Ensure appropriate treatment in the least restrictive environment that maintains the	• (2) To ensure coverage, medical necessity and prevent unnecessary overutilization. • (3) Ensure appropriate treatment in the least restrictive environment that maintains the	• (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 MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
		safety of the individual.	safety of the individual.	increased health or safety risks.
3. What evidence supports the rationale for the assignment?				
• (2) HERC PL • (2) OAR 410-172-0650 for ABA services. • (2) PA requests with insufficient documentation to demonstrate medical necessity is not being met or HERC PL guidelines are not being followed.	• (1) Federal requirements regarding PCSPs for 1915(c), 1915(k), and 1915(j) services (e.g., 42 CFR 441.301, 441.468, and 441.540) and the applicable approved 1915(c) waiver application/State plan amendment. • (1) Federal requirements regarding 1915(c) and 1915(i) services require that HCBS are provided in the least restrictive setting possible.	• (2) OARs, HERC PL and guidelines, and federal guidelines. • (2) Capitation, claim, and encounter reports are reviewed for trends in overutilization on a monthly basis, reviewing a six-month window. Reviews compare provider to provider utilization and procure code utilization. • (2) Annual cost and utilization reports. • (3) State and federal requirements. • (3) Oregon Performance Plan (OPP) requires that BH services be provided in least restrictive setting possible. The OPP is a DOJ-negotiated Olmsted settlement.	• (2) OARs, HERC PL and guidelines, and federal guidelines. • (2) UM and claims reports are reviewed for trends in overutilization on a quarterly basis. • (2) Annual cost and utilization reports. • (3) HERC guidelines re safety concerns. MCG and InterQual.	• (2) HERC PL and guidelines, and clinical practice guidelines. • (2) PA requests with insufficient documentation to demonstrate medical necessity are not being met or HERC PL guidelines are not being followed. • (3) HERC Guidelines - Recommended limits on services for member safety.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
		• (3) HERC guidelines re safety concerns. MCG and ASAM.		
4. What are the NQTL procedures?				
Timelines for authorizations: • Urgent requests are processed in three business days and immediate requests in one business day. Routine requests are processed in 14 days. • OT, PT, ST for MH conditions are managed through RR; PA is not required.	**Timelines for authorizations**: • A PCSP must be approved within 90 days from the date a completed application is submitted.	**Timelines for authorizations:** • Authorizations for SUD MAT and OP OON requests occur within the following timelines: – Urgent pre-service (2 calendar days). – Non urgent pre-service (14 calendar days). • Post-service (within 30 days).	**Timelines for authorizations:** • Authorizations for OON requests are made within the following timelines: – Urgent pre-service (2 calendar days) – Non urgent pre-service (14 calendar days) – Post-service (within 30 days)	**Timelines for authorizations:** • Urgent requests are processed in three business days and immediate requests in one business day. Routine requests are processed in 14 days. • OT, PT, ST for MH conditions are managed through RR; PA is not required.
Documentation requirements: • Form is one cover page. • Require diagnostic and CPT code and rationale for medical necessity plus any additional supporting documentation. • In addition, as part of the supporting	**Documentation requirements**: • The PCSP is based on a functional needs assessment and other supporting documentation. It is developed by the individual, the individual's team, and the individual's case manager.	**Documentation requirements:** • PA form is 1 page long and requires supporting documentation to be submitted. • OON PA form is 2 pages long and requires supporting documentation to be submitted.	**Documentation requirements:** • Most services use a PA form which is 1 page long and requires supporting documentation to be submitted. Some requests may require additional forms or treatment plans.	**Documentation requirements:** • A cover page form is required. In addition, diagnostic information, a CPT code(s), a rationale for medical necessity plus any additional supporting documentation are required.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
documentation ABA must have an evaluation and referral for treatment from a licensed practitioner described in OAR 410-172-0760 (1)(a-d) and a treatment plan from a licensed health care professional described in 410-172-0650(B). • Documentation supporting medical necessity is required at the time of billing for OT, PT, ST services.				• Documentation supporting medical necessity is required at the time of billing for OT, PT, ST services.
Method of document submission: • Paper (fax) or online PA/POC submitted prior to the delivery of services.	**Method of document submission**: • All 1915(c), 1915(k), and 1915(j) services must be included in a participant's PCSP and approved by a qualified case manager at the local case management entity (CME) prior to service delivery. • Information is obtained during a face-	**Method of document submission:** • Requests can be submitted by phone, fax, email or US mail prior to service delivery.	**Method of document submission:** • Imaging requests are submitted via portal, phone or fax with supporting documentation prior to service delivery.	**Method of document submission**: • Paper (fax) or online PA/POC submitted prior to the delivery of services.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
	to-face meeting, often at the individual's location.			
Qualifications of reviewers: • For ABA services, physicians review services. • For OT, PT, ST services, nurses may authorize and deny services. • Professional peers deny for other OP services.	**Qualifications of reviewers:** • 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 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	**Qualifications of reviewers:** • Approvals are made by licensed clinical staff. • Denials are made by licensed physician reviewers.	**Qualifications of reviewers:** • Authorizations decisions are made by a nurse • Medical director determines denials.	**Qualifications of reviewers:** • Nurses may authorize and deny services.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
	• Three years of human services related experience.			
Criteria: • Authorizations are based on applicable HERC PL and guidelines, Oregon Revised Statute, OAR, federal regulations, and evidence-based guidelines from private and professional associations such as the American Psychiatric Association, where no State or federal guidelines exist.	**Criteria**: • Qualified case managers approve or deny services in the PCSP consistent with waiver/state plan and OAR requirements. • Once a PCSP is approved, itis entered into the payment management system as authorization by the CME staff.	**Criteria:** • MCG, ASAM, HERC or OARs.	**Criteria:** • MCG, InterQual or other guidelines specified by OAR or HERC.	**Criteria:** • Authorizations are based on applicable HERC PL and guidelines, Oregon Revised Statute, OAR, federal regulations, and evidence-based guidelines from private and professional associations such as the Society of American Gastrointestinal and Endoscopic Surgeons where no State or federal guidelines exist.
Reconsideration/RR: • A provider may request review of a denial decision, which occurs in weekly MMC meetings or Comagine's own	**Reconsideration/RR:** • (c) NA	**Reconsideration/RR:** • RR is offered for providers who fail to PA medically necessary care; 90-timeframe limit on RR PA requests.	**Reconsideration/RR:** • RR is offered for providers who fail to PA medically necessary care; 90-timeframe limit on RR PA requests.	**Reconsideration/RR:** • A review of a denial decision can be requested and is reviewed in weekly MMC meetings. • RR authorization requests can be made

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
comparable MMC meeting. • RR authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why authorization could not have been obtained within the 90 days. • OT, PT, ST are reviewed after the initial service prior to payment. Additionally, denial decisions can be requested and reviewed at weekly MMC meetings.				within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why authorization could not have been obtained within the 90 days. • OT, PT, ST are reviewed after the initial service prior to payment. Additionally, denial decisions can be requested and reviewed at weekly MCM meetings.
Consequences for failure to authorize: • Failure to obtain authorization may result in non-payment.	**Consequences for failure to authorize:** • Failure to obtain authorization may result in non-payment.	**Consequences for failure to authorize:** • Failure to obtain prior or concurrent authorization can result in no payment	**Consequences for failure to authorize:** • Failure to PA or notify of service can result in delay of or no payment	**Consequences for failure to authorize:** • Failure to obtain authorization may result in non-payment.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
Appeals: • Notice and fair hearing rights apply.	**Appeals**: • Notice and fair hearing rights apply.	**Appeals:** • Providers and members have appeal rights	**Appeals:** • Providers/members have appeal rights	**Appeals**: • Notice and fair hearing rights apply.
5. How frequently or strictly is the NQTL applied?				
Frequency of review: • PA is granted for different LOS depending on the service and can be adjusted. PAs for extensive services usually range from 6 months to 1 year. • ABA is usually multiple service codes approved for 6 months. • Exceptions may be made at the discretion of the MMC, which is led by the HSD medical director.	**Frequency of review:** • PCSPs are reviewed and revised as needed, but at least every 12 months.	**Frequency of review:** • ABA authorizations can be approved for up to 6 months and reauthorizations are per HERC guidelines. • Reviews for ECT are determined by UM medical reviewer. • No UM reviews are required for in-network SUD MAT, as this does not require a PA. • OON OP services are reviewed by a UMC at a maximum of every 12 months. • OON OP is reviewed every 3 months. • Majority of OP is sub-capitated. Other than the services listed above, the only other review for them is RR	**Frequency of review:** • Standard authorizations are issued for a date span of 90 days. If a provider is unable to perform the services within the time span, the provider can call and request an extension. • CBT for pain management related to back pain is authorized for up to 90 days and re-evaluation for effectiveness.	**Frequency of review:** • PA is granted for different authorization periods depending on the service and can be adjusted. PAs for extensive services usually range from six months to 1 year. • Exceptions may be made at the discretion of the MMC, which is led by the HSD medical director.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
		for fraud and abuse purposes.		
Reconsideration/RR: • A provider may request review of a denial decision, which occurs in weekly MMC meetings or Comagine's own comparable MMC meeting. • RR authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why authorization could not have been obtained within the 90 days. • OT, PT, ST are reviewed after the initial service prior to payment. Additionally, denial decisions can be requested and reviewed at weekly MMC meetings.	**Reconsideration/RR:** • NA	**RR conditions and timelines:** • RR is available consistent with OAR requirements. • For certain circumstances, RR may be submitted up to 12 months from the date of service.	**RR conditions and timelines:** • Post service review available except for advanced imaging which has no retro review period) consistent with OAR requirements. • For certain circumstances, RR may be submitted up to 12 months from the date of service.	**Reconsideration/RR:** • A review of a denial decision can be requested and is reviewed in weekly MMC meetings. • RR authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why authorization could not have been obtained within the 90 days. • OT, PT, ST are reviewed after the initial service prior to payment. Additionally, denial decisions can be requested and reviewed at weekly MCM meetings.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
Methods to promote consistent application of criteria: • For ABA, a sample of cases are reviewed for ability to address assessed member needs and whether OARs were met.	**Methods to promote consistent application of criteria:** • DHS Quality Assurance Review teams review a representative sample of PCSPs as part of quality assurance and case review activities to assure that PCSPs meet program standards. • Additionally, OHA staff review a percentage of files to assure quality and compliance.	**Method to promote consistent application of criteria:** • IRR testing is conducted semi-annually.	**Method to promote consistent application of criteria:** • IRR standard is conducted semi-annually.	**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 states that PAs can be approved and renewed up to one year at a time. • Whenever possible, practice guidelines from clinical professional organizations such as the American Medical Association or the American Psychiatric Association, are used to establish PA frequency.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
5. What standard supports the frequency or rigor with which the NQTL is applied?				
Evidence for UM frequency: • HERC guidelines (for ABA and OT, PT, ST) of which there are more M/S than MH/SUD because 1) there are more technological procedures (e.g., surgery, devices, procedures and diagnostic tests); 2) the literature is more robust. • The amount of time a PA covers for services is limited by OAR 410-120-1320(7) which states that PAs can be approved and renewed up to one year at a time. • Whenever possible, practice guidelines from clinical professional organizations such as the American Medical Association or the	**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:** • MCG is evidence for authorization frequency. MCG provides average length of stay for lightly and loosely managed programs. OP management is tied to stages and treatment progress • (rather than average length of treatment).	**Evidence for UM frequency:** • MCG is evidence for authorization frequency.	**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 states that PAs can be approved and renewed up to one year at a time. • Whenever possible, practice guidelines from clinical professional organizations such as the American Medical Association or the American Psychiatric Association, are used

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
American Psychiatric Association, are used to establish PA frequency.				to establish PA frequency.
Data reviewed to determine UM application: • A physician-led group of clinical professionals conduct an annual review to determine which services receive or retain a PA; items reviewed include: – Utilization. – Approval/denial rates. – Documentation/justification of services. – Cost data.	**Data reviewed to determine UM application:** • N/A	**Data reviewed to determine UM application:** • EOCCO/GOBHI track all service authorization requests and evaluates the types of authorizations and denials, tracks number of denials, grievances and appeals and the outcomes	**Data reviewed to determine UM application:** • EOCCO/Moda tracks all service authorization requests for authorizations and denials, tracks number of denials, grievances and appeals and outcomes	**Data reviewed to determine UM application:** • A physician-led group of clinical professionals conduct an annual review to determine which services receive or retain a PA; items reviewed include: – Utilization. – Approval/denial rates. – Documentation/justification of services. – Cost data.
IRR standard (OHA): • KEPRO has a formal policy including an 80% standard using InterQual criteria. **IRR standard (Comagine):**	**IRR standard:** • Spot-checks performed through supervision.	**IRR standard:** • IRR standard is 80%.	**IRR standard:** • IRR standard is 80%.	**IRR standard (OHA):** • KEPRO has a formal policy including an 80% standard using InterQual criteria.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
• Spot-checks performed through supervision. Formal policy to be developed. **IRR standard (Comagine Health):** • Spot-checks performed through supervision.				

Analysis

UM was applied to FFS MH/SUD and M/S HCBS benefits, and CCO MH/SUD and FFS M/S OP benefits listed in comparability and stringency Standard #1. For HCBS, MH/SUD benefits were administered by the Oregon Department of Human Services (DHS) and OHA's subcontractor, Comagine Health, while HCBS M/S benefits were administered by DHS. Pursuant to the 2020 CCO 2.0 Health Care Services Contract, EOCCO did not require PA for MH/SUD services with the exception of more intensive care benefits such as ABA, psychiatric day treatment, and transcranial magnetic stimulation.

Of the total 14,317 IP and OP PA requests reported, 21.54 percent of MH/SUD requests were denied, whereas only 5.76 percent of M/S requests were denied. The majority of the MH/SUD request denials were for OP benefit requests. Based on the data, HSAG determined the larger number of MH/SUD denials and overturns as a parity concern that should be reviewed by EOCCO for opportunities for improvement.

Comparability

UM of MH/SUD and M/S HCBS benefits was required to meet federal HCBS requirements regarding person-centered service plans (PCSPs), providing benefits in the least restrictive environment, and applicable waiver applications/State plan amendments. Evidence for the application of UM to these benefits included federal requirements regarding PCSPs for 1915(c), 1915(i), 1915(k), and 1915(j) services and applicable approved waiver applications/State plan amendments. UM was applied to non-HCBS CCO MH/SUD, and M/S OP services were assigned UM to confirm coverage relative to the HERC PL and guidelines and federal guidelines. Non-HCBS MH/SUD services were also reviewed to ensure services were medically necessary relative to clinical practice guidelines and offered in the least restrictive environment that is safe, as required by the OPP Olmstead settlement for MH/SUD. A subset of CCO M/S OP services were also assigned UM to assure the individual's safety. Evidence for safety issues included HERC guidelines. HSAG determined the rationale and evidence to be comparable.

OARs require authorization decisions within 24 hours for emergencies, 72 hours for urgent requests, and 14 days for standard requests. EOCCO and OHP FFS were following these required time frames for authorizations. For MH/SUD benefits, EOCCO required the submission of specific level-of-care assessments (e.g., CASII, ASAM, and LSI) while M/S level-of-care information was diagnosis-specific. Alternatively,

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
documentation could be submitted via fax. PCSPs for both M/S and MH/SUD were required to be developed within 90 days. The PCSP for both MH/SUD and M/S was based on assessments and other relevant supporting documentation. It was developed by the member, the member's team, and the member's case manager. HSAG determined the MH/SUD PA review time frames and documentation requirements to be comparable to those applied to M/S benefits across all benefit packages. **Stringency** Both the CCO and OHP FFS allowed 90-day RR for MH/SUD and M/S authorization requests. Exceptions outside of the 90 days were able to be considered for approval or payment. MH/SUD and M/S denial decisions could be appealed through appeals and/or State fair hearing processes. Failure to obtain authorization could result in noncoverage. Regarding IRR, the CCO had a MH/SUD and M/S case review standard of 80 percent, which was consistent with OHP FFS's 80 percent standard for cases reviewed. HSAG determined the frequency and rigor of UM applied to MH/SUD benefits were no more stringent than the frequency and rigor applied to M/S benefits.				
Outcome				
HSAG's analysis determined that the rationale, documentation requirements, processes, and frequency of UM applied to OP MH/SUD benefits were comparable to those applied to OP M/S benefits; however, it was determined that the rigor with which UM was applied to MH/SUD benefits was more stringent than the rigor applied to M/S benefits due to significantly higher rates of MH/SUD denials and overturns. **Inconclusive Finding #1:** EOCCO's 21.54 percent denial rate for MH/SUD authorization requests was significantly greater than the 5.76 percent denial rate for M/S. The rate of overturns for MH/SUD authorization denials was also significantly greater than the rate for M/S authorizations; 16.08 percent versus 1.56 percent, respectively. The higher rates of MH/SUD denials and overturns indicate a parity concern in how the CCO makes authorization decisions across the benefit types. **Required Action:** EOCCO should review is application of UM to OP PA requests to determine the basis for the higher rate of denials for MH/SUD and to identify any parity concerns and opportunities for improvement to ensure that the process and decisions applied to MH/SUD authorizations are comparable to and no more stringent than the process and decisions applied to M/S authorizations.				

Category III—Prior Authorization for Prescription Drug Limits

NQTL: PA for Prescription Drugs

Benefit Package: CCOA and CCOB for adults and children

Classification: Prescription Drugs

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
1. To which benefit is the NQTL assigned?		
• A, F, P, S drug groups	• A and F drug groups • MH carve out drugs do not have an enforceable preferred drug list. • While certain higher cost-effect agents are listed as "preferred," this is not enforced by PA.	• A, F, P, S drug groups
2. Why is the NQTL assigned to these benefits?		
• To promote appropriate and safe treatment of funded conditions and to encourage use of preferred and cost-effective agents.	• To promote appropriate and safe treatment of funded conditions.	• To promote appropriate and safe treatment of funded conditions and to encourage use of preferred and cost-effective agents.
3. What evidence supports the rationale for the assignment?		
• In consultation with the P&T Committee, pharmacists review medications based on	• FDA prescribing guidelines, medical evidence, best practices, professional	• In consultation with the P&T Committee, pharmacists review medications based on

CCO MH/SUD	FFS MH Carve Out	CCO M/S
FDA approved indications, the most up-to-date medical evidence, best practices, clinical guidelines, and the Prioritized List.	guidelines, and P&T Committee review and recommendations. Federal and state regulations/OAR and the Prioritized List.	FDA approved indications, the most up-to-date medical evidence, best practices, clinical guidelines, and the Prioritized List.
4. What are the NQTL procedures?		
• EOCCO offers ePA through CoverMyMeds as of Q4 2018, which allows providers to submit electronic PAs directly to EOCCO that have drug specific criteria. Providers can track and monitor the outcome of their ePA through the CoverMyMeds. • A medication request form can contain several pages, including all relevant member information, drug information, and a request for chart notes. Subsequent pages contain all pertinent PA criteria questions needed to make a decision on the request. • If additional information is needed, a fax is sent to the provider requesting the relevant questions and/or chart notes that are needed to make a determination. • All PA requests are responded to within 24 hours. • The PA criteria are developed by pharmacists in consultation with the P&T Committee. • In the absence of medical necessity, and the failure to obtain PA means medication	• 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. • Notice of Benefit Determination sent to both Recipient and Provider. - Denials letters include information on required criteria, denial reasons, and how the provider can appeal and member hearing rights.	• EOCCO offers ePA through CoverMyMeds as of Q4 2018, which allows providers to submit electronic PAs directly to EOCCO that have drug specific criteria. Providers can track and monitor the outcome of their ePA through the CoverMyMeds. • A medication request form can contain several pages, including all relevant member information, drug information, and a request for chart notes. Subsequent pages contain all pertinent PA criteria questions needed to make a decision on the request. • If additional information is needed, a fax is sent to the provider requesting the relevant questions and/or chart notes that are needed to make a determination. • All PA requests are responded to within 24 hours. • The PA criteria are developed by pharmacists in consultation with the P&T Committee. • In the absence of medical necessity, and the failure to obtain PA means medication

CCO MH/SUD	FFS MH Carve Out	CCO M/S
coverage will be denied and providers do not get reimbursed.		coverage will be denied and providers do not get reimbursed.
5. How frequently or strictly is the NQTL applied?		
• PAs are authorized for six months to a year, depending on the disease state, and if the medication is medically appropriate and safe per the recommendations of the P&T Committee. • Approximately 40% 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 12%. • The CCO assesses stringency through review of the number of PA requests and PA denial/approval rates. • In general, PA criteria are reviewed for appropriateness on a biannual basis; however, that depends on the recommendation from the P&T Committee or when new medical evidence arises.	• The State approves PAs for up to 12 months, depending on medical appropriateness and safety, as recommended by the P&T Committee. • Approximately 19% of MH/SUD drugs are subject to PA criteria for clinical reasons. • The State allows providers to submit additional information for reconsideration of a denial. • Providers can appeal denials on behalf of a member, and members have fair hearing rights. • There were 10 client fair hearing requests for denied MH/SUD medications. None were reversed after agency reconsideration or, and none were reversed by hearing. • The State assesses stringency through review of PA denial/approval and appeal rates; number of drugs requiring PA; 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.	• PAs are authorized for six months to a year, depending on the disease state, and if the medication is medically appropriate and safe per the recommendations of the P&T Committee. • Approximately 40% 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 16%. • The CCO assesses stringency through review of the number of PA requests and PA denial/approval rates. • In general, PA criteria are reviewed for appropriateness on a biannual basis; however, that depends on the recommendation from the P&T Committee or when new medical evidence arises.

CCO MH/SUD	FFS MH Carve Out	CCO M/S
6. What standard supports the frequency or rigor with which the NQTL is applied?		
• In consultation with the P&T Committee, the frequency or rigor is based on FDA approved indications, the most up-to-date medical evidence, best practices, clinical guidelines, and the Prioritized List.	• 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.	• In consultation with the P&T Committee, the frequency or rigor is based on FDA approved indications, the most up-to-date medical evidence, best practices, clinical guidelines, and the Prioritized List.
Analysis		
EOCCO and OHP FFS applied PA criteria to MH/SUD and M/S prescription drug benefits to promote appropriate, safe, and cost-effective use of prescription drugs. PA was consistently applied across all benefit packages (CCOA, CCOB, CCOE, and CCOG). EOCCO reported a 46.27 percent denial rate for both MH/SUD and M/S prescription drug authorization requests from January 1, 2020, through June 30, 2020. During that time period, 22 denials were appealed, with 12 appeals resulting in an overturned decision. The majority of the prescription drugs denied through PA were denied for a "Medical Necessity" categorical reason. The CCO stated that the denial rate was consistent with historical denial rates. **Comparability** The State applied PA to certain MH FFS carve-out drugs to promote appropriate and safe treatment. Evidence used by the CCO and OHP FFS to determine which MH/SUD and M/S drugs are subject to PA included Food and Drug Administration (FDA) prescribing guidelines, medical evidence, best practices, professional guidelines, and Pharmacy and Therapeutic (P&T) Committee review and recommendations. The PA criteria for both MH/SUD and M/S drugs were developed by pharmacists in consultation with the P&T Committee. PA requests for both MH/SUD and M/S drugs could be submitted by fax, phone, or online. **Stringency** For both MH/SUD and M/S drugs, most PA criteria required clinical documentation such as chart notes. Failure to obtain PA for MH/SUD and M/S drugs subject to PA in combination with an absence of medical necessity resulted in no reimbursement for the drug. Decisions were responded to within 24 hours. For both MH/SUD and M/S drugs, the length of authorizations was dependent on medical appropriateness and safety, as recommended by the P&T Committee, based on clinical evidence such as FDA prescribing guidelines, best practices, and clinical practice guidelines. Both the CCO and OHP FFS allowed exceptions to the formulary and preferred drug list based on medical necessity. For carve-out drugs covered by OHA, the CCO stated that it works with pharmacies and providers to redirect PA requests and claims to OHA.		

CCO MH/SUD	FFS MH Carve Out	CCO M/S
Outcome		
HSAG determined EOCCO's processes, strategies, and evidentiary standards for PA of MH/SUD prescription drugs to be comparable and no more stringently applied, in writing and in operation, to M/S prescription drugs for both CCOA and CCOB benefit packages.		

Category IV—Provider Admission—Closed Network

NQTL: Provider Admission

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

Classification: IP, OP, and emergency care

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
1. To which benefit is the NQTL assigned?			
• CCO has not closed its network for new MH/SUD providers of inpatient and outpatient services; however, has a policy in place to do so, if indicated.	• The State does not restrict new providers of inpatient or outpatient MH/SUD services from enrollment.	• CCO has not closed its network for new M/S providers of inpatient and outpatient services, however, has a policy in place to do so, if indicated.	• The State does not restrict new providers of inpatient or outpatient MH/SUD services from enrollment.
2. Why is the NQTL assigned to these benefits?			
• When CCO closes its network to new MH/SUD providers, it is done to: – Balance member access needs with safety and quality concerns.	• N/A	• When CCO closes its network to new M/S providers, it is done to: – Balance member access needs with safety and quality concerns.	• N/A

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
– Balance member access needs with cost effectiveness/cost control. – Balance member access need with provider oversight. – Balance member access need with enhanced efficiency and improved provider relations.		– Balance member access needs with cost effectiveness/cost control. – Balance member access need with provider oversight. – Balance member access need with enhanced efficiency and improved provider relations.	
3. What evidence supports the rationale for the assignment?			
• Network sufficiency standards are required by 42 CFR 438.206. • Requirements related to the selection and retention of providers are specified in 42 CFR 438.214. • Requirements in 42 CFR 438.12 for the non-discrimination of provider participation states that this does not require an MCO (CCO) to contract beyond the needs of its enrollees to maintain quality and control costs. • State rule related to network sufficiency standards, OAR 410-141-0220. • OHA CCO contract.	• 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. • OHA CCO contract.	• N/A

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
4. What are the NQTL procedures?			
• New providers that are denied admission into the network due to network closure will not be able to participate in the CCO network and may not be reimbursed for services provided to CCO members. • CCO evaluates provider requests for network inclusion and reviews to determine network need. Provider requests for network inclusion are also tracked and assessed annually. Provider requests and an annual provider and inclusion assessment are reviewed by the credentialing committee, which is responsible for making recommendations to maintain the current network (limit the acceptance of new providers) or solicit new providers. • The CCO Credentialing Physician, Accreditation Manager, Director of Health Systems Integration, and Contracts Manager are responsible for the decision-	• N/A	• New providers that are denied admission into the network due to network closure will not be able to participate in the CCO network and may not be reimbursed for services provided to CCO members. • CCO evaluates provider requests for network inclusion and reviews to determine network need. Provider requests for network inclusion are also tracked and assessed annually. Provider requests and an annual provider and inclusion assessment are reviewed by the credentialing committee, which is responsible for making recommendations to maintain the current network (limit the acceptance of new providers) or solicit new providers. • The CCO Credentialing Physician, Accreditation Manager, Director of Health Systems Integration, and Contracts Manager are responsible for the decision-	• N/A

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
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, demographic makeup), 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 challenge the CCO's decision. • Exceptions may be made when management identifies a potential special network development need. • The evaluation includes determining: the validity of the need; whether the need is Network-wide or limited to a particular area(s) or region(s); the timeline for addressing the need based on the urgency		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, demographic makeup), 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 challenge the CCO's decision. • Exceptions may be made when management identifies a potential special network development need. • The evaluation includes determining: the validity of the need; whether the need is Network-wide or limited to a particular rea(s) or region(s); the timeline for addressing the need based on the urgency	

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
of the situation; and, whether an existing Network Provider can address the need. • If the evaluation finds that the potential need is valid, a plan is developed to address the need including: interim solutions to address immediate needs; and, a timetable for affecting a comprehensive solution. • After CCO and the Provider reach agreement on the services to be provided and the associated costs, the Provider will enter CCO's Network via the standard Practitioner credentialing or Facility assessment processes if the Provider is not in the Network. • Staff authorized to make exception determination is the CEO or designee and credentialing committee.		of the situation; and, whether an existing Network Provider can address the need. • If the evaluation finds that the potential need is valid, a plan is developed to address the need including: interim solutions to address immediate needs; and, a timetable for affecting a comprehensive solution. • After the CCO and the Provider reach agreement on the services to be provided and the associated costs, the Provider will enter the CCO's Network via the standard Practitioner credentialing or Facility assessment processes if the Provider is not in the Network. • Staff authorized to make exception determination is the CEO or designee and credentialing committee.	
5. How frequently or strictly is the NQTL applied?			
• When the CCO decides to close the network to particular provider/provider types, all new outpatient providers applying for those	• N/A	• When the CCO decides to close the network to particular provider/provider types, all new outpatient	• N/A

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
particular providers/provider types are subject to this NQTL. • No provider or provider types were impacted by CCO's decision to close all or part of its network to new providers in the last contract year.		providers applying for those particular • providers/provider types are subject to this NQTL. • No provider or provider types were impacted by CCO's decision to close all or part of its network to new providers in the last contract year.	
6. What standard supports the frequency or rigor with which the NQTL is applied?			
• The CCO reviews the following data/information to determine how strictly to apply the criteria/ considerations to close the CCO network to new providers: – Member access to care measures (e.g., timely access, distance) – Provider to member ratios – Provider availability – Inpatient rates – Number of requests for OON. – Membership profile (cultural, racial, ethnic, linguistic, demographic makeup)	• 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: – Member access to care measures (e.g., timely access, distance) – Provider to member ratios – Provider availability – Inpatient rates – Number of requests for OON. – Membership profile (cultural, racial, ethnic, linguistic, demographic makeup)	• N/A

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
– Member needs based on knowledge of prior services used, physio, social factors and member and family suggestions.		– Member needs based on knowledge of prior services used, physio, social factors and member and family suggestions.	

Analysis

EOCCO has an established policy to permit the CCO to close its network to IP and OP providers of MH/SUD and M/S services but has not done so in operation. The CCO's policies for closing its network to MH/SUD and M/S providers were the same. Under the CCO's policy, network closure could be done to balance member access needs with safety and quality concerns, cost effectiveness/cost control, provider oversight, and enhanced provider relations. Developing a network based on network adequacy and sufficiency standards is supported by federal regulation, including the ability of a managed care organization (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 category. In addition, provider network admission limits do not apply to FFS benefits, and the application of provider network admission NQTLs for benefits delivered under managed care is supported by 42 CFR §438.206 and §438.12. Accordingly, parity was not analyzed.

Comparability

EOCCO denied enrollment to particular provider types determined unnecessary to meet network adequacy standards. Monitoring for network adequacy included annual reviews, provider requests for network inclusion, and network capacity. Provider requests and annual provider inclusion assessments were reviewed by the credentialing committee for network management. The CCO considered capacity reports, access complaints, time to appointments, IP rates, complaints and grievances, internal reports on unmet needs, number of requests for OON providers, membership profile (cultural, racial, ethnic, linguistic, demographic makeup), and other data in making the determination to close the network. If the evaluation found that the potential need was valid, a plan would be developed to address the need including interim solutions to address immediate needs and a timetable for affecting a comprehensive solution. Providers denied the opportunity to participate in the CCO's network could challenge the CCO's decision. Network staff authorized to make exception determinations were the CCO's chief executive officer or designee and the credentialing committee.

Stringency

Under the CCO's policies for both MH/SUD and M/S providers, 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 the NQTL. In operation, no MH/SUD or M/S provider were denied admission on the basis of network closure. In determining how strictly to apply network closure, the CCO monitors and

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
reviews information such as member access to care measures; provider-to-member ratios; provider availability; IP rates; number of requests for OON; the membership profile (cultural, racial, ethnic, linguistic, demographic makeup); and member needs based on knowledge of prior services used, social factors, and member and family suggestions.			
Outcome			
Because EOCCO did not close its network to either MH/SUD or M/S providers, HSAG determined that the CCO's provider admission/network closure processes for MH/SUD providers was comparable to and no more stringently applied to M/S providers across all benefit packages.			

Category V—Provider Admission—Network Credentialing

NQTL: Provider Admission

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

Classification: IP, OP, and emergency care

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
1. To which benefit is the NQTL assigned?			
• CCO requires all participating providers to meet facility and independent practitioner 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 facility and independent practitioner credentialing and re-credentialing requirements. • N/A	• All FFS providers must be enrolled as a provider with Oregon Medicaid • The State does not apply provider requirements in addition to State licensing
2. Why is the NQTL assigned to these benefits?			
• CCO applies credentialing and re-credentialing requirements to: – Reduce and/or eliminate the potential for	• Provider enrollment is required by State law and Federal regulations. The State also specifies requirements for provider enrollment in	• CCO applies credentialing and re-credentialing requirements to: – Reduce and/or eliminate the potential for	• Provider enrollment is required by State law and Federal regulations. The State also specifies requirements for provider enrollment in

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
negligent/ inappropriate care, Medicare/Medicaid fraud or abuse and unnecessary liability to either the member or the CCO. – Ensure equity by not excluding practitioners based on specialization, services to high risk populations, or the cost of treatment. – Meet State and Federal requirements – Ensure capabilities of provider to deliver high quality of care – Ensure provider meets minimum competency standards	order to ensure beneficiary health and safety and to reduce Medicaid provider fraud, waste, and abuse.	negligent/ inappropriate care, Medicare/Medicaid fraud or abuse and unnecessary liability to either the member or the CCO. – Ensure equity by not excluding practitioners based on specialization, services to high risk populations, or the cost of treatment. – Meet State and Federal requirements – Ensure capabilities of provider to deliver high quality of care – Ensure provider meets minimum competency standards	order to ensure beneficiary health and safety and to reduce Medicaid provider fraud, waste, and abuse.
3. What evidence supports the rationale for the assignment?			
• Credentialing/recred requirements are supported by the following evidence: – OAR 410-141-3120, CCO Contract Exhibit B - Part 8 (18), 42 CFR 438.214, and the National Committee on Quality	• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E-Provider Screening and Enrollment.	• Credentialing/recred requirements are supported by the following evidence: – Required under OAR 410-141-3120, CCO Contract Exhibit B - Part 8 (18), 42 CFR 438.214, and NCQA guidelines.	• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E-Provider Screening and Enrollment.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Assurance (NCQA) guidelines. – OAR 309-008-0100 through 1600 (IP)			
4. What are the NQTL procedures?			
• All facility and independent practitioner providers must meet credentialing and re-credentialing requirements. • Independent practitioners must complete and provide proof of: – Oregon Practitioner Credentialing Application (20 pages) – Independent Practitioner liability insurance coverage – Professional license/certification – DEA registration and CDS certification or validation of a formal arrangement with a DEA registered physician and a CDS certified physician who can write all prescriptions requiring this registration	• All providers are eligible to enroll as a provider and receive reimbursement provided they meet all relevant Federal and State licensing and other rules and are not on an exclusionary list. Providers must complete forms and documentation required for their provider type. This includes information demonstrating the provider meets provider enrollment requirements such as NPI, tax ID, disclosures, and licensure/certification. The provider enrollment forms vary from 1 to 19 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	• All facility and independent practitioner providers must meet credentialing and re-credentialing requirements. • Independent practitioners must complete and provide proof of: – Oregon Practitioner Credentialing Application (20 pages) – Independent Practitioner liability insurance coverage – Professional license/certification – DEA registration and CDS certification or validation of a formal arrangement with a DEA registered physician and a CDS certified physician who can write all prescriptions requiring this registration	• All providers are eligible to enroll as a provider and receive reimbursement provided they meet all relevant Federal and State licensing and other rules and are not on an exclusionary list. Providers must complete forms and documentation required for their provider type. This includes information demonstrating the provider meets provider enrollment requirements such as NPI, tax ID, disclosures, and licensure/certification. The provider enrollment forms vary from 1 to 19 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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
– Written explanations if any positive attestations contained within the application package – Appropriate and highest level of education and training for services to be provided – Verification of licensing or Board certification or successful completion of residency for physicians not Board certified – At least five years of relevant work history with explanation of gaps of either six months or one year – Absence of sanctions, restrictions, or limitation on professional license or certification as verified with the NPDB – Absence of Medicare or Medicaid restrictions as verified with the NPDB – Possession of appropriate admitting privileges or admit plan as required • Facility providers (MH/SUD inpatient; MH/SUD	and documentation can be faxed in or completed and submitted electronically to the State's provider enrollment unit. The State's provider enrollment process includes checking the forms for completeness, running the provider name against exclusion databases, and verifying any licenses, certifications or equivalents. The State's enrollment process averages 7 to 14 days. State staff in the provider enrollment unit are responsible for reviewing information and making provider enrollment decisions	– Written explanations if any positive attestations contained within the application package – Appropriate and highest level of education and training for services to be provided – Verification of licensing or Board certification or successful completion of residency for physicians not Board certified – At least five years of relevant work history with explanation of gaps of either six months or one year – Absence of sanctions, restrictions, or limitation on professional license or certification as verified with the NPDB – Absence of Medicare or Medicaid restrictions as verified with the NPDB – Possession of appropriate admitting privileges or admit plan as required • Facility providers (MH/SUD inpatient; MH/SUD	and documentation can be faxed in or completed and submitted electronically to the State's provider enrollment unit. The State's provider enrollment process includes checking the forms for completeness, running the provider name against exclusion databases, and verifying any licenses, certifications or equivalents. The State's enrollment process averages 7 to 14 days. State staff in the provider enrollment unit are responsible for reviewing information and making provider enrollment decisions.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
residential; and MH/SUD outpatient for adults, children, and youth) are required to possess – Current accreditation by – (CARF, JCAHO, or DNV GL) or evidence of site by Federal or State authority – Medicare certification if applicable – Confirmation that the facility is in good standing with Oregon State and Federal regulatory body • Non-accredited IP facilities go through a 4-day outside assessment by CCO unless a recent (within previous 36 months or prior to expiration of certification) Oregon State certificate of approval has been awarded or another Federal regulatory body has awarded a certification or neither the State of Oregon or CMS has conducted a site review but the provider is in a rural area). The facilities prepare a		residential; and MH/SUD outpatient for adults, children, and youth) are required to possess – Current accreditation by – (CARF, JCAHO, or DNV GL) or evidence of site by Federal or State authority – Medicare certification if applicable – Confirmation that the facility is in good standing with Oregon State and Federal regulatory body • Non-accredited IP facilities go through a 4-day outside assessment by CCO unless a recent (within previous 36 months or prior to expiration of certification) Oregon State certificate of approval has been awarded or another Federal regulatory body has awarded a certification or neither the State of Oregon or CMS has conducted a site review but the provider is in a rural area). The facilities prepare a	

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• "non-accredited facility assessment form" at least 30 calendar days prior to the review which details all required documentation and interviews and they must be in compliance with CCOs' standards of participation for non-accredited facilities. • Providers may submit supporting documentation by fax, email, USPS and/ or in person. • The complete process from receipt of application to final admission into network for OP providers depends on the contents of the application and findings during the credentialing process. • The complete process from receipt of application to final admission into network for IP providers is 60 days for the credentialing process; the contracting process has a separate timeline. • CCO's Credentialing committee meets every 30 days and only reviews applications that are found to		• "non-accredited facility assessment form" at least 30 calendar days prior to the review which details all required documentation and interviews and they must be in compliance with CCOs' standards of participation for non-accredited facilities. • Providers may submit supporting documentation by fax, email, USPS and/ or in person. • The complete process from receipt of application to final admission into network for OP providers depends on the contents of the application and findings during the credentialing process. • The complete process from receipt of application to final admission into network for IP providers is 60 days for the credentialing process; the contracting process has a separate timeline. • CCO's Credentialing committee meets every 30 days and only reviews applications that are found to	

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
not meet the minimum requirements. • CCO's Medical Director or Credentialing Committee (meets every 6 weeks) are responsible for reviewing required information and Credentialing Committee for making provider credentialing decisions. • CCO performs re-credentialing at least every three years. • Providers who do not meet credentialing/re-credentialing requirements will not be able to join the network. • Providers who are denied at the initial credentialing cycle may re-apply after one year. Providers who are denied at the re-credentialing cycle may appeal the decision.		not meet the minimum requirements. • CCO's Medical Director or Credentialing Committee (meets every 6 weeks) are responsible for reviewing required information and Credentialing Committee for making provider credentialing decisions. • CCO performs re-credentialing at least every three years. • Providers who do not meet credentialing/re-credentialing requirements will not be able to join the network. • Providers who are denied at the initial credentialing cycle may re-apply after one year. Providers who are denied at the re-credentialing cycle may appeal the decision.	
5. How frequently or strictly is the NQTL applied?			
• All facility and independent practitioner providers must be credentialed. • Exceptions can be authorized by CCO's Chief Medical Officer (CMO) and the	• All providers/provider types are subject to enrollment/re-enrollment requirements. • There are no exceptions to meeting provider	• All facility and independent practitioner providers must be credentialed. • Exceptions can be authorized by CCO's Chief Medical Officer (CMO) and the	• All providers/provider types are subject to enrollment/re-enrollment requirements. • There are no exceptions to meeting provider

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Credentialing Committee. Exceptions are made on a case by case basis, but cannot include any licensing/certification sanction or sanction imposed by CMS (must pass). If provider has not completed residency and not board certified, can make an exception. • No providers were denied admission or terminated from the network in the last contract year as a result of credentialing and re-credentialing.	enrollment/re-enrollment requirements.	Credentialing Committee. Exceptions are made on a case by case basis, but cannot include any licensing/certification sanction or sanction imposed by CMS (must pass). If provider has not completed residency and not board certified, can make an exception. • No providers were denied admission or terminated from the network in the last contract year as a result of credentialing and re-credentialing.	enrollment/re-enrollment requirements.
6. What standard supports the frequency or rigor with which the NQTL is applied?			
• The frequency with which CCO performs re-credentialing is based upon: – State law and Federal regulations – State contract requirements 2018 CCO Contract, Exhibit B SOW, Part 4 Providers and Delivery System, #3(b) Provider Selection Part 8	• 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.	• The frequency with which CCO performs re-credentialing is based upon: – State law and Federal regulations – State contract requirements 2018 CCO Contract, Exhibit B SOW, Part 4 Providers and Delivery System, #3(b) Provider Selection Part 8	• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E - Provider Screening and Enrollment. The frequency with which the State re-enrolls providers is based on State law and Federal regulations.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Operations #18 Credentialing (a) – National accreditation standards, National Committee for Quality Assurance (NCQA.) • CCO monitors the following • data/information to determine how strictly to apply credentialing/ re-credentialing criteria: – Patient complaints are monitored quarterly, – License action and sanctions are monitored monthly. – Adverse events are monitored on an ongoing basis.		Operations #18 Credentialing (a) – National accreditation standards, National Committee for Quality Assurance (NCQA) • CCO monitors the following • data/information to determine how strictly to apply credentialing/ re-credentialing criteria: – Patient complaints are monitored quarterly, – License action and sanctions are monitored monthly. – Adverse events are monitored on an ongoing basis.	
Analysis			
All IP and OP providers of MH/SUD and M/S services are subject to CCO credentialing and recredentialing requirements. EOCCO conducts credentialing and recredentialing for both providers of MH/SUD and M/S services to meet State and federal requirements, ensure capabilities of providers to deliver high-quality care, and to ensure providers meet minimum competency standards. The CCO has delegated the credentialing and recredentialing of some MH/SUD providers to CMHPs. The CCO's processes were the same across all benefit packages (CCOA, CCOB, CCOE, and CCOG). EOCCO reported it had 8,267 MH/SUD and M/S providers credentialed in its network during the reporting period. Of the 188 providers seeking credentialing with the CCO, none of them were denied credentialing. HSAG's analysis of EOCCO's provider credentialing data did not reveal any parity concerns due to no denials reported and a low rate of terminations. Provider terminations were primarily due to the providers leaving their practice group or lack of response for recredentialing.			

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Comparability EOCCO required providers of MH/SUD and M/S services to successfully meet credentialing and recredentialing requirements in order to be admitted to and continue to participate in the CCO's network. Providers were required to complete and submit a credentialing application (dated within 90 days of submission to the CCO) and provide supporting documentation as part of the credentialing process. Both MH/SUD and M/S providers had several methods of submitting their application and supporting documentation, including by fax, by mail, or electronically. For both MH/SUD and M/S provider credentialing, the CCO's medical director or credentialing committee met every six weeks to review required information. The credentialing committee made provider credentialing decisions. Nonlicensed MH care providers (e.g., qualified mental health providers/assistants and traditional health care works) were vetted similarly, with verifications completed according to qualifications and certifications related to specific provider type. For facilities that validated nonlicensed providers, EOCCO reviewed the facility's process for verifying credentials. The CCO's credentialing process for MH/SUD providers included primary source verification of licensing, board certification, Medicare Excluded Providers (Office of Inspector General), Medicare sanction (Excluded Parties List System/System for Award Management), Medicare opt-out (if applicable), and a National Practitioner Database query match to look for unexplained gaps in work history greater than six months. The process for M/S providers involved a similar review of each application to determine whether standards were met. **Stringency** The credentialing process for both MH/SUD and M/S providers was around 60 days. EOCCO's credentialing process involved the review of required information and credentialing decision by the CCO's chief medical officer. Recredentialing for both MH/SUD and M/S providers was conducted every three years, or as needed based on self-disclosure of certain kinds of incidents or background checks. Failure for MH/SUD and M/S providers to meet credentialing and recredentialing requirements resulted in exclusion from the CCO's network. MH/SUD and M/S providers who were adversely affected by credentialing decisions could re-apply after one year, while adverse recredentialing decisions could be challenged by filing an appeal.			
Outcome			
HSAG's analysis of EOCCO's credentialing processes and data resulted in a determination of parity compliance across all benefit packages, meeting all comparability and stringency standards.			

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

NQTL: OON and OOS limits

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

Classification: IP, OP, and emergency care

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
1. To which benefit is the NQTL assigned?			
• Out of Network (OON) and Out of State (OOS) Benefits	• OOS Benefits	• Out of Network (OON) and Out of State (OOS) Benefits	
2. Why is the NQTL assigned to these benefits?			
• 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 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	• 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.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	• 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 PA for non-emergency OOS services is to ensure the criteria in OAR 410-120-1180 are met.	requested benefit and the availability of an in-State provider. • The CCO requires referrals for non-emergency OOS office visits and consultations to ensure that the PCP is central to all health care pertinent to the members they manage and to identify potential gaps in the network.	• 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 PA for non-emergency OOS services is to ensure the criteria in OAR 410-120-1180 are met.
3. What evidence supports the rationale for the assignment?			
• The CCO covers OON/OOS benefits in accordance with Federal and State requirements, including OAR and the CCO contract.	• The State covers OOS benefits in accordance with OARs.	• The CCO covers OON/OOS benefits in accordance with Federal and State requirements, including OAR and the CCO contract.	• The State covers OOS benefits in accordance with OARs.
4. What are the NQTL procedures?			
• A member has the right to request care from an OON/OOS provider. • CCO has an open network so any service delivered by OON/OOS 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.	• 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	• 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.

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. • The CCO establishes a single case agreement (SCA) with OON/OOS providers if the provider will not accept the DMAP rate. • The CCO's process for establishing a SCA includes contacting the OON/OOS provider to collect information and negotiating the terms of the SCA. EOCCO has a separate OON behavioral	• Requests for non-emergency OOS services are made through the State PA process. • The timeframe for approving or denying a non-emergency OOS request is the same as for other PAs (14 days for standard and three business days for urgent). • OOS providers must enroll with Oregon Medicaid. • The State pays OOS providers the Medicaid FFS rate.	authorized, the provider will 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. • Non-emergency OOS services are not covered unless medically necessary services are not available in-State. • Requests for non-emergency OOS services are made through the prior authorization process. • The timeframe for approving or denying a non-emergency OOS request is the same as for other prior authorizations	• Requests for non-emergency OOS services are made through the State PA process. • The timeframe for approving or denying a non-emergency OOS request is the same as for other PAs (14 days for standard and three business days for urgent). • OOS providers must enroll with Oregon Medicaid. • The State pays OOS providers the Medicaid FFS rate.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
health provider authorization form. • SCAs can be established within 24 hours of request. • Only providers enrolled in Oregon Medicaid can qualify as an OON/OOS provider. • The CCO generally pays OON/OOS providers the Medicaid FFS rate but in special circumstances pays a negotiated rate.		(14 days for standard requests). • The CCO establishes a single case agreement (SCA) with OON/OOS providers if the provider will not accept the DMAP rate. • 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. • Only providers enrolled in Oregon Medicaid can qualify as an OON/OOS provider. • The CCO generally pays OON/OOS providers the Medicaid FFS rate but in special circumstances pays a negotiated rate.	
5. How frequently or strictly is the NQTL applied?			
• If a non-emergency OON/OOS benefit is not medically necessary or is delivered by a provider not-qualified to provide Medicaid services in Oregon, the	• If a request for a non-emergency OOS benefit does not meet the OAR criteria, it will not be authorized. • If a non-emergency OOS benefit is not authorized, the	• If an OON/OOS claim does not meet the criteria for payment, including referral for OON and prior authorization for OOS,	• If a request for a non-emergency OOS benefit does not meet the OAR criteria, it will not be authorized. • If a non-emergency OOS benefit is not authorized, the

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
service will not be covered and payment for the service will be denied. • Members/providers may appeal the denial of payment for an OON/OOS service. • The CCO tracks OON/OOS utilization through the CCO's utilization management software and reports trends and findings to the UM committee quarterly. Utilization trends and claims are analyzed annually.	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.	payment for the claim may be denied. • Members/providers may appeal the denial of an OOS request or any non-payment. • The CCO reviews all OON claims quarterly and annually to identify gaps in network coverage and PCP referral patterns. • The CCO tracks OON/OOS utilization through the CCO's utilization management software and reports trends and findings to the UM committee quarterly. Utilization trends and claims are analyzed annually.	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.
6. What standard supports the frequency or rigor with which the NQTL is applied?			
• Federal and State requirements, including OAR and the CCO contract.	• The State covers OOS benefits in accordance with OAR.	• Federal and State requirements, including OAR and the CCO contract.	• The State covers OOS benefits in accordance with OAR.
Analysis			
EOCCO had an open network for both MH/SUD and M/S, meaning that any service delivered by an OON Medicaid provider was treated identically to network providers from a coverage standpoint. In other words, if the benefit was covered and properly delivered, billed, and authorized, the provider would be paid for those services at the Medicaid rate. The CCO ensured OON/OOS coverage to provide needed MH/SUD and M/S benefits when they were not available INN or in-state. Similarly, for MH/SUD FFS benefits, the State provided OOS coverage to provide needed benefits when they were not available in-state. The same PA processes and evidentiary standards described in NQTL categories I, II, and III were applied to OOS coverage of MH/SUD and M/S benefits across all benefit packages (CCOA, CCOB,			

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
CCOE, and CCOG). EOCCO established SCAs with OON providers in the absence of INN providers to ensure the provision of medically necessary services, while OHP FFS ensured OON providers were enrolled with Medicaid. **Comparability** For both nonemergency MH/SUD and M/S OON/OOS benefits, the CCO (and OHP FFS for FFS MH/SUD and M/S OOS benefits) required prior authorization to determine medical necessity and to ensure no INN/in-State providers were available to provide the benefit. The same PA processes and evidentiary standards described in NQTL categories I, II, and III were applied to OOS coverage of MH/SUD and M/S requests. For OON coverage requests, the CCO would determine if an INN provider was available or work with the OON provider to establish a SCA with payment of applicable Medicaid FFS rates. This process was applied comparably to both MH/SUD and M/S providers across all benefit packages. **Stringency** Requests for nonemergency OON/OOS CCO MH/SUD and M/S benefits were made through the CCO's PA process and reviewed for medical necessity and INN/in-state coverage. The PA time frames (14 days for standard requests and 72 hours for urgent requests) applied. Similarly, the State reviewed requests for nonemergency OOS MH/SUD services through its PA process, adhering to its PA time frames identified at 14 days for standard requests and 72 hours for urgent requests. The CCO and OH FFS required 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 did not agree to the FFS rate, then the CCO will establish a SCA. EOCCO provided an SCA template for review that identified compliant agreement information and confirmed the CCO's processes related to its use of OON providers. The CCO also described a process for handling a complex OON/OOS MH/SUD member case, identifying how it would appropriately apply the PA and SCA process to ensure benefits were provided in relation to the member's needs.			
Outcome			
HSAG determined EOCCO's processes, strategies, and evidentiary standards for OON/OOS limits applied to MH/SUD benefits to be comparable and no more stringently applied, in writing and in operation, to M/S OON/OOS limits across all benefit packages.			

Appendix C. Improvement Plan Template

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