Oregon Health Authority

2020 Mental Health Parity Analysis Report

for

Health Share of Oregon

February 2021

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Introduction

Overview of Mental Health Parity in Oregon

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 Health Share of Oregon (Health Share).

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.

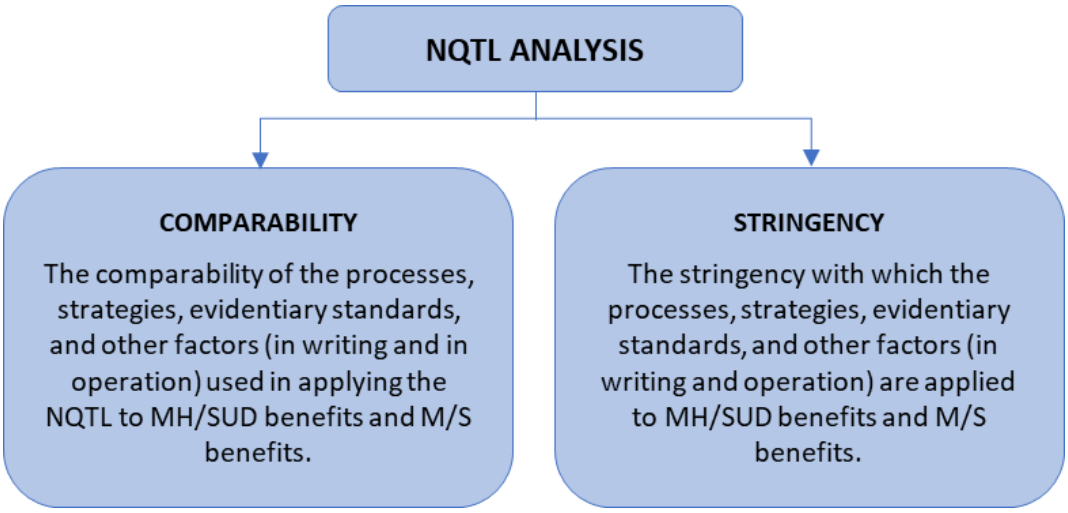
Non-Quantitative Treatment Limitations

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



Categories of NQTLs

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.

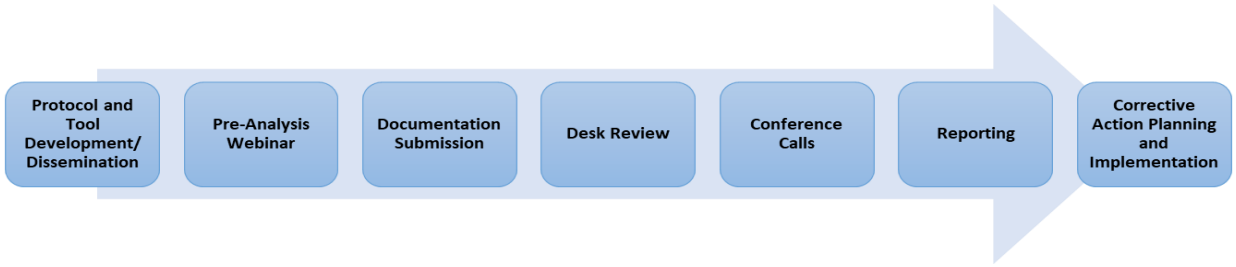
2. Process and Methodology

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, 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 Health Share. 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 Health Share's data submitted using the MHP Required Documentation Template and supporting documentation as provided.
- Observations from conversations during the conference call conducted with Health Share.

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 Health Share's completed MHP questionnaire and finalized MHP reporting details by each NQTL category, respectively.

Overall Assessment

Health Share 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. Health Share subcontracted with four Integrated Delivery Systems and one Integrated Community Network (ICN), CareOregon, which assume full financial risk for providing and managing MH/SUD and M/S benefits for the CCO's members, with the ICN providing MH/SUD services to members. Each Health Share delegate has its own policies, formularies, and PA grids used to manage benefits for the CCO's members. While the CCO and its delegates did not appear to have segregated policies for the management of benefits based on benefit package, the operational variation across delegate policies was difficult to discern and created parity and quality concerns related to consistency in the management of OHP benefits and the availability of information for both members and providers.

For limits applied to IP and OP health benefits, Health Share and its delegates 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. Health Share 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, Milliman Care Guidelines (MCG), and InterQual guidelines. Health Share and its delegates, and OHP FFS, applied the required time frames for urgent and standard PA requests and made determinations based on medical necessity. Both the CCO and OHP FFS allowed RR for MH/SUD and M/S when providers failed to obtain authorization and allowed for exceptions past the

RR time frames. OHP FFS had a 90-day time frame from the date of service for the allowance of RR, whereas Health Share delegate policies identified variances ranging from four months up to one year for M/S benefits. However, Health Share's primary MH/SUD delegate, CareOregon, did not have a retrospective review cut-off and processed all authorizations (IP and OP) requests when received. Because Health Share's time frame restrictions for MH/SUD PA requests was relative to the management of M/S benefits, HSAG did not determine the variances as a parity concern. 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 interrater reliability (IRR) for both IP and OP MH/SUD and M/S benefits, Health Share did not have a formal or standardized process for its delegates to adhere to, but the CCO provided information regarding its delegates' IRR process that ensured IRR was performed at least annually. The testing standards across Health Share delegates ranged from 80 percent to 90 percent passing rates, with the standards being equitably applied across both MH/SUD and M/S IRR testing. OHP FFS was applying an 80 percent standard for authorization reviews conducted at least annually. This did not present a parity concern.

HSAG's analysis of Health Share processes and operations across the benefit packages did not reveal any MHP concerns for the authorization of prescription drugs or for either of the provider admission NQTL categories. 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. Related to the provider admission NQTL categories, Health Share's delegates primarily conducted the credentialing and recredentialing of MH/SUD and M/S providers with the CCO regularly auditing delegate processes and outcomes of the related functions.

HSAG determined the processes, strategies, and evidentiary standards for OON/OOS limits applied to MH/SUD to be comparable and no more stringently applied, in writing and in operation, to M/S OON/OOS limits across all benefit packages. OHP FFS did not use single case agreements (SCAs) to secure the provision of benefits from OON providers but instead enrolled the providers. This also did not present a parity concern.

While no parity concerns were identified, HSAG recommends that Health Share work with its delegates to standardize the application of UM across MH/SUD and M/S benefits to ensure consistency in the management of OHP benefits and the availability of information for both members and providers.

Table 3-1 presents HSAG's overall assessment of Health Share's compliance based on the analysis of the comparability of NQTL strategies and the stringency applied by Health Share 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	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 Health Share, 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. Overall, Health Share's application of NQTLs for MH/SUD benefits across the NQTL categories and all benefits packages was determined to be comparable to and applied no more stringently, in writing or in operation, than to M/S benefits. Health Share achieved full compliance with MHP requirements, receiving no findings.

Data Analysis Results

Health Share 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).

Utilization Management for Inpatient/Outpatient Services

Health Share provided requested UM data for IP and OP services pertaining to authorization request counts and outcomes of requests. Table 3-2 presents Health Share's counts for IP and OP PAs by benefit type, identifying the number of PA requests denied, appealed, and overturned.

Table 3-2—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	66,036	106	0.16%	5	4.72%	2	1.89%
M/S	89,989	6,940	7.71%	454	6.54%	182	2.62%
Total	**156,025**	**7,046**	**4.52%**	**459**	**6.51%**	**184**	**2.61%**

Observation

HSAG's analysis of Health Share's PA data for IP and OP benefits did not reveal any concerns related to MHP due to low denial rates for both MH/SUD and M/S PA requests. The following data points were observed:

- Of the total 156,025 IP and OP PA requests reported, 4.52 percent were denied.
- The 106 MH/SUD PA denials represented 1.50 percent of total denials, which were primarily denied due to administrative reasons, with only two resulting in an overturned decision on appeal.
- Only one of the 106 MH/SUD PA denials was attributed to an IP benefit request; the remainder were for OP benefit requests.

Utilization Management for Prescription Drugs

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

Table 3-3—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
10,402	5,120	49.22%	189	3.69%	94	1.84%

Observation

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

- Of the total 10,402 prescription drug PA requests reported, 49.22 percent were denied.

- Only 3.69 percent of the 5,120 denials were appealed, with only 94 PA denials resulting in an overturned decision.
- The majority of the denied prescription drug PA requests were denied for "not covered" and "non-formulary" categorical reasons.

Enrollment/Credentialing

Health Share provided requested data pertaining to provider enrollment requests and outcomes. Table 3-4 presents Health Share's enrollment/credentialing counts by provider type, identifying the number of terminations and denials, which includes applications not accepted.

Table 3-4—Enrollment/Credentialing Counts by Provider Type

Enrollment/Credentialing Counts by Provider Type						
Provider Type	**Avg. # Enrolled Providers**	**# Providers Terminated**	**% Terminated**	**# of Cred. Requests**	**# of Cred. Requests Denied/Not Accepted**	**% of Cred. Requests Denied/Not Accepted**
MH/SUD	3,428	0	0.00%	326	0	0.00%
M/S	21,451	111	0.52%	5,906	9	0.15%
Total	**24,879**	**111**	**0.45%**	**6,232**	**9**	**0.14%**

Observation

HSAG's analysis of Health Share's provider credentialing data did not reveal any parity concerns due to low rates of denials for MH/SUD and M/S providers seeking credentialing. The following data points were observed:

- Of the 24,879 reported average number of providers enrolled during the reporting period, 13.78 percent were MH/SUD providers.
- The total denial rate for all provider types was less than 1 percent (0.14 percent), with no MH/SUD providers denied credentialing.

Additional Requirement Results

HSAG requested information from Health Share 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. Health Share described its policies on notices of adverse benefit determination (NOABDs) and how the notices describe denial reasons for members. HSAG reviewed Health Share's template NOABD used by all of its delegates for notifying members and providers of

MH/SUD and M/S benefit denials, which included denial reasons. A review of Health Share's website showed that the CCO had resources available from its website for members that included information on MH/SUD benefits available, a prescription drug formulary, and clinical practice guidelines; however, most of this information was only accessible to members and providers through links to Health Share delegate websites. HSAG ultimately determined that Health Share 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 IP template is provided in Appendix C. For each of the findings documented in Section 3 of this report, Health Share 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

Health Share 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

Health Share 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, 4) PA and CR are required for planned non-emergency admissions to acute IP (in and out-of-network (OON)), PRTS, subacute and 10 days after an IP SUD detoxification admission. (1, 2, 3, 4) Emergency admissions require notification within 1-3 days of admission; re-assessment if not in a bed within 8 hours of notification to address least restrictive environment requirement; and subsequent CR. • (1, 4) Extra-contractual and experimental/investigational/ unproven benefit requests (i.e., exceptions) are submitted through a PA-like process.	• (1, 4) PA (only) for MH/SUD procedures performed in a medical facility (e.g., gender reassignment surgery authorizations, experimental/investigational, and extra-contractual benefits are conducted by OHA consistent with the information in column 2). • (2, 4) A level-of-care review is required for SCIP, SAIP and subacute care that is conducted by an OHA designee. • (1, 4) PA for SCIP, SAIP and subacute admission is obtained through a peer-to-peer review between a Comagine psychiatrist and the referring psychiatrist. • (1, 2, 4) CR Comagine RR for SCIP and SAIP are performed by Comagine. • (1, 2, 4) CR and RR for subacute care are conducted by Comagine. • (1, 2, 4) PA, inclusive of a Certificate of Need (CONS)	• (1, 2, 3, 4) PA and CR are required for planned non-emergency admissions to IP hospital, (in and OON) and IP hospice/palliative care. (1, 2, 3, 4) Emergency admissions require notification within 1-3 days of admission and subsequent CR. (1, 2, 3, 4) Skilled nursing facility benefits (first 20 days) require PA. (1, 4) Extra-contractual and experimental/investigational/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?			
• (1) To ensure coverage, medical necessity and prevent unnecessary overutilization (e.g., in violation of relevant OARs and associated Health Evidence Review Commission (HERC) guidelines)1. • (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. • (3) Maximize the use of INN providers to promote cost-effectiveness (when appropriate). • (4) To comply with federal and State requirements	• (1) UM is assigned to ensure medical necessity of services and prevent overutilization • (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual (e.g., matching the level of need to the least restrictive setting using the LOCUS – Level-of-Care Utilization System and LSI – Level of Service Inventory or PCSP – Person Centered Service Plan and IBL – Individually-Based Limitations). • (4) To comply with federal and State requirements.	• (1) To ensure coverage, medical necessity and prevent unnecessary overutilization (e.g., in violation of relevant OARs and associated Health Evidence Review Commission (HERC) guidelines). • (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. • (3) Maximize the use of INN providers to promote cost-effectiveness (when appropriate). • (4) To comply with federal and State requirements	• (1) PA and CR are assigned to 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 4) HERC PL and guidelines.	• (1, 2, and 4) Health Evidence Review Commission (HERC)	• (1, 2 and 4) HERC PL and guidelines.	• (1, 2 and 4) The HERC PL and guidelines. There are

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• (1) Detailed UM and level of care reports are reviewed monthly relative to prior years' claims history and similar provider types. • (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. • (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.	Prioritized List (PL) and 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	• (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) Network providers' credentials have been verified and they have contracted to accept the network rate. • (4) Applicable federal and State requirements.	more guidelines for M/S than 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
• (3) Network providers' credentials have been verified and they have contracted to accept the network rate. • (4) Applicable federal and State requirements.	same codes, no surgeries, few devices); 2) the MH/SUD literature is not as robust (e.g., fewer randomized trials, more subjective diagnoses (or the ICD-10-CM diagnoses represent a spectrum) and less standardization in interventions). • (1) InterQual.		
4. What are the NQTL procedures?			
Timelines for authorizations: • Providers are expected to call prior to admission to facilitate possible diversion, but if the admission is emergent, they are expected to notify within 1-3 days of admission. There is no consequence for failure to meet these timelines. • Once the CCO has needed information, authorizations are made the same business day.	**Timelines for gender reassignment surgery authorizations:** **(OHA)** • Standard requests are to be processed within 14 days. **Timelines for child residential authorizations**: **(OHA)** • OHA provides the initial authorization (level-of-care review) within three days of receiving complete requests for SCIP, SAIP or subacute. **(Comagine)** • Authorization requests for PRTS are submitted prior to admission or within 14 days of an emergency admission.	**Timelines for authorizations:** • Providers are required to call within 1-3 days of emergency admission. • Once the CCO has needed information, authorizations are made the same business 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 one business day, urgent

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	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.		requests within three business days and standard requests within 14 days.
Documentation requirements: • Providers are expected to fax in clinical information supporting the medical necessity of an admission including a mental health assessment and other supporting evidence when clinically indicated. • Most MH services require a call. SUD residential requires an intake form. • PA includes eligibility and benefit coverage confirmation and a medical necessity review of the requested procedure or service.	**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	**Documentation requirements:** • Provider must supply clinical information, no specific form is required. • PA includes eligibility, benefit coverage confirmation and a MN review of the requested procedure or service. • Provider is required to submit updated clinical information for CR. .	**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
• Provider is required to submit updated clinical information for CR.	information may be reviewed when available. **Documentation requirements for PRTF CONS and CR for PRTF, SCIP and SAIP (Comagine)**: • PRTS CONS requires documentation that supports the justification for child residential services, including: – A cover sheet detailing relevant provider and recipient – 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		

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	information supporting medical justification for the services requested; – For substance use disorder services (SUD), the Division uses the American Society of Addiction Medicine (ASAM) Patient Placement Criteria second edition-revised (PPC-2R) to determine the appropriate level of SUD treatment of care. • There are no specific documentation requirements for CR of PRTS, SCIP or SAIP. **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: • Fax, email or telephonic.	**Method of document submission (OHA):** • For non-residential MH/SUD services, paper (fax) or	**Method of document submission:** • Fax, email or telephonic.	**Method of document submission**: • Paper (fax) or online PA requests are submitted prior

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	online PA requests are submitted prior to the delivery of services for which PA is required. • For SCIP, SAIP and subacute level-of-care review, the OHA designee may accept information via fax, mail or secure email and has also picked up information. Supplemental information may be obtained by phone. **Method of document submission (Comagine):** • Packets are submitted to Comagine by mail, fax, email or web portal for review for child 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		to the delivery of services for which PA is required.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	faxed if the request is through portal. Telephonic clarification may be obtained.		
Qualifications of reviewers: • All reviewers are masters level or above. Unlicensed MA clinicians are supervised by licensed master's level clinicians. • Professional peers make denial determinations.	**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	**Qualifications of reviewers:** • Nurses may authorize services, but only physicians can issue a denial.	**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
	conduct and review an assessment, including identifying precipitating events, gathering histories of mental and physical health, substance use, past mental health services and criminal justice contacts, assessing family, cultural, social and work relationships, and conducting/reviewing a mental status examination, complete a DSM diagnosis, and write and supervise the implementation of a PCSP. • A QMHP must meet one of the follow conditions: – Bachelor's degree in nursing and licensed by the State of Oregon; – 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;		

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	– Graduate degree in a behavioral science field; or – A qualified Mental Health Intern, as defined in 309-019-0105(61).		
Criteria: • Authorization decisions are based on regional UM guidelines that are annotated and evidence-based • (although the CCO is also evaluating the purchase of third parity criteria). ASAM criteria are used for SUD in addition to HERC guidelines. • Regional guidelines (rather than third party national criteria) are used to allow for more varied levels of care specific to MH/SUD and the region. • UM guidelines are updated when a problem is identified. Updates are developed by UM leadership and UM physicians based on up to	**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	**Criteria:** • PA and CR authorization decisions are based on the ALOS determined by InterQual Criteria or MCG (depending on the health plan), HERC PL and guidelines.	**Criteria**: • Authorizations are based on the HERC PL and guidelines; Oregon Statute, OAR, and federal regulations; InterQual guidelines; and evidence-based guidelines from private and professional associations, such as the Society of American Gastrointestinal and Endoscopic Surgeons and InterQual, where no State or federal guidelines exist.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
date clinical evidence and bests practices.	OAR requirements and develop a PCSP. • The PCSP components are entered into MMIS as an authorization.		
Reconsideration/RR: • If PA was not obtained prior to service, and a provider requests RR, a RR is conducted by a licensed provider to determine MN for admission and continued stay. • MH/SUD delegate allows RR for up to one year.	**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.	**Reconsideration/RR:** • If PA was not obtained prior to service, and a provider requests RR, a RR is conducted by a licensed provider to determine MN for admission and continued stay. • Delegates allow RR ranging from four months up to one year for M/S benefits. • Provider appeal process- If the health plan upholds denial of payment, the provider may appeal to Health Share who reviews and makes the final determination to uphold or overturn.	**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 a provider requests review of an OHA delegate level-of-care determination, KEPRO may conduct the second review. **Reconsideration (Comagine)**: • If the facility requests a reconsideration of a CONS denial, a second psychiatrist (who did not make the initial decision) will review the documentation and discuss with the facility in a formal meeting. • No policy for CR denials. **Reconsideration (Comagine Health)**: • 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.		

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Consequences for failure to authorize: • Failure to obtain authorization can result in non-payment. There is no member liability for payment of any MH/SUD denial per written contracts between the provider and the plan.	**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 obtain authorization can result in non-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.
Appeals: • Members may request an appeal.	**Appeals (OHA)**: • Members may request a hearing on any denial decision.	**Appeals:** • In the case of any denial, the member has the right to file an appeal of a denial within	**Appeals**: • Standard appeal and fair hearing rights apply.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• A provider is allowed to file an appeal for payment.	**Appeals (Comagine)**: • Members may request a hearing on any denial decision. **Appeals (Comagine Health)**: • Members may request a hearing on any denial decision.	60 days of receipt of the Notice of Adverse Benefit Determination.	
5. How frequently or strictly is the NQTL applied?			
Frequency of review (and method of payment): • The average frequency of CR for acute inpatient admissions is 1-3 days. All MH/SUD facilities are currently paid on a per diem basis. • CR ranges for other services: – 4 days for detox level 3.7. – Applied to all cases upon notice of admission and individualized based on treatment history and response to treatment, complexity, treatment plan, level of care and primary payor.	**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	**Frequency of review (and method of payment):** • CR every 1-3 days to facilitate transition of care for facilities paid by DRG. • SNF review frequency ranges from initial approval for entire 20 days to every 7 days depending on the diagnosis, treatment assessment/evaluation which is based on medical necessity. • Exceptions to the PA process are at the discretion of the reviewing clinician.	**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
– Eating disorder titrated by weight gain. – 30 days for residential SUD within 1 week of initial auth. – Every 3 days following first week of subacute. – Every 14 days for PRTS.	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.		
RR conditions and timelines: • MHSUD delegate allows RR for up to one year. • Retro authorization is provided at any time during the hospitalization or after the hospitalization (based upon medical necessity) for up to a year.	**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	**RR conditions and timelines:** • For RR, the CCO's health plans follow the timely filing processes set forth for claims. In the majority of cases the member has been discharged and services have already been rendered. • Delegates allow RR ranging from four months up to one year for M/S benefits. • Review is completed per timely filing claims processes (within 30 days of receipt of claim).	**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
	granted at the discretion of the MMC, which is led by the HSD medical director. • If a provider requests review of an OHA delegate level-of-care determination, KEPRO may conduct the second review. **Reconsideration (Comagine)**: • If the facility requests a reconsideration of a CONS denial, a second psychiatrist (who did not make the initial decision) will review the documentation and discuss with the facility in a formal meeting. • No policy for CR denials. **Reconsideration (Comagine Health)**: • 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		

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	medical management meeting.		
Methods to promote consistent application of criteria: • IRR testing conducted at least annually. • Delegate testing standards vary from 80% to 90%.	**Methods to promote consistent application of criteria (OHA)**: • Nurses are trained on the application of the HERC PL and guidelines, which is spot-checked through ongoing supervision. Whenever possible, practice guidelines from clinical professional organizations such as the American Medical Association or the American Psychiatric Association, are used to establish PA frequency for non-residential MH/SUD services. • KEPRO has a formal policy including an 80% standard using InterQual criteria, conducted at least annually. • 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):**	**Methods to promote consistent application of criteria:** • IRR testing conducted at least annually. • Delegate testing standards vary from 80% to 90%.	**Methods to promote consistent application of criteria**: • Nurses are trained on the application of the HERC PL and guidelines, which is spot-checked through ongoing supervision. Whenever possible, practice guidelines from clinical professional organizations such as the American Medical Association or the American Psychiatric Association, are used to establish PA frequency for services in the FFS system. • KEPRO has a formal policy including an 80% standard using InterQual criteria, conducted at least annually.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	• 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 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: • Recent studies show that the average LOS for psychiatric admissions is very short, approximately 5-6 days. Due to the short LOS, CR is done	**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	**Evidence for UM frequency:** • The average LOS is approximately 5 days. • HERC, MCG, InterQual, OARs, federal guidelines.	**Evidence for UM frequency**: • PA length and CR frequency are tied to HERC PL and guidelines, DRGs, OAR, CFRs, InterQual, reviewer

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
often. Link to the study for evidence: https://www.hcup-us.ahrq.gov/reports/statbriefs/sb191-Hospitalization-Mental-Substance-Use-Disorders-2012.pdf. • ASAM, HERC, OARs, federal guidelines, regional guidelines • The CCO plans to evaluate the use of MCG to obtain ALOS data to better tie frequency of review to evidence. If purchase is not feasible, the CCO will develop evidence for the frequency of review for each type of residential benefit.	guidelines, OAR, CFRs, InterQual, reviewer expertise and timelines for expectations of improvement.		expertise and timelines for expectations of improvement.
Data reviewed to determine UM application: • Review of notices of action along with appeal and hearing rates. • Routine (monthly or quarterly) utilization reports compare requests vs approval and denial rates. • These reports are reviewed quarterly by quality management staff who have	**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:** • Number of PA and CR requests.	**Data reviewed to determine UM application**: • A physician led group of clinical professionals conducts an annual review to determine which services receive or retain PA. Items reviewed include: – Utilization. – Approval/denial rates. – Documentation/ justification of services.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
not participated in the original authorization decision.	**Data reviewed to determine UM application (Comagine)**: • N/A **Data reviewed to determine UM application (Comagine Health):** • N/A		– Cost data.
IRR standard: • IRR testing conducted at least annually. • Delegate testing standards vary from 80% to 90%.	**IRR standard:** • KEPRO has a formal policy including an 80% standard using InterQual criteria.	**IRR standard:** • IRR testing conducted at least annually. • Delegate testing standards vary from 80% to 90%.	**IRR standard:** • KEPRO has a formal policy including an 80% standard using InterQual criteria.
Analysis			
Health Share was responsible for delivering IP MH/SUD and M/S Medicaid benefits, through its delegates, 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 PRTS benefits (e.g., SCIP, SAIP, and adult and adolescent residential services) delivered under all benefit packages, OHP FFS's subcontractor, Comagine Health, conducted the CON and PA processes, with the CCO's delegates conducting CR for those services. The CCO's delegates 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. HSAG's analysis of Health Share's PA data for IP and OP benefits did not reveal any concerns related to MHP. Of the total 156,025 IP and OP PA requests reported, 4.52 percent were denied. Less than 1 percent of MH/SUD PA requests were denied, the majority denied being PA requests for OP MH/SUD benefits rather than for IP MH/SUD benefits, with none resulting in an appeal.			

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

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 across Health Share delegates and OHP FFS, 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. Health Share delegates 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 CONS 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, masters-level reviewers conducted UM applying OARs, HERC, MCG, InterQual, national guidelines, and ASAM for CCO SUD. The CCO and OHP FFS subcontractors required all MH/SUD and M/S denials to be made by 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 FFS allowed RR for MH/SUD and M/S when providers failed to obtain authorization and allowed for exceptions past the RR time frames. OHP FFS had a 90-day time frame from the date of service for the allowance of RR, whereas Health Share delegate policies identified variances ranging from four months up to one year for M/S benefits. Health Share's primary MH/SUD delegate, CareOregon, did not have a retrospective review cut-off and processed all authorization requests when received. Because Health Share's time frame restrictions for MH/SUD PA requests was relative to the management of M/S benefits and were all greater than OHP FFS' 90-day RR allowance, HSAG did

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
not determine the variances as a parity concern. 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, Health Share did not have a formal or standardized process for its delegates to adhere to, but the CCO provided information regarding its delegates' IRR process that ensured IRR was performed at least annually. The testing standards across Health Share delegates ranged from 80 percent to 90 percent passing rates, with the standards being equitably applied across both MH/SUD and M/S IRR testing. OHP FFS was applying an 80 percent standard at least annually. The frequency and standards applied to promote of consistency consistent application of criteria did not present a parity concern.			
Outcome			
HSAG's analysis determined that Health Share's rationale, documentation requirements, processes, and frequency of UM applied to IP MH/SUD benefits were comparable to and no more stringently applied to IP M/S benefits. While not required for parity, HSAG recommends that Health Share establish standardized requirements for its delegates in relation to consistency of criteria applied to make medical necessity determinations, CR time frames, and IRR standards. This will ensure quality and consistency in the application of UM for the delivery of benefits to members.			

Category II—Utilization Management Limits Applied to Outpatient Services

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

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

Classification: OP

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

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

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
1. To which benefit is the NQTL assigned?				
• (2) Applied Behavior Analysis (ABA). • (2) OT, PT, ST for MH conditions are	The following services are managed by DHS:	• PA, CR and RR are required for: • (2, 3, 4) ABA (includes PT, ST, OT)	• PA, CR and RR are required for: • (2, 3, 4) PT, OT, ST	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) Comprehensive DD waiver. • (1) 1915(c) Support Services DD waiver. • (1) 1915(c) Behavioral DD Model waiver. • (1) 1915(c) Aged & Physically Disabled waiver. • (1) 1915(c) Hospital Model waiver. • (1) 1915(c) Medically Involved Children's NF waiver. • (1) 1915(k) Community First Choice State Plan option. • (1) 1915(j): Self-directed personal assistance.	• (2, 3, 4) DBT • (2, 3, 4) ECT • (2, 3, 4) High intensity OP services in early childhood & HB stabilization. • (2, 3, 4) Hormone and surgical benefits for gender dysphoria • (2, 3, 4) Specialty transition age youth-defined as youth ages 16- 24. Services include age appropriate supportive services. • (2, 3, 4) Psychiatric Day treatment. • (2, 3) Psychological testing. • Partial & IOP for – (2-4) Eating disorders. – (2, 3) SUD non-formulary MAT.	• (2, 3, 4) Certain office procedures. • (2, 3, 4) Certain ambulatory surgeries. • (2, 3, 4) Neuropsychological testing. • (2, 3) Some naturopathic services.	• (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.	• (1) The State requires PA of HCBS in order to meet federal	• (2) To ensure coverage, medical necessity and prevent	• (2) To ensure coverage, medical necessity and prevent	• (2) To prevent services being delivered in violation of relevant

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
• (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.	requirements regarding PCSPs and ensure services are provided in accordance with a participant's PCSP and in the last restrictive setting.	unnecessary overutilization. • (3) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. • (4) To determine appropriate reimbursement (i.e., whether MH/SUD or M/S should pay).	unnecessary overutilization. • (3) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. • (4) To determine appropriate reimbursement (i.e., whether MH/SUD or M/S should pay).	OARs, associated HERC PL and guidelines and federal regulations. • (3) Services are associated with increased health or safety risks.
3. What evidence supports the rationale for the assignment?				
• (2) HERC PL • (2) OAR 410-172-0650 for ABA services. • (2) PA requests with insufficient documentation to demonstrate medical necessity is not being met or HERC PL guidelines are not being followed.	• (1) Federal requirements regarding PCSPs for 1915(c), 1915(k), and 1915(j) services (e.g., 42 CFR 441.301, 441.468, and 441.540) and the applicable approved 1915(c) waiver application/State plan amendment. • (1) Federal requirements regarding 1915(c) and 1915(i) services	• (2-3) ASAM, OARs, HERC PL and guidelines, and federal guidelines. • (2) UM and encounter reports (for providers paid by case rate) are reviewed for trends in over and under-utilization on a monthly basis. • (2) Annual cost and utilization reports. • (3) State and federal requirements.	• (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. • (4) Contract.	• (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
	require that HCBS are provided in the least restrictive setting possible.	• (3) Oregon Performance Plan • (OPP) requires that BH services be provided in least restrictive setting possible. The OPP is a DOJ-negotiated Olmsted settlement. • (2) Practice Guidelines for the Treatment of Psychiatric Disorders, Treatment of Patients with Eating Disorders, Third Edition, American Psychiatric Association Publishing, 2010; National Institute for Clinical Excellence, Eating Disorders, Clinical Guide 9, January 2004; American Academy of Family Physicians, Diagnosis of Eating Disorders in Primary Care, Table 6, Level-of-care Criteria for patients with eating disorders, 2003. • (4) Contract		

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
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:** • Standard authorization decisions are processed within 14 days.	**Timelines for authorizations:** • Standard authorization decisions are processed within 14 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 ABA must have an evaluation and referral for treatment from a	**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:** • Most OP services require submission of a form for PA.	**Documentation requirements:** • 1-2 page PA request form with clinical information.	**Documentation requirements**: • A cover page form is required. In addition, diagnostic information, a CPT code(s), a rationale for medical necessity plus any additional supporting documentation are required. • Documentation supporting medical necessity is required at

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
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.				the time of billing for OT, PT, ST services.
Method of document submission: • Paper (fax) or online PA/POC submitted prior to the delivery of services.	**Method of document submission**: • All 1915(c), 1915(k), and 1915(j) services must be included in a participant's PCSP and approved by a qualified case manager at the local case management entity (CME) prior to service delivery. • Information is obtained during a face-to-face meeting, often at the individual's location.	**Method of document submission:** • Documentation is provided through secure email or fax.	**Method of document submission:** • Documentation is provided through secure email or fax. • One provider can submit using EHR.	**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
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 • Three years of human services related experience.	**Qualifications of reviewers:** • All reviewers are masters level or above. Unlicensed MA clinicians are supervised by licensed master's level clinicians. • Professional peers make denial determinations.	**Qualifications of reviewers:** • Nurses may authorize services, but only physicians can issue a denial.	**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
Criteria: • Authorizations are based on applicable HERC guidelines, Oregon Statute, Oregon Administrative rules, 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:** • Authorizations are based on ASAM criteria, regional UM guidelines (although the CCO is evaluating the purchase of third party criteria), HERC PL and guidelines, SAMHSA EBP, OHA rules, National Guidelines such as American Psychological Association or World professional association for transgender health.	**Criteria:** • Authorizations are based on HERC PL and guidelines, DMAP provider guidelines, MCG and InterQual.	**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 comparable MMC meeting. • RR authorization requests can be made	**Reconsideration/RR:** • (c) NA	**Reconsideration/RR:** • MH/SUD delegate allows RR for up to one year.	**Reconsideration/RR:** • Delegates allow RR ranging from four months up to one year for M/S benefits.	**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

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
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.				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 authorization can result in non-payment.	**Consequences for failure to authorize:** • Failure to obtain authorization can result in non-payment.	**Consequences for failure to authorize:** • Failure to obtain authorization may result in non-payment.
Appeals: • Notice and fair hearing rights apply.	**Appeals**: • Notice and fair hearing rights apply.	**Appeals:** • Notice and fair hearing rights apply.	**Appeals:** • Notice and fair hearing rights apply.	**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	**Frequency of review:** • PCSPs are reviewed and revised as needed,	**Frequency of review** and method of payment • PAs vary by service:	**Frequency of review** and method of payment	**Frequency of review**: • PA is granted for different authorization

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
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.	but at least every 12 months.	• Eating disorder titrated by weight gain • 7 days for respite • 90 days for HB • 6 months for DBT • 1 year for TAY • Concurrent review ranges from: – 6-12 sessions for ECT. – 30 days for most OP services. – 6 months to 1 year for TAY.	• A CR for a second authorization is required when the initial number of units is exhausted. • CR frequencies vary by service: – Ancillary services such as PT, OT, SLP up to 30 visits/year, combination. – Acupuncture up to 30 visits per year. – Chiropractic up to 30 visits per year.	periods depending on the service and can be adjusted. PAs for extensive services usually range from 6 months to 1 year. • Exceptions may be made at the discretion of the MMC, which is led by the HSD medical director.
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	**Reconsideration/RR:** • NA.	**RR conditions and timelines:** • MH/SUD delegate allows RR for up to one year.	**RR conditions and timelines:** • Retro reviews are conducted when submitted with clinical documentation that supports medical necessity and rationale why a PA was not submitted. • Delegates allow RR ranging from four months up to one year for M/S benefits.	**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

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
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.				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.
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	**Methods to promote consistent application of criteria:** • Conduct IRR testing at least annually. • Delegate testing standards vary from 80% to 90%.	**Methods to promote consistent application of criteria:** • Conduct IRR testing at least annually. • Delegate testing standards vary from 80% to 90%.	**Methods to promote consistent application of criteria**: • Nurses are trained on the application of the HERC guidelines, which is spot checked through ongoing supervision.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
	assure quality and compliance.			
6. What standard supports the frequency or rigor with which the NQTL is applied?				
Evidence for UM frequency: • HERC guidelines (for ABA and OT, PT, ST) of which there are more M/S than MH/SUD because 1) there are more technological procedures (e.g., surgery, devices, procedures and diagnostic tests); 2) the literature is more robust. • 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	**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:** • HERC guidelines, ASAM and diagnostic-specific practice guidelines provide evidence for certain conditions that can be translated into a frequency of review, which occurs one to two weeks prior to expected improvement.	**Evidence for UM frequency:** • HERC guidelines provide evidence that can be translated into a frequency of review, which occurs one to two weeks prior to expected improvement.	**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

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
organizations such as the American Medical Association or the American Psychiatric Association, are used to establish PA frequency.				Association or the American Psychiatric Association, are used to establish PA frequency.
Data reviewed to determine UM application: • A physician-led group of clinical professionals conduct an annual review to determine which services receive or retain a PA; items reviewed include: – Utilization. – Approval/denial rates. – Documentation/justification of services. – Cost data.	**Data reviewed to determine UM application:** • N/A	**Data reviewed to determine UM application:** • Monthly utilization reports comparing requests for services to approval and denial rates. • Provider appeal process.	**Data reviewed to determine UM application:** • Number of PA and CR requests/cost trends.	**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	**IRR standard:** • Spot-checks performed through supervision.	**IRR standard:** • 90% standard.	**IRR standard:** • 90% standard.	**IRR standard (OHA):** • KEPRO has a formal policy including an

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
80% standard using InterQual criteria. **IRR standard (Comagine):** • Spot-checks performed through supervision. Formal policy to be developed. **IRR standard (Comagine Health):** • Spot-checks performed through supervision.				80% standard using InterQual criteria.

Analysis

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

HSAG's analysis of Health Share's PA data for IP and OP benefits did not reveal any concerns related to MHP. Of the total 156,025 IP and OP PA requests reported, 4.52 percent were denied. Less than 1 percent of MH/SUD PA requests were denied, the majority denied being PA requests for OP MH/SUD benefits, with none resulting in an appeal.

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

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

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. Health Share delegates and OHP FFS were following these required time frames for authorizations. For MH/SUD benefits, Health Share required the submission of specific level-of-care assessments (e.g., the Child and Adolescent Service Intensity Instrument [CASII], ASAM, and LSI) while M/S level-of-care information was diagnosis-specific. Alternatively, 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 and 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

Health Share's delegates applied OARs, HERC, MCG, InterQual, national guidelines, and ASAM for CCO SUD in making UM decisions. For MH/SUD PA requests, Health Share's delegates ensured professional peers made decisions, whereas M/S PA denials required a physician denial decision. Under CCO and CCG benefit packages, OHP FFS allowed nurses to deny PA requests. This did not present a parity concern. Both the CCO and OHP FFS allowed RR for MH/SUD and M/S when providers failed to obtain authorization and allowed for exceptions past the RR time frames. OHP FFS had a 90-day time frame from the date of service for the allowance of RR, whereas Health Share delegate policies identified variances ranging from four months up to one year for M/S benefits. Health Share's primary MH/SUD delegate, CareOregon, did not have a retrospective review cut-off and processed all authorization requests when received for up to one year. Because the time frame restrictions applied by Health Share's delegates were relative to the management of M/S benefits and were all greater than OHP FFS' 90-day RR allowance, HSAG did not consider the variances to be a parity concern. 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, Health Share did not have a formal or standardized process for its delegates to adhere to, but the CCO provided information regarding its delegates' IRR process that ensured IRR was performed at least annually. The testing standards across Health Share delegates ranged from 80 percent to 90 percent passing rates with the standards being equitably applied across both MH/SUD and M/S IRR testing. OHP FFS was applying an 80 percent standard at least annually. The frequency and standards applied to promote of consistency consistent application of criteria did not present a parity concern.

Outcome

HSAG's analysis determined that Health Share's rationale, documentation requirements, processes, and frequency of UM applied to OP MH/SUD benefits were comparable to and no more stringently applied to OP M/S benefits. While not required for parity, HSAG recommends

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
that Health Share establish standardized requirements for its delegates in relation to consistency of criteria applied to make medical necessity determinations, CR time frames, and IRR standards. This will ensure quality and consistency in the application of UM for the delivery of benefits to members.				

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 Health Share'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 reduce the use of risky medications; to ensure that the most cost-effective medication is used; to ensure the most appropriate treatment approach to reduce services prescribed in the absence of medical necessity or continued after they are no longer medically necessary.	• To promote appropriate and safe treatment of funded conditions.	• To reduce the use of risky medications; to ensure that the most cost-effective medication is used; to ensure the most appropriate treatment approach to reduce services prescribed in the absence of medical necessity or continued after they are no longer medically necessary.

CCO MH/SUD	FFS MH Carve Out	CCO M/S
3. What evidence supports the rationale for the assignment?		
• Professional society guidelines or industry resources, such as FDA prescribing guidelines, medical evidence, the AHRQ Tobacco Cessation Guidelines; the Prioritized List; CCO's Pharmacy and Therapeutics Committees; and OAR, including 410-141-3070 and 410-141-0070.	• 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.	• Professional society guidelines or industry resources, such as FDA prescribing guidelines, medical evidence, the AHRQ Tobacco Cessation Guidelines; the Prioritized List; CCO's Pharmacy and Therapeutics Committees; and OAR, including 410-141-3070 and 410-141-0070.
4. What are the NQTL procedures?		
• Generally, PA requests faxed to the CCO accompanied by appropriate clinical documentation that supports the request. The majority of forms are 1 page. • Requests are responded to within 24 hours. • Failure to obtain PA results in prescription being denied, delayed, or discontinued.	• 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	• Generally, PA requests faxed to the CCO accompanied by appropriate clinical documentation that supports the request. The majority of forms are 1 page. • Requests are responded to within 24 hours. • Failure to obtain PA results in prescription being denied, delayed, or discontinued.

CCO MH/SUD	FFS MH Carve Out	CCO M/S
	letters include information on required criteria, denial reasons, and how the provider can appeal and member hearing rights.	
5. How frequently or strictly is the NQTL applied?		
• Depending on the subcontractor, PAs are either authorized for 6 months and then re-evaluated for ongoing treatment or authorized for a period of 6 to 12 months. • The length of authorization depends on medical appropriateness and safety, as recommended by the P&T Committee. • Continuity of care approvals may be made if member was receiving the drug prior to enrollment, but PA still needs to be provided for continued treatment. • Providers may provide additional information for a reconsideration of a denial. • Providers and members may appeal any denial; members may request a fair hearing. • The CCO assesses stringency through review of denial/appeal overturn rates, number of requests, and drug utilization reports.	• 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.	• Depending on the subcontractor, PAs are either authorized for 6 months and then re-evaluated for ongoing treatment or authorized for a period of 6 to12 months. • The length of authorization depends on medical appropriateness and safety, as recommended by the P&T Committee. • Continuity of care approvals may be made if member was receiving the drug prior to enrollment, but PA still needs to be provided for continued treatment. • Providers may provide additional information for a reconsideration of a denial. • Providers and members may appeal any denial; members may request a fair hearing. • The CCO assesses stringency through review of denial/appeal overturn rates, number of requests, and drug utilization reports. • PA criteria are reviewed for appropriateness on a 1-2 year cycle or as indicated as new guidelines are updated.

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• PA criteria are reviewed for appropriateness on a 1-2 year cycle or as indicated as new guidelines are updated.	• PA criteria are reviewed as needed due to clinical developments, literature, studies, and FDA medication approvals.	
6. What standard supports the frequency or rigor with which the NQTL is applied?		
• Professional society guidelines or industry resources, such as FDA prescribing guidelines, medical evidence, the AHRQ Tobacco Cessation Guidelines; the Prioritized List; CCO's Pharmacy and Therapeutics Committees; and OAR, including 410-141-3070 and 410-141-0070.	• 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.	• Professional society guidelines or industry resources, such as FDA prescribing guidelines, medical evidence, the AHRQ Tobacco Cessation Guidelines; the Prioritized List; CCO's Pharmacy and Therapeutics Committees; and OAR, including 410-141-3070 and 410-141-0070.
Analysis		
Health Share 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). Health Share reported a 49.22 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, only 3.69 percent of denials were appealed, with 94 denials resulting in an overturned decision. The majority of the prescription drugs denied through PA were denied for "Not Covered" and "Non-Formulary" categorical reasons. **Comparability** The State was applying 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		

CCO MH/SUD	FFS MH Carve Out	CCO M/S
were responded to within 24 hours, with decisions generally made within 72 hour if additional information was needed. 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 CareOregon works with pharmacies and providers to redirect PA requests and claims to OHA.		
Outcome		
HSAG determined the 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 Health Share'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 does not close its network for new providers of inpatient MH/SUD services when CCO determines there is no need or gap in the service delivery network. • CCO may close its network for new MH/SUD providers of outpatient services when CCO determines there is no need or gap in the service delivery network.	• The State does not restrict new providers of inpatient or outpatient MH/SUD services from enrollment.	• N/A • CCO may close its network for new M/S providers of outpatient services when CCO determines there is no need or gap in the service delivery network.	• The State does not restrict new providers of inpatient or outpatient MH/SUD services from enrollment.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
2. Why is the NQTL assigned to these benefits?			
• When CCO closes its network to new MH/SUD providers, it is done because the CCO has determined there is an adequate provider network.	• N/A	• When CCO closes its network to new M/S providers, it is done because the CCO has determined there is an adequate provider network.	• N/A
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. • Network Needs Assessment/Network Geo-Assessment.	• 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. • Network Needs Assessment/Network Geo-Assessment.	• N/A

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Demographic characteristics of population. • CCO contract requirements for network adequacy.		• Demographic characteristics of population. • CCO contract requirements for network adequacy.	
4. What are the NQTL procedures?			
• CCO closes its network to new providers of outpatient MH/SUD services when CCO determines there is no need or gap in the service delivery network. • The Network Management Committee reviews provider applications for network admission and determines whether the provider fills an identified network gap or need. • The Behavioral Health Operating Committee decides whether to close the network to particular provider types based upon recommendations made by the Network Management Committee. • CCO uses tri-county access standards, network needs assessment/network geo-assessment, demographic characteristics of the	• N/A	• CCO closes its network to new providers of outpatient M/S services when CCO determines there is no need or gap in the service delivery network. • The CCO reviews provider applications for network admission and determines whether the provider fills an identified provider gap or need. (Note - the CCO employs providers to serve members as opposed to contracting with a provider network). • The Plan uses a workgroup and committee-type structure to decide whether a need exists to accept new providers (employees). • CCO uses tri-county access standards, network needs assessment/network geo-assessment, demographic	• N/A

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
population, growth rates of membership into different zip codes, appointment availability, access to provider specialties and population specific needs to support decisions to close the network. • Providers that are denied the opportunity to participate in CCO's network may challenge CCO's decision by invoking Health Share's provider review process which is consistent with OAR 410-141-3120]. • Exceptions may be made based upon a of the provider's specialty and determination that the services provide a unique skill set that would be beneficial to include in the network.		characteristics of the population, growth rates of membership into different zip codes, appointment availability, access to provider specialties and population specific needs to support decisions to close the network. • Providers that are denied the opportunity to participate in CCO's network may challenge CCO's decision by invoking their provider review process which is consistent with OAR 410-141-3120]. • Exceptions may be made based upon a review of the provider's specialty and determination that the services provide a unique skill set that would be beneficial to include in the network.	
5. How frequently or strictly is the NQTL applied?			
• If the CCO decides to close the network to particular provider types, all new providers applying for those particular provider types are	• N/A	• When CCO determines that they have a sufficient number of particular. • Providers/provider types, all new providers applying for	• N/A

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
subject to this NQTL. However, the application gives providers an opportunity to demonstrate a unique skill set or specialty that may result in admission into the network.		those particular provider types are subject to this NQTL.	
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: – Network Needs Assessment/Network Geo-Assessment. – Demographic characteristics of population. – Number of out of network requests/single case agreements.	• 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: – Network Needs Assessment/Network Geo-Assessment. – Demographic characteristics of population. – Number of out of network requests/single case agreements.	• N/A
Analysis			
Health Share may close its network to OP providers of MH/SUD and M/S services when the CCO determines there is no community need for new providers to meet service capacity and access standards. Developing a network based on network adequacy and sufficiency standards is supported by federal regulation, including the ability of an MCO (CCO) to limit contracting beyond the needs of its members to maintain quality and control costs (42 CFR §438.12). OAR 410-141-0220 also requires the CCO to meet network sufficiency standards, which impacts			

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

the application of this NQTL. In addition, provider network admission limits do not apply to FFS benefits, and the application of provider network admission NQTLs for benefits delivered under managed care is supported by 42 CFR §438.206 and §438.12. Accordingly, parity for CCOE and CCOG benefit packages was not analyzed.

Comparability

Health Share reported that it was unaware of any network closures, although this was not able to be confirmed with the CCO's delegates through the analysis. Based on 2018 reporting, requests for network admission of OP providers of MH/SUD and M/S services should be reviewed by committee structures and based on the adequacy of the current provider network. When a decision was made that a particular provider type is not needed, network closures would result in requests to join the network being declined. The CCO evaluates tri-county access standards, a network needs assessment, demographic characteristics of the population, growth rates of membership into different ZIP Codes, appointment availability, access to provider specialties, and population-specific needs to support decisions to close the network. Exceptions may be made for MH/SUD and M/S providers based on a review of the provider's specialty and determination that the services provide a unique skill set that would be beneficial to include in the network. Providers may challenge the CCO's decision to close the network. Based on these findings, the CCO's network closure processes for providers of MH/SUD services were comparable and applied no more stringently than to providers of M/S services.

Stringency

Requests for network admission of MH/SUD and M/S providers services were reviewed for need by Health Share delegates based on the network adequacy of the current provider network. Health Share's reporting indicated that when it determined particular provider types were not needed, provider requests to join the network would be declined and the provider may not be reimbursed for provided services. For MH/SUD providers, monitoring included reviewing the provider capacity report/mapping quarterly to ensure adequate geographic coverage, provider capacity reports by county and/or ZIP Code, and provider specialty and the number of covered lives in each county. Access to care complaints, timeliness of accessing care from the date of referral to first appointment, and the number of behavioral health integration sites in the community were being reviewed to determine whether or not to close the network to providers.

Outcome

HSAG's analysis of Health Share's reported information resulted in the determination that the CCO's network closure processes and decisions for MH/SUD providers were comparable to and no more stringently applied to M/S providers.

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 Health Share's provider admission processes based on comparability and stringency standard information related to credentialing and recredentialing provided below. Since Medicaid provider enrollment for OHP FFS did not include a provider credentialing component, HSAG deemed provider admission processes not applicable for OHP FFS and did not include that classification in the provider admission analysis.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
– Ensure capabilities of provider to deliver high quality of care. – Ensure provider meets minimum competency standards.	health and safety and to reduce Medicaid provider fraud, waste, and abuse.	– Ensure capabilities of provider to deliver high quality of care. – Ensure provider meets minimum competency standards.	health and safety and to reduce Medicaid provider fraud, waste, and abuse.
3. What evidence supports the rationale for the assignment?			
• Credentialing/re-credentialing requirements are supported by the following evidence: – State law and Federal regulations, including 42 CFR 438.214. – State contract requirements. – Accreditation guidelines (NCQA).	• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E-Provider Screening and Enrollment.	• Credentialing/re-credentialing requirements are supported by the following evidence: – State law and Federal regulations, including 42 CFR 438.214. – State contract requirements – Accreditation guidelines (NCQA)	• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E-Provider Screening and Enrollment.
4. What are the NQTL procedures?			
• All providers must meet credentialing and re-credentialing requirements to participate in the network. • Providers interested in becoming part of the network may work with CCO Provider Relations staff to complete the credentialing process. • CCO's credentialing process involves completing all	• 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	• All providers must meet credentialing and re-credentialing requirements to participate in the network. • Providers interested in becoming part of the network may work with Provider Relations staff at the various health plans to complete the credentialing process.	• 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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
credentialing documents, as listed below, a site visit when applicable, and review by Health Share Medical Director and Credentialing Committee. • Providers must be able to bill Oregon Medicaid and not be on the exclusion list. • Providers must complete and provide: – Oregon Practitioners Credentialing Application. – New Provider Information Form. – Contract Completion Expectations. • Providers may submit supporting documentation by mail, email, fax or online through the Health Share portal. • CCO's credentialing process averages no more than 90 days. • CCO's Credentialing Committee is responsible for reviewing required information and making provider credentialing	information demonstrating the provider meets provider enrollment requirements such as NPI, tax ID, disclosures, and licensure/certification. The provider enrollment forms vary from 1 to 19 pages, depending on the provider type. Supporting documentation includes the provider's IRS letter, licensure, SSN number, and/or Medicare enrollment as applicable to the provider type. The enrollment forms and documentation can be faxed in or completed and submitted electronically to the State's provider enrollment unit. The State's provider enrollment process includes checking the forms for completeness, running the provider name against exclusion databases, and verifying any licenses, certifications or equivalents. The State's enrollment process averages 7 to 14 days. State staff in the provider enrollment unit are responsible for reviewing	• CCO's credentialing process involves completing all credentialing documents, as listed below, a site visit when applicable, and review by the health plan Medical Director and Credentialing/Quality Management Committee. • Providers must be able to bill Oregon Medicaid and not be on the exclusion list. • Providers must complete and provide: – Oregon Practitioners Credentialing Application. – New Provider Information Form. – Contract Completion Expectations. • Providers may submit supporting documentation by mail, email or fax. • CCO's credentialing process averages no more than 90 days. • CCO's Credentialing or Quality Committee is responsible for reviewing required information and making provider credentialing	information demonstrating the provider meets provider enrollment requirements such as NPI, tax ID, disclosures, and licensure/certification. The provider enrollment forms vary from 1 to 19 pages, depending on the provider type. Supporting documentation includes the provider's IRS letter, licensure, SSN number, and/or Medicare enrollment as applicable to the provider type. The enrollment forms and documentation can be faxed in or completed and submitted electronically to the State's provider enrollment unit. The State's provider enrollment process includes checking the forms for completeness, running the provider name against exclusion databases, and verifying any licenses, certifications or equivalents. The State's enrollment process averages 7 to 14 days. State staff in the provider enrollment unit are responsible for reviewing

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
recommendations to the Health Share Quality Committee (a sub-committee of the Health Share Board that is delegated the responsibility of reviewing Credentialing Committee recommendations). The Quality Committee considers and approves, denies or modifies Credentialing Committee recommendations. • CCO performs re-credentialing every three years. • Providers who do not meet credentialing/re-credentialing requirements will not be admitted to the network. • Providers who are adversely affected by re-credentialing decisions may challenge the decision through an appeals process, as outlined by Health Share policy.	information and making provider enrollment decisions	recommendations to the board and the board determines whether the CCO accepts the provider into the CCO's panel. • CCO performs re-credentialing every three years. • Providers who do not meet credentialing/re-credentialing requirements will not be admitted to the network. • Providers who are adversely affected by re-credentialing decisions may challenge the decision through an appeals process, according to the process outlined in the CCO's provider manuals.	information and making provider enrollment decisions
5. How frequently or strictly is the NQTL applied?			
• All licensed providers/provider types must be credentialed.	• All providers/provider types are subject to enrollment/re-enrollment requirements.	• All licensed providers/provider types must be credentialed.	• All providers/provider types are subject to enrollment/re-enrollment requirements.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• There are no exceptions to meeting these requirements.	• There are no exceptions to meeting provider enrollment/re-enrollment requirements.	• There are no exceptions to meeting these requirements.	• There are no exceptions to meeting provider enrollment/re-enrollment requirements.
6. What standard supports the frequency or rigor with which the NQTL is applied?			
• Requirement to conduct credentialing for all new providers is established by State law and Federal regulations. • The frequency with which CCO performs re-credentialing is based upon: – State law and Federal regulations – State contract requirements • Monitoring of provider performance (claims data, onsite audits, grievance and appeal data)	• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E - Provider Screening and Enrollment. The frequency with which the State re-enrolls providers is based on State law and Federal regulations.	• Requirement to conduct credentialing for all new providers is established by State law and Federal regulations. • The frequency with which CCO performs re-credentialing is based upon: – State law and Federal regulations – State contract requirements – Monitoring of provider performance (claims data, onsite audits, grievance and appeal data) – National accreditation standards through NCQA	• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E - Provider Screening and Enrollment. The frequency with which the State re-enrolls providers is based on State law and Federal regulations.
Analysis			
All IP and OP providers of MH/SUD and M/S services were subject to CCO credentialing and recredentialing requirements. Health Share's delegates conducted credentialing and recredentialing for providers of both MH/SUD and M/S services to meet State and federal requirements, ensure capabilities of provider to deliver high-quality care, and ensure providers meet minimum competency standards. The CCO's processes were reported to be the same across all benefit packages (CCOA, CCOB, CCOE, and CCOG).			

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Health Share reported an average of 24,879 MH/SUD and M/S providers credentialed in its network during the reporting period. The total denial rate for all provider types was less than 1 percent (0.14 percent), with no MH/SUD providers denied credentialing. **Comparability** Health Share 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 the Oregon Practitioner Credentialing and Re-Credentialing Application and provide supporting documentation including a Contract Completion Expectations and New Provider Information Form. Through the CCO's delegates, MH/SUD and M/S providers had several methods of submitting their application and supporting documentation, including by fax, by mail, or electronically. Nonlicensed MH care providers (e.g., qualified mental health providers/assistants and traditional health care works) were vetted similarly by CareOregon, with verifications done according to qualifications and certifications related to specific provider type. Health Share conducted audits of its delegates' credentialing and recredentialing functions. The CCO's credentialing process for MH/SUD providers included the primary source verification of licensing, board certification, Medicare Excluded Providers (Office of Inspector General), Medicare sanction (Excluded Parties List System/System for Award Management), Medicare opt-out (if applicable) and a National Practitioner Database query match to look for unexplained gaps in work history greater than six months. The process for M/S providers involved a similar review of each application to determine whether standards were met. **Stringency** Health Share's delegates consistently managed the credentialing process for both MH/SUD and M/S providers, which entailed the completion and submittal of all documents; a site visit when applicable; and review, recommendation, and decision by a credentialing committee. The respective credentialing processes averaged no more than 90 days. Recredentialing for both MH/SUD and M/S providers was conducted every three years. 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 or recredentialing decisions may challenge the decision through an appeal process.			
Outcome			
HSAG's analysis of Health Share'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 Health Share's application of limits applied to OON/OOS limits based on comparability and stringency standard information provided below.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
1. To which benefit is the NQTL assigned?			
• Out of Network (OON) and Out of State (OOS) Benefits	• OOS Benefits	• Out of Network (OON) and Out of State (OOS) Benefits	• OOS Benefits
2. Why is the NQTL assigned to these benefits?			
• CCO seeks to maximize use of in-network providers because in-network providers have alignment with care services for members and have been credentialed and contracted with the CCO. • The purpose of providing OON/OOS coverage is to provide needed services when they are not available in-network/in-State.	• The 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 seeks to maximize use of in-network providers because in-network providers have alignment with care services for members and have been credentialed and contracted with the CCO. • The purpose of providing OON/OOS coverage is to provide needed services when they are not available in-network/in-State.	• The 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 prior authorizing non-emergency OON/OOS benefits is to determine the medical necessity of the requested benefit and the availability of an in-network/in-State provider.	• The purpose of 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.	• The purpose of prior authorizing non-emergency OON/OOS benefits is to determine the medical necessity of the requested benefit and the availability of an in-network/in-State provider.	• The purpose of 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?			
• Except as otherwise required by OHA, non-emergency OON/OOS services are not covered unless services are not available within network/in-State. • The CCO's criteria for non-emergency OON/OOS coverage include when a provider has a clinical specialty not available in the CCO's network, to ensure	• 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.	• Except as otherwise required by OHA, non-emergency OON/OOS services are not covered unless services are not available within network/in-State. • The CCO's criteria for non-emergency OON/OOS coverage include when a provider has a clinical specialty not available in the CCO's network, to ensure	• 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
continuity of care for new members with OON/OOS provider, the service is not available in the State of Oregon, or the client is OOS and requires covered services. • Requests for non-emergency OON/OOS services are made through the prior authorization process. • The timeframe for approving or denying a non-emergency OON/OOS request is the same as other prior authorizations (14 days for a standard request). • The CCO establishes a single case agreement (SCA) with all OON/OOS providers. • The CCO's process for establishing a SCA includes gathering the information to complete the SCA form and sending the completed SCA to the OON/OOS provider for signature. • The average length of time to negotiate a SCA is 1 to 3 days.	• 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.	continuity of care for new members with OON/OOS provider, the service is not available in the State of Oregon, or the client is OOS and requires covered services. • Requests for non-emergency OON/OOS services are made through the prior authorization process. • The timeframe for approving or denying a non-emergency OON/OOS request is the same as other prior authorizations (14 days for a standard request). • The CCO establishes a single case agreement (SCA) with OON/OOS providers that will not accept the DMAP rate or at the provider's request. • The CCO's process for establishing a SCA includes gathering the information to complete the SCA form and sending the completed SCA to the OON/OOS provider for signature.	• 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
• Only providers enrolled in Oregon Medicaid who are not on the exclusions list can qualify as an OON/OOS provider. • The CCO generally pays OON/OOS providers the CCO contract rate, which is generally higher than the DMAP rate. In certain circumstances the CCO might pay a negotiated rate.		• The average length of time to negotiate a SCA is 1 to 3 days. • Only providers enrolled in Oregon Medicaid who are not on the exclusions list can qualify as an OON/OOS provider. • The CCO pays OON/OOS providers: – The Medicaid FFS rate; – A percentage of the Medicaid FFS rate; or – A negotiated rate.	
5. How frequently or strictly is the NQTL applied?			
• If a request for a non-emergency OON/OOS benefit does not meet the CCO's OON/OOS criteria, it will not be prior authorized. • If a non-emergency • OON/OOS benefit is not prior authorized, the service will not be covered, and payment for the service will be denied. • Members/providers may appeal the denial of an OON/OOS request.	• If a request for a non-emergency OOS benefit does not meet the OAR criteria, it will not be authorized. • If a non-emergency OOS benefit is not authorized, the service will not be covered, and 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	• If a request for a non-emergency OON/OOS benefit does not meet the CCO's OON/OOS criteria, it will not be prior authorized. • If a non-emergency • OON/OOS benefit is not prior authorized, the service will not be covered, and payment for the service will be denied. • Members/providers may appeal the denial of an OON/OOS request.	• If a request for a non-emergency OOS benefit does not meet the OAR criteria, it will not be authorized. • If a non-emergency OOS benefit is not authorized, the service will not be covered, and 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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• The CCO measures the stringency of the application of OON/OOS requirements by reviewing OON/OOS denial/appeal rates. • The CCO evaluates the number of SCAs monthly to determine whether the network should be expanded or a particular OON/OOS should be recruited to be a network provider.	of OOS requirements by reviewing OOS denial/appeal rates.	• The CCO measures the stringency of the application of OON/OOS requirements by reviewing OON/OOS denial/appeal rates. • The CCO evaluates the number of SCAs quarterly or bi-annual intervals. • (depending on the health plan) to determine whether the network should be expanded or a particular OON/OOS should be recruited to be a network provider.	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			
Health Share and its delegates ensured OON/OOS coverage to provide needed MH/SUD and M/S benefits when they were not available INN or in-state. Similarly, for MH/SUD FFS benefits, the State provided OOS coverage to provide needed benefits when they were not available in-state. The same PA processes and evidentiary standards described in NQTL categories I, II, and III were applied to OOS coverage of MH/SUD and M/S benefits across all benefit packages (CCOA, CCOB, CCOE, and CCOG). Health Share delegates 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 the State for FFS MH/SUD OOS benefits) required prior authorization to determine medical necessity and to ensure no INN/in-state providers are available to provide the benefit. The same PA processes and evidentiary standards described in NQTL categories I, II, and III were applied to OOS coverage of MH/SUD and M/S requests.			

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
For OON coverage requests, the CCO's delegates 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 delegate PA processes 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) were adhered to by all delegates. Similarly, the State reviewed requests for nonemergency OOS MH/SUD services through its PA process, adhering to its PA time frames identified at 14 days for standard requests and 72 hours for urgent requests. The CCO described a process for handling a complex OON/OOS MH/SUD member case, identifying how it would appropriately apply the PA and SCA process to ensure benefits were provided in relation to the member's needs. Health Share reported that its delegates each used their individual SCA templates to secure services from OON providers. While not regularly audited by Health Share, SCAs were being tracked at the delegate level.			
Outcome			
HSAG determined Health Share's processes, strategies, and evidentiary standards for OON/OOS limits applied to MH/SUD to be comparable and no more stringently applied, in writing and in operation, to M/S OON/OSS limits across all benefit packages.			

Appendix C. Improvement Plan Template

Health Share of Oregon 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					