HEALTH WEALTH CAREER

HEALTH SHARE OF OREGON (HEALTH SHARE)

NQTL ANALYSIS

CONTENTS

INTRODUCTION

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

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

OHA analyzed the following four NQTLs for each CCO:

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

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

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

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

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

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

INPATIENT UTILIZATION MANAGEMENT

NQTL: Utilization Management (PA, CR, Retrospective Review)
Benefit Package: A, B, E and G for Adults and Children
Classification: Inpatient (IP)
CCO: Health Share of Oregon (Health Share or HS)

Benefit package A and B: MH/SUD benefits in columns 1 (CCO MH/SUD) and 2 (FFS MH/SUD) compared using strategies 1-4 to M/S benefits in column 3 (CCO M/S). These benefit packages include MH/SUD IP benefits managed by the CCO (3 counties combined into a regional behavioral health system), OHA, HIA and KEPRO, compared to M/S IP benefits in column 3 managed by the CCO (four health plans).

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

1. To which benefits is the NQTL assigned?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• (1, 2, 3, 4) PA and CR are required for planned non-emergency admissions to acute IP (in and out-of-network (OON)), PRTS, subacute and 10 days after an IP SUD detoxification admission. • (1, 2, 3, 4) Emergency admissions require notification within 1-3 days of admission; re-assessment if not in a bed within 8 hours of notification to address least restrictive environment	• (1, 2, 4) PA (only) for MH/SUD procedures performed in a medical facility (e.g., gender reassignment surgery authorizations for benefit packages E and G), experimental/investigational, and extra-contractual benefits are conducted by OHA consistent with the information in column 4 for benefit packages E and G. • (2, 4, 5) A level-of-care review is required for SCIP, SAIP and subacute care that is conducted by an OHA	• (1, 2, 3, 4) PA and CR are required for planned non-emergency admissions to IP hospital, (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/u	• (1, 2, 4) PA and CR are required for in-state and OOS planned surgical procedures (including transplants) and associated imaging, rehabilitation and professional surgical services delivered in an IP setting and listed in OAR 410-130-0200, Table 130-0200-1; rehabilitation, and long term acute care (LTAC). (Notification is required for all IP admissions.) • (1, 2, 4) PA, CR and RR for Behavior Rehabilitation

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• (1) To ensure coverage, medical necessity and prevent unnecessary overutilization (e.g., in violation of relevant OARs and associated Health Evidence Review Commission (HERC) guidelines)[1]. • (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. • (3) Maximize 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/prevent overutilization of these high cost services. • (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual (e.g., matching the level of need to the least restrictive setting using the LOCUS – Level-of-care Utilization System and LSI – Level of Service Inventory). • (4) To comply with federal and State requirements. • (5) Most MH residential services were excluded from the capitated arrangements with the CCOs due to the	• (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 prevent overutilization (e.g., requests for care that are not medically necessary in violation of relevant OARs, the Health Evidence Review Commission (HERC) PL and guidelines). • (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. • (4) To comply with federal and State requirements.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	high cost and unpredictability of services and associated risk.		

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• (1, 2 and 4) HERC PL and guidelines. • (1) Detailed UM and level of care reports are reviewed monthly relative to prior years' claims history and similar provider types. • (1) Medical literature demonstrates high cost of unnecessary medical care (i.e. 30% of medical costs). (Institute of Medicine Report, (2012). Also see Fisher, Elliott S., MD, MPH, Wennberg, David E., MD, MPH, Stukel, Therese A., PhD et al., The Implications of Regional Variations in Medicare Spending: Part 2. Health Outcomes and Satisfaction with Care, Center	• (1, 2 and 4) HERC PL and guidelines. (HERC provides outcome evidence and clinical indications for certain diagnoses that may be translated into UM requirements.) • (1) Medical literature demonstrates high cost of unnecessary medical care (i.e., 30% of medical costs). (Institute of Medicine Report, (2012). Also see Fisher, Elliott S., MD, MPH, Wennberg, David E., MD, MPH, Stukel, Therese A., PhD et al., The Implications of Regional Variations in Medicare Spending: Part 2. Health Outcomes and Satisfaction with Care, Center	• (1, 2 and 4) HERC PL and guidelines. • (1) UM and claims reports are reviewed for trends in overutilization on a quarterly basis. • (1) Annual cost and utilization reports that confirm IP as a cost driver based on percentage of spend. • (1) Medical literature demonstrates high cost of unnecessary medical care (i.e. 30% of medical costs). (Institute of Medicine Report, (2012)). Also see Fisher, Elliott S., MD, MPH, Wennberg, David E., MD, MPH, Stukel, Therese A., PhD et al., The Implications of Regional Variations in Medicare Spending: Part 2. Health Outcomes and Satisfaction with Care, Center	• (1, 2 and 4) The HERC PL and guidelines. • (1) PA staff reports. If the UM team identifies any services for which utilization appears to be increasing (e.g., number of requests) or it appears that the State is paying for medically unnecessary care, the UM team consults with the health analytics team to analyze and evaluate adjustments to PA or CR. • (1) Health analytics reports. The health analytics team and policy analysts refer services that have been identified to have increasing utilization to the UM team for evaluation.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
for the Evaluative Clinical Sciences, Dartmouth Medical School, VA Outcomes Group, White River Junction VT, Center for Outcomes Research and Evaluation, Maine Medical Center, & Institute for the Evaluative Clinical Sciences, Toronto, Canada, Financial support was provided by grants from the Robert, Wood Johnson Foundation, the National Institutes of Health (Grant Number CA52192) and the National Institute of Aging (Grant Number 1PO1AG19783-01), 2002, pp 1-32. • (2) Oregon Performance Plan (OPP) requires that BH services be provided in least restrictive setting possible. 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	for the Evaluative Clinical Sciences, Dartmouth Medical School, VA Outcomes Group, White River Junction VT, Center for Outcomes Research and Evaluation, Maine Medical Center, & Institute for the Evaluative Clinical Sciences, Toronto, Canada, Financial support was provided by grants from the Robert, Wood Johnson Foundation, the National Institutes of Health (Grant Number CA52192) and the National Institute of Aging (Grant Number 1PO1AG19783-01), 2002, pp 1-32. • (2) The Oregon Performance Plan (OPP) requires that BH services be provided in the least restrictive setting possible. The OPP is a DOJ-negotiated Olmsted settlement.	for the Evaluative Clinical Sciences, Dartmouth Medical School, VA Outcomes Group, White River Junction VT, Center for Outcomes Research and Evaluation, Maine Medical Center, & Institute for the Evaluative Clinical Sciences, Toronto, Canada, Financial support was provided by grants from the Robert, Wood Johnson Foundation, the National Institutes of Health (Grant Number CA52192) and the National Institute of Aging (Grant Number 1PO1AG19783-01), 2002, pp 1-32. • (2) Medical errors in the hospital is the third leading cause of death in the US. Makary, M. & Daniel, M. Medical Error - The Third Leading Cause of Death in the US, BMJ, 2016;353:i2139.	

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
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. • (3) Network providers' credentials have been verified and they have contracted to accept the network rate. • (4) Applicable federal and State requirements.	• (4) PRTS CONS: OAR 410-172-0690 and 42 CFR 441.156. • (4) OARs and other applicable federal and State requirements. • (5) Cost and utilization reports	• (3) Network providers' credentials have been verified and they have contracted to accept the network rate. • (4) Applicable federal and State requirements	• (4) Applicable federal and State requirements.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Timelines for authorizations: • 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 (for benefit packages E and G):** **(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 3 days of requests for SCIP, SAIP or subacute. **(HIA)** • Authorization requests for PRTS are submitted prior to admission or within 14 days of an emergency admission. An emergency admission is acceptable only under unusual and extreme circumstances, subject to RR by HIA. **Timelines for adult residential and YAP authorizations**:	**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 24 hours, urgent requests within 72 hours and standard requests within 14 days; although a backlog may develop.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Documentation requirements: • 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. • Provider is required to submit updated clinical information for CR.	**(KEPRO)** • OARs require emergency requests be processed within 24 hours, urgent within 72 hours, and standard requests within 14 days. **Documentation requirements (OHA):** • PA documentation requirements for non-residential MH/SUD benefits in benefit packages E and G include a form that consists of a cover page. Diagnostic and CPT code information and a rationale for medical necessity must be provided, plus any additional supporting documentation. • The documentation requirement for level-of-care assessment for SCIP, SAIP and subacute is a psychiatric evaluation. Other information may be reviewed when available.	**Documentation requirements:** • 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
	Documentation requirements for PRTS CONS and CR for SCIP and SAIP (HIA): • PRTS CONS requires documentation that supports the justification for child residential services including: (a) A cover sheet detailing relevant provider and recipient Medicaid numbers; (b) Requested dates of service; (c) HCPCS or CPT Procedure code requested; and (d) Amount of service or units requested; (e) A behavioral health assessment and service plan meeting the requirements described in OAR 309-019-0135 through 0140; or (f) Any additional supporting clinical information supporting medical justification for the services requested; (g) For substance use disorder services (SUD), the Division uses the American Society of Addiction Medicine		

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	(ASAM) Patient Placement Criteria second edition-revised (PPC-2R) to determine the appropriate level of SUD treatment of care. • There were no reported specific documentation requirements for CR of SCIP or SAIP. **Documentation requirements (KEPRO)**: • Documentation may include assessment, service plan, plan-of-care, Level-of-care Utilization System (LOCUS), Level of Service Inventory (LSI) or other relevant documentation.		**Method of document submission**: • Paper (fax) or online PA requests are submitted prior to the delivery of services for which PA is required.
Method of document submission: • Fax, email or telephonic	**Method of document submission (OHA):** • For non-residential MH/SUD services in benefit packages E and G, paper (fax) or online PA requests are submitted prior to the delivery of services for which PA is required.	**Method of document submission:** • Telephonic, fax, mail or online.	

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	• For SCIP, SAIP and subacute level-of-care review, the OHA designee may accept information via fax, mail or email and has also picked up information. Supplemental information may be obtained by phone. **Method of document submission (HIA):** • Packets are submitted to HIA by mail, fax, email or web portal for review for child residential services. Telephonic clarification may be obtained. • Psychiatrist to psychiatrist review is telephonic. **Method of document submission (KEPRO):** • Providers submit authorization requests for adult MH residential to KEPRO by mail, fax, e-mail or via portal, but documentation must still be faxed if the request is through the portal. Telephonic clarification may be obtained.		

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
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 (for benefit packages E and G). (See processes, strategies and evidentiary standards in column 4.) • The OHA designee is a licensed, masters'-prepared therapist that reviews psychiatric evaluations to approve or deny the level-of-care requested. Psychiatric consultation is available if needed. **Qualifications of reviewers (HIA)**: • Two LCSWs with QMHP designation make residential authorization decisions. • Two psychiatrists make CONS determinations. **Qualifications of reviewers (KEPRO)**: • KEPRO QMHPs must meet minimum qualifications (see below) and demonstrate the	**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
	ability to conduct and review an assessment, including identifying precipitating events, gathering histories of mental and physical health, substance use, past mental health services and criminal justice contacts, assessing family, cultural, social and work relationships, and conducting/reviewing a mental status examination, complete a DSM diagnosis, and write and supervise the implementation of a PCSP. • A QMHP must meet one of the follow conditions: – Bachelor's degree in nursing and licensed by the State or Oregon; – Bachelor's degree in occupational therapy and licensed by the State of Oregon; – Graduate degree in psychology; – Graduate degree in social work;		

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	– Graduate degree in recreational, art, or music therapy; – Graduate degree in a behavioral science field; or – A qualified Mental Health Intern, as defined in 309-019-0105(61).		
Criteria: • Authorization decisions are 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	**Criteria (OHA)**: • Authorizations for non-residential MH/SUD services in benefit packages E and G are based on the HERC PL and guidelines, Oregon Statute, OAR, federal regulations, and evidence-based guidelines from private and professional associations. • The OHA designee reviews requests relative to the least restrictive environment requirement. **Criteria (HIA)**: • HERC PL and HIA policy are used for residential CR. **Criteria (KEPRO)**:	**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 applicable guidelines, Oregon Statute, OAR, federal regulations, evidence-based guidelines from private and professional associations such as the Society of American Gastrointestinal and Endoscopic Surgeons and InterQual, where no State or federal guidelines exist.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
UM leadership and UM physicians based on up to date clinical evidence and bests practices.	• QMHPs review information submitted by providers relative to State plan and OAR requirements and develop a PCSP. • The PCSP components are entered into MMIS as an authorization.		
Reconsideration/RR: • 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.	**Reconsideration/RR (OHA)**: • A provider may request review of an OHA denial decision. The review occurs in weekly Medical Management Committee (MMC) meetings. (Applies to non-residential MH/SUD services in benefit packages E and G.) • Exception requests for experimental and other non-covered benefits (for benefit packages E and G) may be granted at the discretion of the MMC, which is led by the HSD medical director. • If a provider requests review of an OHA designee level-of-care determination, HIA may conduct the second review.	**Reconsideration/RR:** • 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.	**Reconsideration/RR**: • A provider may request review of a denial decision. The review occurs in weekly MMC meetings. • Exception requests for experimental and other non-covered benefits may be granted at the discretion of the MMC, which is led by the HSD medical director.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
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	**Reconsideration/RR (HIA)**: • If the facility requests a reconsideration of a CONS denial, a second psychiatrist (who did not make the initial decision) will review the documentation and discuss with the facility in a formal meeting. • No policy for CR denials. **Reconsideration/RR (KEPRO)**: • Within 10 days of a denial, the provider may send additional documentation to KEPRO for reconsideration. • A provider may request review of a denial decision, which occurs in weekly MMC meetings or KEPRO's comparable MM meeting. **Consequences for failure to authorize (OHA)**: • Failure to obtain authorization for non-residential MH/SUD services in benefit packages E and G can result in non-payment for benefits for which it is required.	**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.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
between the provider and the plan. **Appeals:** • Members may request an appeal. • A provider is allowed to file an appeal for payment.	• Failure to obtain notification for non-residential MH/SUD services in benefit packages E and G does not result in a financial penalty. • For SCIP, SAIP and subacute, if coverage is retroactively denied, general funds may be used to cover the cost of care. **Consequences for failure to authorize (HIA)**: • Non-coverage. **Consequences for failure to authorize (KEPRO)**: Failure to obtain authorization can result in non-payment for benefits for which it is required. **Appeals (OHA)**: • Members may request a hearing on any denial decision. **Appeals (HIA)**: • Documentation has not included the fair hearing process. **Appeals (KEPRO)**:	**Appeals:** • In the case of any denial, the member has the right to file an appeal of a denial within 60 days of receipt of the Notice of Adverse Benefit Determination. • Provider appeal process- If the health plan upholds denial of payment, the provider may appeal to Health Share who	• Failure to obtain notification does not result in a financial penalty. **Appeals**: • Members may request a hearing on any denial decision.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	• Members may request a hearing on any denial decision.	reviews and makes the final determination to uphold or overturn.	

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Frequency of review (and method of payment): • 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. – Eating disorder titrated by weight gain – 30 days for residential SUD within 1 week of initial auth.	**Frequency of review (and method of payment) (OHA)**: • Gender reassignment surgery (for benefit packages E and G) is authorized as a procedure. • The initial authorization for SCIP, SAIP and subacute is 30 days. **Frequency of review (and method of payment) (HIA)**: • Child residential services are paid by per diem. • Child residential services authorizations are conducted every 30-90 days. **Frequency of review (and method of payment) (KEPRO)**: • Adult residential and YAP authorizations are conducted at least once per year. In practice reviews average every 6 months.	**Frequency of review (and method of payment):** • 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 after the first 20 days (which are managed by the CCO) at a frequency that is determined by the care manager, but not less than one time a year. • Authorization lengths are individualized by condition and are valid for up to a year. • Procedural authorizations are valid for 3 months.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
– Every 3 days following first week of subacute – Every 14 days for PRTS. **RR conditions and timelines:** • Retro authorizations are based on OHA and CMS timeline requirements. • Retro authorization is provided at any time during the hospitalization or after the hospitalization (based upon medical necessity) for up to a year.	**RR conditions and timelines (OHA)**: • RR for non-residential MH/SUD services in benefit packages E and G is only available for retro eligibility situations (e.g., the person became eligible during the stay). **RR conditions and timelines (HIA):** • No policy **RR conditions and timelines (KEPRO)**: • The request for authorization is received within 30 days of the date of service. • Any requests for authorization after 30 days from date of service require documentation from the provider that authorization could not have been obtained within 30 days of the date of service.	**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. • Review is completed per timely filing claims processes (within 30 days of receipt of claim).	**RR conditions and timelines**: • RR is only available for retro eligibility situations (e.g., the person became eligible during the stay).

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Methods to promote consistent application of criteria: • IRR testing conducted annually	**Methods to promote consistent application of criteria (OHA)**: • Nurses are trained on the application of the HERC PL and guidelines, which is spot-checked through ongoing supervision. Whenever possible, practice guidelines from clinical professional organizations such as the American Medical Association or the American Psychiatric Association, are used to establish PA frequency for services in the FFS system. (Applicable to non-residential MH/SUD services in benefit packages E and G.) • There is only one OHA designee reviewer for level-of-care review for SCIP, SAIP, and subacute and no specific criteria, so N/A. **Methods to promote consistent application of criteria (HIA):** • Parallel chart reviews for the two reviewers. (No criteria.)	**Methods to promote consistent application of criteria:** • IRR testing conducted annually	**Methods to promote consistent application of criteria**: • Nurses are trained on the application of the HERC PL and guidelines, which is spot-checked through ongoing supervision. Whenever possible, practice guidelines from clinical professional organizations such as the American Medical Association or the American Psychiatric Association, are used to establish PA frequency for services in the FFS system.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	Methods to promote consistent application of criteria (KEPRO): • Monthly clinical team meetings in which randomly audited charts are reviewed/discussed by peers using the KEPRO compliance department-approved audit tool. • Results of the audit are compared, shared and discussed by the team and submitted to the Compliance Department monthly for review and documentation. • Individual feedback is provided to each clinician during supervision on their authorization as well as plan-of-care reviews.		

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
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), HIA 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, reviewer expertise and

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, reviewer expertise and timelines for expectations of improvement. • The Commission that develops HERC consists of 13 appointed members, which include five physicians, a dentist, a public health nurse, a pharmacist and an insurance industry representative, a provider of complementary and alternative medicine, a behavioral health representative and two consumer representatives. The Commission is charged with maintaining a priority list of services, developing or identifying evidence-based health care guidelines and conducting comparative effectiveness research. • HERC guidelines of which there are fewer for MH/SUD than M/S. This is because 1) there are fewer technological procedures for MH/SUD (e.g., cognitive behavioral therapy and psychodynamic therapy		timelines for expectations of improvement. • The Commission that develops HERC consists of 13 appointed members, which include five physicians, a dentist, a public health nurse, a pharmacist and an insurance industry representative, a provider of complementary and alternative medicine, a behavioral health representative and two consumer representatives. The Commission is charged with maintaining a priority list of services, developing or identifying evidence-based health care guidelines and conducting comparative effectiveness research. • HERC guidelines of which there are more M/S than MH/SUD because 1) there are more technological procedures (e.g., surgery, devices, procedures and diagnostic tests); and 2) the literature is more robust.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	are billed using the same codes, no surgeries, few devices); 2) the MH/SUD literature is not as robust (e.g., fewer randomized trials, more subjective diagnoses (or the ICD-10-CM diagnoses represent a spectrum) and less standardization in interventions).		
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 not participated in the original authorization decision.	**Data reviewed to determine UM application (OHA)**: • Denial/appeal overturn rates; number of PA requests; stabilization of cost trends; and number of hearings requested. These data are reviewed in contractor reports, on a quarterly basis by the State. (Applicable to non-residential MH/SUD services in benefit packages E and G.) **Data reviewed to determine UM application (HIA)**: N/A **Data reviewed to determine UM application (KEPRO):** N/A	**Data reviewed to determine UM application:** • 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 – Cost data

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
IRR standard: • Inter-rater reliability will be tested annually by a 3rd party vendor with a standard of 90% beginning in September/October 2018. **Results of criteria application:** • 0 appeal overturns for 2017.	**IRR standard:** • OHA: N/A • HIA: N/A • KEPRO: N/A **Results of criteria application**: • OHA: 0 appeal overturns. • HIA: 0 appeal overturns. • KEPRO: 0 appeal overturns.	**IRR standard:** • IRR is tested annually with a standard of 90%. **Results of criteria application:** • Denial/overturn rates- There were 319 denials for IP stay in 2017. 29 denials were appealed and 9 were overturned which is an appeal rate of 9.1% and an overturn rate of 31%.	**IRR Standard**: • N/A **Results of criteria application**: • 0 appeal overturns.

7. Compliance Determination for Benefit Packages CCO A and B

IP Benefits: All non-emergent CCO MH/SUD and M/S IP admissions require PA or a level-of-care approval. SUD detoxification is reviewed after 10 days. Emergency CCO IP MH/SUD and M/S admissions require notification within 1-3 days. Most ongoing IP services require subsequent CR. Emergency child residential admissions require notification within 14 days. The CCO conducts PA and CR for MH/SUD and M/S IP hospital benefits. An OHA designee conducts level-of-care review for SCIP, SAIP and subacute. CR for SCIP and SAIP youth residential benefits is conducted by HIA. HIA conducts the CONS procedure and PA for PRTS. KEPRO conducts PA and CR for adult residential and YAP. The CCO conducts CR for subacute and PRTS. SNF CR is conducted by the CCO for the first 20 days (after which the State conducts CR).

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

promote cost-effectiveness. Maximizing network utilization only applies to MH/SUD and M/S benefits administered by the CCO.[2] Evidence for the cost-effectiveness of network utilization for both MH/SUD and M/S includes the contracted fees and credentials verification process associated with network participation. 4) To comply with federal and State requirements. As a result, the strategies and evidence are comparable**.**

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

For MH/SUD CCO, qualified individuals conduct UM applying OARs, HERC, ASAM, and regional, evidence-based guidelines developed by the CCO. The OHA designee reviews requests to determine if the level-of-care is the least restrictive environment. HIA reviews requests relative to policy. KEPRO develops PCSPs according to the State plan and OAR requirements. For M/S CCO, qualified individuals conduct UM applying OARs, HERC, MCG and InterQual. *OHA plans to enhance the evidence base for child residential authorization decisions through additional research, resulting in admission and CR criteria development. The CCO plans to evaluate incorporating MCG into its criteria. If not feasible, the CCO will document the evidence base of its regional criteria*. All CCO denials are made by professional peers. The OHA designee, who is a licensed MH professional, makes denial determinations for level-of-care review for certain child residential services. *OHA plans to ensure that all clinical-medical denial decisions are made by professional peers*. The CCO makes RR available. Upon provider request, the OHA designee obtains RR by HIA. HIA allows reconsideration of CONS determinations, but reported they do not have an RR policy for HIA's CR denials for child residential services. For adult residential and YAP services, KEPRO allows reconsideration of denials with the submission of additional documentation within 10 days of the denial. For OHA and KEPRO, the review of a denial decision occurs in a weekly MMC meeting. *OHA*

[2] Residential benefits were not assigned to CCO administration because of the unpredictable costs associated with these services and the CCO's associated financial risk. As a result, the State administers most residential benefits through other subcontractors on a FFS basis.

intends to standardize RR processes when feasible. Providers may appeal a MH/SUD and M/S denial decision by the CCO. All systems except HIA and the OHA designee encourage denial review through the fair hearing process. *OHA plans to confirm all notices of action, appeal and fair hearing processes are consistent with federal requirements.* Failure to obtain authorization may result in non-coverage, although SCIP, SAIP and subacute services may be covered by general fund dollars. Inclusive of OHA and CCO action plans, the MH/SUD and M/S processes are comparable and no more stringently applied to MH/SUD benefits.

Stringency of Strategy and Evidence: Concurrent review is conducted consistent with the average length of stay which is 5-6 days for CCO MH/SUD IP hospital, and 6 days for M/S acute IP hospital services. SUD residential is reviewed every 30 days, PRTS every 14 days and subacute every 3 days (after the first week). SNF review ranges from weekly to authorization of the full 20 day benefit. *The CCO plans to establish an evidence base for the varied residential authorization lengths.* FFS child residential is reviewed every 30-90 days while FFS adult residential and YAP are reviewed no less than annually, but in practice averages 6 months. Evidence for the frequency of CCO review includes ASAM for MH/SUD and MCG for M/S. *OHA plans to task the FFS residential subcontractors with review of CR frequencies relative to the most recent research to confirm MH/SUD review frequency is directly tied to evidence rather than historical standard practice.* CCO MH/SUD offers RR for up to a year post-hospitalization. KEPRO makes RR available for 30 days post-admission. The OHA designee and HIA do not have standard policies describing when RR is available. M/S CCO offers RR consistent with timely claim filing practices. In addition, it was discovered that there are conflicting State rules regarding RR timelines. *OHA plans to standardize the availability of RR, including the conditions under which it is permissible and the timeframes. OHA will align OARs requirements and RR offerings by contractors.* The CCO and State review utilization data to determine if PA or CR should be added or adjusted for MH/SUD and M/S IP benefits. MH/SUD and M/S CCO conduct IRR testing to promote consistent criteria application. *The CCO plans to contract with a third party vendor to conduct IRR testing for MH/SUD and will match the M/S standard of 90%.* HIA conducts parallel chart reviews for its two reviewers and KEPRO team meetings include random chart audits using a compliance tool followed by team discussion. There is no formal oversight of criteria application for the OHA designee level-of-care review process for certain child residential services. *OHA plans to institute a more formalized measurement of criteria application when feasible.* M/S CCO reported a 31% appeal overturn rate while CCO and FFS MH/SUD had 0 appeal overturns in 2017. Inclusive of OHA and CCO action plans, the strategy and evidence are no more stringently applied to MH/SUD than to M/S in writing or in operation.

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

Below are the OHA action plans:

1. *OHA is evaluating the purchase of third party MNC, especially as it relates to MNC for child residential authorization decisions. Criteria will be selected that include information upon which CR frequency may be established. In addition, formal measurement (e.g., IRR) of consistency of criteria application will be initiated once criteria are selected and implemented.*
2. *OHA will ensure that all FFS denial decisions are made by professional peers.*

3. *OHA will standardize RR processes, which will include a rule change extending the time RR must be available for MH/SUD from 30 to 90 days to match M/S.*
4. *OHA will confirm all FFS and CCO notices of action and appeal and fair hearing processes are consistent with federal requirements.*

Below are the CCO-specific action plans:

1. *The CCO plans to evaluate the use of MCG. If MCG is not feasible, the CCO will document the evidence base of its regional criteria and methods for updating within 60 days.*
2. *By early October, the CCO will increase the IRR standard for MH/SUD from 85% to 90% to match M/S.*

8. Compliance Determination for Benefit Packages CCO E and G

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

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

Comparability and Stringency of Processes: OARs require authorization decisions within 24 hours for emergencies, 72 hours for urgent requests and 14 days for standard requests. SUD detoxification is reviewed after the 10th day. The MH/SUD CCO requires notification within 1-3 days of an emergency admission. Emergency MH residential authorization requests for youth must be submitted within 14 days of the admission. OHA M/S requires notification without timelines. Providers are encouraged to submit requests for authorization sufficiently in advance to be consistent with OAR time frames. For CCO MH, documentation requirements include a call, a mental health assessment, and other supporting evidence. SUD documentation includes a completed intake form. MH/SUD CCO documentation may be submitted by email, fax or telephone. Documentation requirements for child residential PA/level-of-care review include a psychiatric evaluation or a psychiatrist-to-

psychiatrist telephonic review. HIA accepts information for child residential CR via mail, email, fax and web portal. Adult residential and YAP require an assessment (i.e., completion of a relevant level-of-care tool (e.g., ASAM, LSI, LOCUS)) and plan-of-care consistent with State plan requirements. KEPRO documentation submission is via mail, email, fax, and web portal. Consistent with OARs, federal CONS procedures, and due to the potential absence of a psychiatric referral, the PRTS documentation requirements include a cover sheet, a behavioral health assessment and service plan meeting the requirements described in OAR 309-019-0135 through 0140. FFS M/S requires documentation that is supportive of medical necessity via paper (fax) and web portal.

For MH/SUD CCO, qualified individuals conduct UM applying OARs HERC, ASAM and regional, evidence-based guidelines developed by the CCO. The OHA designee reviews requests to determine if the level-of-care is the least restrictive environment. HIA reviews requests relative to policy. KEPRO develops PCSPs according to the State plan and OAR requirements. FFS M/S reviews authorization requests relative to HERC PL and guidelines and national practice guidelines. *OHA plans to enhance the evidence base for child residential authorization decisions through additional research, resulting in admission and CR criteria development.* Physicians make most MH/SUD CCO denial determinations. FFS MH/SUD and M/S allows MA licensed therapists and nurses to make a denial determination. *Although not a parity issue for these benefit plans*, *OHA plans to ensure that all denial decisions are made by professional peers*. The MH/SUD CCO makes RR available when providers fail to obtain authorization. Upon provider request, the OHA designee obtains RR by HIA. HIA allows reconsideration of CONS determinations, but reported they do not have an RR policy for HIA's CR denials for child residential services. For adult residential and YAP services, KEPRO allows reconsideration of denials with the submission of additional documentation within 10 days of the denial. For OHA and KEPRO, the review of a denial decision occurs in a weekly MMC meeting. *Although not a parity issue for these benefit packages, OHA intends to standardize RR processes when feasible.* Providers may appeal a MH/SUD denial decision by the CCO to the CCO. OHA FFS reviews denials through the fair hearing process, but HIA and the OHA designee do not encourage denial review through the fair hearing process. *OHA plans to confirm all notice of action, appeal and fair hearing processes are consistent with federal requirements.* Failure to obtain authorization may result in non-coverage although general fund dollars may be used to cover treatment costs. Inclusive of OHA action plans, the MH/SUD and M/S processes are comparable and no more stringently applied to MH/SUD benefits.

Stringency of Strategy and Evidence: Concurrent review is conducted consistent with the average length of stay which is 5-6 days for MH/SUD IP hospital (which is paid on a per diem), while FFS IP hospital services infrequently have CR due to DRG reimbursement. *The frequency of CCO MH/SUD residential (i.e., subacute, PRTS and SUD) frequency of review will be more directly tied to evidence.* FFS child residential is reviewed every 1-3 months while FFS adult residential and YAP are reviewed no less than annually. SNF is also reviewed no less than annually after the first 20 days. LTAC and rehab hospital (M/S IP) are reviewed monthly. Evidence for the frequency of CCO MH/SUD review includes ASAM and expected length of stay. *OHA plans to task the FFS residential subcontractors with review of CR frequencies relative to the most recent research to confirm MH/SUD review frequency is directly tied to evidence rather than historical standard practice.* RR is available for CCO MH/SUD IP benefits for one year post hospitalization. The OHA designee and HIA do not have standard policies describing

when RR is available. KEPRO makes RR available for 30 days post-admission. FFS MH/SUD and M/S only allow RR for retro-eligibility circumstances. In addition, it was discovered that there are conflicting State rules regarding RR timelines. *OHA plans to standardize the availability of RR, including the conditions under which it is permissible and the timeframes. OHA will align OARs requirements and RR offerings by contractors.* The CCO and State review utilization data to determine if PA or CR should be added or adjusted for MH/SUD and M/S IP benefits. MH/SUD CCO reviewers participate in IRR testing *and the CCO will increase the standard to 90%*. HIA conducts IRR and parallel chart reviews for its two reviewers and KEPRO team meetings include random chart audits using a compliance tool followed by team discussion. HIA and the OHA designee do not have specific criteria against which decisions are made. FFS M/S conducts spot-checks through supervision to assess criteria application. *Although not a parity concern for these benefit packages, OHA plans to institute a more formalized measurement of criteria application when feasible for FFS*. CCO and FFS MH/SUD reported 0 appeal overturns in 2017. FFS M/S's appeal overturn rate was also 0. Inclusive of OHA and CCO-specific action plans, the strategy and evidence are no more stringently applied to MH/SUD than to M/S in writing or in operation.

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

OUTPATIENT UTILIZATION MANAGEMENT

NQTL: Utilization Management (PA, CR, Retrospective Review)
Benefit Package: A, B, E and G for Adults and Children
Classification: Outpatient (OP)
CCO: Health Share of Oregon (Health Share or HS)

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

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

1. To which benefits is the NQTL assigned?

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
• (1) 1915(c) Comprehensive DD waiver (operated/managed by DHS) • (1) 1915(c) Support Services DD waiver (operated/managed by DHS) • (1) 1915(c) Behavioral DD Model waiver (operated/managed by DHS)	The following services are managed by DHS: • (1) 1915(c) Comprehensive DD waiver • (1) 1915(c) Support Services DD waiver • (1) 1915(c) Behavioral DD Model waiver • (1) 1915(c) Aged & Physically Disabled waiver • (1) 1915(c) Hospital Model waiver	PA, CR and RR are required for: • (2, 3, 4) ABA (includes PT, ST, OT) • (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	PA, CR and RR are required for: • (2, 3, 4) PT, OT, ST • (2, 3, 4) Certain office procedures • (2, 3, 4) Certain ambulatory surgeries • (2, 3, 4) Neuropsychological testing • (2, 3) Some naturopathic services	The following services are managed by OHA: • (2, 3) Out of hospital births • (2) Home health services • (2) OT, PT, ST, and audiology for M/S conditions (and autistic disorder, which is also managed according to the processes, strategies and

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
• (1)1915(i)(HK) services for adults (home-based habilitation, behavioral habilitation and psychosocial rehab for persons with CMI) (managed by KEPRO under contract with OHA)	• (1) 1915(c) Medically Involved Children's NF waiver • (1) 1915(k) Community First Choice State Plan option • (1) 1915(j): Self-directed personal assistance	• (2, 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		evidentiary standards described for FFS M/S OP) • (2, 3) Imaging • (2) DME

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
• (1) The State requires PA of HCBS in order to meet federal requirements regarding PCSPs and ensure services are provided in accordance with a participant's PCSP	• (1) The State requires PA of HCBS in order to meet federal requirements regarding PCSPs and ensure services are provided in accordance with a participant's PCSP	• (2) To ensure coverage, medical necessity and prevent unnecessary overutilization. • (3) Ensure appropriate treatment in the least restrictive environment that maintains the	• (2) To ensure coverage, medical necessity and prevent unnecessary overutilization. • (3) Ensure appropriate treatment in the least restrictive environment that maintains the	• (2) To prevent services being delivered in violation of relevant OARs, associated HERC PL and guidelines and federal regulations. • (3) Services are associated with

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
and in the least restrictive setting.	and in the least restrictive setting.	safety of the individual. • (4) To determine appropriate reimbursement (i.e., whether MH/SUD or M/S should pay)	safety of the individual. • (4) To determine appropriate reimbursement (i.e., whether MH/SUD or M/S should pay)	increased health or safety risks.

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
• (1) Federal requirements regarding PCSPs for 1915(c) and 1915(i) services (e.g., 42 CFR 441.301 and 441.725) and the applicable approved 1915(c) waiver application/1915(i) State plan amendment. • (1) Oregon Performance Plan (OPP) requires that all BH services are provided in the least restrictive setting possible as do federal	• (1) Federal requirements regarding PCSPs for 1915(c), 1915(k), and 1915(j) services (e.g., 42 CFR 441.301, 441.468, and 441.540) and the applicable approved 1915(c) waiver application/State plan amendment. • (1) Federal requirements regarding 1915(c) and 1915(i) services require that HCBS are provided in the least	• (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. • (2) Medical literature demonstrates high cost of unnecessary medical care (i.e. 30% of medical costs).	• (2) OARs, HERC PL and guidelines, and federal guidelines. • (2) UM and claims reports are reviewed for trends in overutilization on a quarterly basis. • (2) Annual cost and utilization reports. • (2) Medical literature demonstrates high cost of unnecessary medical care (i.e. 30% of medical costs). (Institute of Medicine Report, (2012).	• (2) HERC PL • (2) PA requests with insufficient documentation demonstrate MNC are not being met or HERC PL guidelines are not being followed.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
requirements regarding 1915(c) and 1915(i) services.	restrictive setting possible.	(Institute of Medicine Report, (2012). • (3) State and federal requirements. • (3) Oregon Performance Plan (OPP) requires that BH services be provided in least restrictive setting possible. The OPP is a DOJ-negotiated Olmsted settlement. • (2) 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	• (3) HERC guidelines re safety concerns. • (4) Contract	• (3) HERC Guidelines - Recommended limits on services for member safety.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
		Family Physicians, Diagnosis of Eating Disorders in Primary Care, Table 6, Level-of-care Criteria for patients with eating disorders, 2003. • (4) Contract		

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Timelines for authorizations: • A PCSP must be approved within 90 days from the date a completed application is submitted. **Documentation requirements:** • (c)The PCSP is based on a functional needs assessment and other supporting documentation. It is developed by the	**Timelines for authorizations**: • A PCSP must be approved within 90 days from the date a completed application is submitted. **Documentation requirements**: • The PCSP is based on a functional needs assessment and other supporting documentation. It is developed by the	**Timelines for authorizations:** • Standard authorization decisions are processed within 14 days. **Documentation requirements:** • Most OP services require submission of a form for PA.	**Timelines for authorizations:** • Standard authorization decisions are processed within 14 days. **Documentation requirements:** • 1-2 page PA request form with clinical information	**Timelines for authorizations**: • Urgent requests are processed in 72 hours and immediate requests in 24 hours. Routine requests are processed in 14 days. **Documentation requirements**: • A cover page form is required. In addition, diagnostic information, a CPT code(s), a rationale for medical

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
individual, the individual's team and the individual's case manager. • (i)The PCSP is based on an assessment, service plan, plan-of-care, Level-of-care Utilization System (LOCUS), Level of Service Inventory (LSI) or other relevant documentation. The PSCP is developed by the member's treatment team in consultation with the member. **Method of document submission**: • All 1915(c) services must be included in a participant's PCSP and approved by a qualified case manager at the local case management	individual, the individual's team and the individual's case manager. **Method of document submission**: • All 1915(c), 1915(k), and 1915(j) services must be included in a participant's PCSP and approved by a qualified case manager at the local case management	**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.	necessity plus any additional supporting documentation are required. **Method of document submission**: • Paper (fax) or online PA/POC submitted prior to the delivery of services.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
entity (CME) prior to service delivery. • Information is obtained during a face-to-face meeting, often at the individual's location. • (i) Providers submit authorization requests to KEPRO by mail, fax email or via portal, but documentation must still be faxed if the request is submitted via portal. **Qualifications of reviewers**: • (c) A case manager must have at least: – A bachelor's degree (BA) in behavioral science, social science, or a closely related field; or – A BA in any field AND one year of	entity (CME) prior to service delivery. • Information is obtained during a face-to-face meeting, often at the individual's location. **Qualifications of reviewers**: • A case manager must have at least: – A BA in behavioral science, social science, or a closely related field; or – A BA in any field AND one year of human services	**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 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
human services related experience; or – An associate's degree (AA) in a behavioral science, social science, or a closely related field AND two years human services related experience; or – Three years of human services-related experience. (i) **Qualifications of reviewers**: • KEPRO QMHPs must meet minimum qualifications (see below) and demonstrate the ability to conduct and review an assessment, including identifying precipitating events, gathering histories of	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.			

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
– Graduate degree in psychology; – Graduate degree in social work; – Graduate degree in recreational, art, or music therapy; – Graduate degree in a behavioral science field; or A qualified Mental Health Intern, as defined in 309-019-0105(61).				
Criteria: • (c) Qualified case managers approve or deny services in the PCSP consistent with waiver and OAR requirements. • Once a PCSP is approved, services in the PCSP are entered into the payment management system by the CME staff as authorizations.	**Criteria**: • Qualified case managers approve or deny services in the PCSP consistent with waiver/state plan and OAR requirements. • Once a PCSP is approved, it is entered into the payment management system as authorization by the CME staff.	**Criteria:**	**Criteria:** • Authorizations are based on HERC PL and guidelines, DMAP provider guidelines, MCG and InterQual.	**Criteria:** • Authorizations are based on the HERC PL and guidelines, Oregon Statute, Oregon Administrative rules, federal regulations, and evidence-based guidelines from private and professional associations such as the Society of American Gastrointestinal and

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
denial decision, which occurs in weekly MMC meetings or KEPRO's own comparable MMC meeting. **Consequences for failure to authorize**: • Failure to obtain authorization may result in non-payment. **Appeals**: • Notice and fair hearing rights apply.	**Consequences for failure to authorize**: • Failure to obtain authorization may result in non-payment. **Appeals**: • Notice and fair hearing rights apply.	**Consequences for failure to authorize:** • Failure to obtain authorization can result in non-payment. **Appeals:** • Notice and fair hearing rights apply.	**Consequences for failure to authorize:** • Failure to obtain authorization can result in non-payment. **Appeals:** • Notice and fair hearing rights apply.	**Consequences for failure to authorize**: • Failure to obtain authorization may result in non-payment. **Appeals**: • Members may request a hearing on any denial decision.

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Frequency of review: • PCSPs are reviewed and revised as needed, but at least every 12 months.	**Frequency of review:** • PCSPs are reviewed and revised as needed, but at least every 12 months.	**Frequency of review and method of payment** PAs vary by service: • Eating disorder titrated by weight gain • 7 days for respite • 90 days for HB • 6 months for DBT	**Frequency of review and method of payment** • A CR for a second authorization is required when the initial number of units is exhausted.	**Frequency of review**: • PA is granted for different authorization periods depending on the service and can be adjusted. • Authorizations for extensive services

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
RR conditions and timelines: • (c) N/A • (i) Within 10 days of a denial, the provider may send additional documentation to KEPRO for reconsideration • (i) A provider may request review of a denial decision, which occurs in weekly Medical Management meetings or KEPRO's own comparable MM meeting.	**RR conditions and timelines:** • N/A	• 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 **RR conditions and timelines:** • Retro requests are reviewed as long as the assessment was conducted within the past 2 years.	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 **RR conditions and timelines:** • Retro reviews are conducted when submitted within one year of discharge with clinical documentation that supports medical necessity and rationale why a PA was not submitted.	usually range from 6 months to 1 year. • PT, ST, OT authorizations are usually for one year (i.e., 30 visits). • Exceptions may be made at the discretion of the MMC which is led by the HSD medical director. **RR conditions and timelines:** • RR available for retro eligibility circumstances.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Methods to promote consistent application of criteria: • For 1915(c), DHS Quality Assurance Review teams review a representative sample of PCSPs as part of quality assurance and case review activities to assure that PCSPs meet program standards. • Additionally, OHA staff review a percentage of 1915(c) participant files to assure quality and compliance. • For 1915(i), monthly clinical team meetings in which randomly audited charts are reviewed/discussed by peers using the KEPRO compliance department-approved audit tool.	**Methods to promote consistent application of criteria:** • DHS Quality Assurance Review teams review a representative sample of PCSPs as part of quality assurance and case review activities to assure that PCSPs meet program standards. • Additionally, OHA staff review a percentage of files to assure quality and compliance.	**Methods to promote consistent application of criteria:** • Conduct IRR testing	**Methods to promote consistent application of criteria:** • Conduct IRR testing.	**Methods to promote consistent application of criteria**: • Nurses are trained on the application of the HERC guidelines, which is spot-checked through ongoing supervision.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
• Results of the audit are compared, shared and discussed by the team and submitted to Compliance Department monthly for review and documentation. • Individual feedback is provided to each clinician during supervision on their PA. • For 1915(i), on a quarterly basis a representative sample of cases are reviewed for ability to address assessed member needs, whether the PCSPs are updated annually, whether OARs are met, and whether member's choices regarding services and providers were documented.				

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Evidence for UM frequency: • Federal requirements regarding PCSPs and 1915(c) and 1915(i) services (e.g., 42 CFR 441.301 and 441.725) and the applicable approved 1915(c) waiver application/1915(i) State plan amendment.	**Evidence for UM frequency**: • Federal requirements regarding PCSPs and 1915(c), 1915(k), and 1915(j) services (e.g., 42 CFR 441.301, 441.468, and 441.540) and the applicable approved 1915(c) waiver application/State plan amendment.	**Evidence for UM frequency:** • 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 1 year at a time. • Whenever possible, practice guidelines from clinical professional organizations such as the American Medical Association or the

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
				American Psychiatric Association, are used to establish PA frequency. **Data reviewed to determine UM application**: • A physician-led group of clinical professionals conducts an annual review to determine which services receive or retain a PA; items reviewed include: – Utilization – Approval/denial rates – Documentation/ justification of services – Cost data
Data reviewed to determine UM application: • N/A	**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/	

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
IRR standard: • N/A **Results of criteria application (appeal overturn rates)**: • (c): 0 appeal overturns. • (i) (KEPRO) 11% appeal overturn rate (1 out of 9 hearings)	**IRR standard:** • N/A **Results of criteria application (appeal overturn rates):** • (c) for I/DD: 0 appeal overturns. • (c) for APD plus (k) and (j): 0.8% appeal overturn rate	**IRR standard:** • Will implement 90% standard during fourth quarter 2018. **Results of criteria application (appeal overturn rates):** • 0 denials/0 appeals.	**IRR standard:** • 90% **Results of criteria application (appeal overturn rates):** • Denial/overturn rates-denial is 9.0%/ appeal overturn rate is 22.4%.	**IRR standard:** • N/A **Results of criteria application (appeal overturn rates):** • 0 appeal overturns.

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

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

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

Some non-HCBS CCO MH/SUD and M/S OP services are assigned UM because medical necessity review offers an opportunity to avoid unnecessary costs, prevent over and under-utilization and confirm coverage. Evidence of the potential for over and under-utilization includes utilization review reports and research studies. A subset of these MH/SUD and M/S OP services are also assigned UM to assure the individual's safety in the least restrictive environment. Evidence for safety issues includes HERC guidelines for both MH/SUD and M/S, and the need to review for least restrictive environment is related to the OPP for MH/SUD. These strategies and evidence are comparable.

Comparability and Stringency of Processes: HCBS MH/SUD benefits are administered by DHS and KEPRO while HCBS M/S benefits are administered by DHS. PCSPs for both M/S and MH/SUD must be developed within 90 days. The PCSP for both MH/SUD and M/S is based on

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

Non-HCBS CCO MH/SUD and M/S OP benefit reviews are conducted by qualified clinicians who evaluate clinical information that is submitted via email or fax relative to regional criteria, ASAM, HERC, or OARs for MH/SUD and InterQual and MCG for M/S. *The CCO plans to evaluate MCG for purchase. If not feasible, the CCO will provide the evidence base and evidentiary standard for its regional criteria.* CCO MH/SUD requires submission of a form with an evaluation or assessment. Timelines for authorization decisions are the same for MH/SUD and M/S and defined in OARs. Failure to obtain authorization may result in non-payment for MH/SUD and M/S services; although an exception process allows RR for CCO benefits and standard appeal processes apply. There are no differences in processes for children and adults that are not tied to practice guidelines. Inclusive of CCO action plan, UM processes are comparable to, and no more stringently applied, to non-HCBS CCO MH/SUD benefits than to M/S benefits.

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

Non-HCBS MH/SUD service authorizations are specific to the service and the individual. In general, OP authorizations last 30 days. DBT authorizations are for 6 months, ECT is authorized for 6-12 treatments, and TAY is authorized for one year. CCO M/S authorizations are commonly sufficient for one year. Evidence for the frequency of CCO review is based in expected improvement, HERC, ASAM and diagnostic-specific practice guidelines. *The CCO plans to more directly tie frequency of OP MH/SUD review to evidence.* CCO allows RR up to two years for MH/SUD and up to one year for M/S. CCO MH/SUD reviewers participate in IRR testing to promote consistent MNC application*, and the CCO will increase the standard to 90% in Q4 2018 to match M/S*. The CCO reviews utilization information to determine if PA or CR should be added or adjusted for MH/SUD and M/S OP benefits. MH/SUD and M/S report appeal overturn rates of 0 and 22.4% respectively. Inclusive of

the OHA and CCO action plans, the UM strategy and evidence are no more stringently applied to MH/SUD than to M/S OP benefits in operation or in writing for non-HCBS services.

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

8. Preliminary Compliance Determination for Benefit Packages CCO E and G (inclusive of HCBS)

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

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

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

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

Non-HCBS CCO MH/SUD benefit reviews are conducted by qualified clinicians who evaluate clinical information that is submitted via fax or web-portal, relative to regional criteria, ASAM, HERC, and OARs. Similarly, FFS M/S benefit reviews are conducted by qualified clinicians that evaluate clinical information that supports medical necessity (which may include POCs) submitted via paper (fax) or online relative to OARs and HERC. CCO MH/SUD documentation requirements include form plus an evaluation. FFS M/S documentation requirements include a 1 page form and information supporting medical necessity. Timelines for authorization decisions are the same for MH/SUD and M/S and defined in OARs. Failure to obtain authorization may result in non-payment for MH/SUD and M/S services; although an exception process allows RR for CCO MH/SUD and FFS M/S benefits. Appeal processes apply for both CCO MH/SUD and FFS M/S. There are no differences in processes for children and adults that are not tied to practice guidelines. Inclusive of CCO action plans, UM processes are comparable to, and no more stringently applied, to non-HCBS MH/SUD benefits than to M/S benefits.

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

Non-HCBS MH/SUD OP service authorizations are specific to the service and the individual. In general, OP MH/SUD authorizations last 30 days. DBT authorizations are for 6 months, ECT is authorized for 6-12 treatments, and TAY is authorized for one year. Evidence for the frequency of CCO review is based in expected improvement and diagnostic-specific practice guidelines. FFS M/S authorizations typically authorize 30 visits for the equivalent of 6 months to one year. *The CCO plans to more directly tie frequency of OP MH/SUD review to evidence*. CCO allows RR up to two years for MH/SUD and up to one year for M/S. CCO MH/SUD reviewers participate in IRR testing to promote consistent MNC application *and the CCO will move to a 90% standard in Q4 2018.* FFS M/S criteria application is evaluated through supervision and spot-checks. *Although not a parity issue for these benefit packages, OHA plans to formalize criteria application measurement.* The CCO and State review utilization information to determine if PA or CR should be added or adjusted for MH/SUD and M/S OP benefits. In 2017, appeal overturn rates were 0 for CCO MH/SUD and FFS M/S. Inclusive of CCO action plan, UM strategy and evidence are no more stringently applied to MH/SUD than to M/S OP benefits in operation or in writing.

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

PRIOR AUTHORIZATION FOR PRESCRIPTION DRUGS

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

1. To which benefits is the NQTL assigned?

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

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• To 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.

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• 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. Comparability and Stringency of Processes: Describe the NQTL procedures (e.g., steps, timelines and requirements from the CCO, member, and provider perspectives).

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• 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.	• 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.

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

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• For one of the subcontractors, approximately 48% of MH/SUD drugs are subject to PA criteria for clinical reasons; for the other subcontractors it is 0%. • 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 appeal overturn rate for CY 2017 was 0%. • 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.	• Approximately 17% of MH drugs are subject to PA criteria for clinical reasons. • The State allows providers to submit additional information for reconsideration of a denial. • Providers can appeal denials on behalf of a member, and members have fair hearing rights. • The appeal overturn rates for MH carve out drugs was 8:2 (25%). • The State assesses stringency through review of PA denial/approval and appeal rates; number of drugs requiring PA; number of PA requests; and pharmacy utilization data/reports. • PA criteria are reviewed as needed due to clinical developments, literature, studies, and FDA medication approvals.	• For one of the subcontractors, approximately 28% of M/S drugs are subject to PA criteria for clinical reasons for the other subcontractors it is 10%. • 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 appeal rate for CY 2017 was 1.1% and the overturn rate was 30.5%. • 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 a1-2 year cycle or as indicated as new guidelines are updated.

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• 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.

7. Compliance Determination for Benefit Packages CCO A and B

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

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

Stringency of Strategy and Evidence: Both the State and CCO approve PAs for up to 12 months, depending on medical appropriateness and safety, as recommended by the applicable P&T Committee based on evidence such as FDA prescribing guidelines, best practices, and professional guidelines. The CCO and the State assess the stringency of strategy through review of PA denial/approval and appeal rates; the CCO also considers the number of requests and reviews utilization data. The percent of MH/SUD drugs subject to PA requirements is

comparable to M/S drugs. In addition, the appeal overturn rates are comparable. As a result, the strategies and evidentiary standards for prior authorization of prescription drugs are applied no more stringently to MH/SUD drugs than to M/S drugs.

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

PROVIDER ADMISSION — CLOSED NETWORK

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• CCO does not close its network for new 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.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• When CCO closes its network to new MH/SUD providers, it is done 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. Comparability of Evidentiary Standard: What evidence supports the rationale for the assignment?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Network sufficiency standards are required by 42 CFR 438.206.	• N/A	• Network sufficiency standards are required by 42 CFR 438.206.	• N/A

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• 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 • Demographic characteristics of population • CCO contract requirements for network adequacy		• 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 • Demographic characteristics of population • CCO contract requirements for network adequacy	

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• CCO closes its network to new providers of outpatient MH/SUD services when CCO determines there is no need or gap in the service delivery network.	• 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.	• N/A

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• If the CCO decides to close the network to particular provider types, all new providers applying for those particular provider types are 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.	• N/A	• When CCO determines that they have a sufficient number of particular providers/provider types, all new providers applying for those particular provider types are subject to this NQTL.	• N/A

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• The CCO reviews the following data/information to determine how strictly to apply the criteria/considerations to	• N/A	• The CCO reviews the following data/information to determine how strictly to apply the criteria/considerations to	• N/A

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
close the CCO network to new providers 1. Network Needs Assessment/Network Geo-Assessment 2. Demographic characteristics of population 3. Number of out of network requests/single case agreements.		close the CCO network to new providers 1. Network Needs Assessment/Network Geo-Assessment 2. Demographic characteristics of population 3. Number of out of network requests/single case agreements.	

7. Compliance Determination for Benefit Packages CCO A and B

Comparability of Strategy and Evidence: The CCO may close its network to new providers of MH/SUD and M/S outpatient services. When the CCO closes its network to new MH/SUD and M/S providers, it is done because the CCO has determined that there is no need or gap in the service delivery network. For both providers of MH/SUD and M/S services, the CCO strategy is similar in that both are limiting the size of the network based upon an assessment of network adequacy. The CCO follows established State rules and Federal regulations when imposing limitations upon new MH/SUD and M/S providers applying to participate in network.

Developing a network based upon network adequacy and sufficiency standards is supported by Federal regulation, including the ability of a MCO (CCO) to limit contracting beyond the needs of its enrollees to maintain quality and control costs (42 CFR 438.12). OAR 410-141-0220 also requires the CCO to meet network sufficiency standards, which impacts the application of this NQTL. Based upon these findings, the CCO does not apply a limitation for inpatient MH/SUD providers and accordingly does not require further analysis. The CCO's strategy and evidence for closing the network to outpatient providers when the CCO determines that it has met network adequacy and sufficiency standards are comparable for providers of outpatient MH/SUD and M/S services.

Comparability and Stringency of Processes: All requests for network admission of outpatient providers of MH/SUD and M/S services are reviewed against the CCO's assessment of provider need based on the network adequacy of the current provider network. Both MH/SUD and MS use committee structures to make the decision that particular provider types are not needed, based upon assessment of need. When such a decision is made, requests to join the network are declined. For both MH/SUD and M/S providers, the CCO considers the same kinds of

factors to determine network adequacy. The CCO evaluates tri-county access standards, a network needs assessment/network geo-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. The CCO reviews provider applications for network admission and determines whether the provider may fill an identified network gap or need and an internal workgroup decides whether or not to close the network. Both MH/SUD and M/S providers may challenge the CCO's decision to close the network.

Exceptions may be made for MH/SUD and M/S providers 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. Based upon these findings, the CCO's network closure processes for providers of MH/SUD services are comparable and applied no more stringently than to providers of M/S services.

Stringency of Strategy and Evidence: When the CCO decides to close the network to particular specialties/provider types, all new MH/SUD and M/S providers applying for those particular specialties/provider types are subject to the NQTL. The CCO monitors similar metrics related to decisions to close the network across MH/SUD and M/S, reviewing information such as a network needs assessment/network geo-assessment, demographic characteristics of population, and the number of out of network requests/single case agreements. As a result, the strategies and evidentiary standards for network closure are no more stringently applied to MH/SUD providers than to M/S providers.

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

8. Compliance Determination for Benefit Packages CCO E and G

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

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

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

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

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

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

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Credentialing/re-credentialing requirements are supported by the following evidence: – State law and Federal regulations, including 42 CFR 438.214. – State contract requirements – Accreditation guidelines (NCQA)	• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E - Provider Screening and Enrollment.	• Credentialing/re-credentialing requirements are supported by the following evidence: – State law and Federal regulations, including 42 CFR 438.214. – State contract requirements – Accreditation guidelines (NCQA)	• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E - Provider Screening and Enrollment.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• All providers must meet credentialing and re-credentialing requirements 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 credentialing documents, as listed below, a site visit when applicable, and review by Health Share Medical	• All providers are eligible to enroll as a provider and receive reimbursement provided they meet all relevant Federal and State licensing and other rules and are not on an exclusionary list. • Providers must complete forms and documentation required for their provider type. This includes information demonstrating the provider meets provider enrollment requirements such	• 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. • 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	• All providers are eligible to enroll as a provider and receive reimbursement provided they meet all relevant Federal and State licensing and other rules and are not on an exclusionary list. • Providers must complete forms and documentation required for their provider type. This includes information demonstrating the provider meets provider enrollment requirements such

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
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 recommendations to the Health Share Quality Committee (a sub-committee of the Health Share Board	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.	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 recommendations to the board and the board determines whether the CCO accepts the provider into the CCO's panel.	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 averages7 to 14 days.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
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.	• State staff in the provider enrollment unit are responsible for reviewing information and making provider enrollment decisions. • The State reviews all provider enrollment every three years, as required by Federal regulations. • Providers who are not enrolled/re-enrolled are not eligible for Medicaid reimbursement. • Providers who are denied enrollment or re-enrollment may appeal the decision to the State.	• CCO 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.	• State staff in the provider enrollment unit are responsible for reviewing information and making provider enrollment decisions. • The State reviews all provider enrollment every three years, as required by Federal regulations. • Providers who are not enrolled/re-enrolled are not eligible for Medicaid reimbursement. • Providers who are denied enrollment or re-enrollment may appeal the decision to the State.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• All licensed providers/provider types must be credentialed. • There are no exceptions to meeting these requirements. • Zero providers were denied admission or terminated from the network in the last contract year as a result of credentialing and re-credentialing.	• All providers/provider types are subject to enrollment/re-enrollment requirements. • There are no exceptions to meeting provider enrollment/re-enrollment requirements. • Less than 1% of providers were denied admission, and .005% of providers were terminated last CY for failure to meet enrollment/re-enrollment requirements.	• All licensed providers/provider types must be credentialed. • There are no exceptions to meeting these requirements. • CareOregon-1 provider out of 12,000; Providence- 3 not approved, 87 terminations out of 7424 credentialed; and Kaiser had no denials or terminations in the last contract year as a result of credentialing and re-credentialing.	• All providers/provider types are subject to enrollment/re-enrollment requirements. • There are no exceptions to meeting provider enrollment/re-enrollment requirements. • Less than 1% of providers were denied admission, and .005% of providers were terminated last CY for failure to meet enrollment/re-enrollment requirements.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Requirement to conduct credentialing for all new providers is established by State law and Federal regulations. • The frequency with which CCO performs re-credentialing is based upon: – State law and Federal regulations – State contract requirements	• 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	• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E - Provider Screening and Enrollment. • The frequency with which the State re-enrolls providers is based on State law and Federal regulations.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
– Monitoring of provider performance (claims data, onsite audits, grievance and appeal data)		– Monitoring of provider performance (claims data, onsite audits, grievance and appeal data) – National accreditation standards through NCQA	

7. Compliance Determination for Benefit Packages CCO A and B

Comparability of Strategy and Evidence: All IP and OP providers of MH/SUD and M/S services are subject to CCO credentialing and re-credentialing requirements. Credentialing and re-credentialing is conducted for both providers of MH/SUD and M/S services to meet State and Federal requirements, ensure capabilities of providers to deliver high quality of care, and ensure providers meets minimum competency standards. Credentialing and re-credentialing of providers is supported by State law and Federal regulations and the CCO's contract with the State. The CCO uses national accreditation guidelines (NCQA) to guide credentialing and re-credentialing as applicable. Based upon these findings, the CCO's strategy and evidence for conducting credentialing and re-credentialing are comparable for providers of MH/SUD and M/S services.

Comparability and Stringency of Processes: All providers of MH/SUD and M/S services must successfully meet credentialing and re-credentialing requirements in order to be admitted to and continue to participate in the CCO's network. New MH/SUD and M/S providers are required to complete and submit the same substantially the same type of information and documentation as part of the credentialing process. Providers complete the Oregon Practitioner Credentialing and Re-credentialing application and supporting documents that include Contract Completion Expectations and a New Provider Information Form. Both MH/SUD and M/S providers are offered several methods of submitting their application and supporting documentation, including email, mail, or fax, and MH/SUD providers are offered an additional online option to complete the application package.

Provider Relations staff work with both providers of MH/SUD and M/S services throughout the credentialing process, which entails completion and submittal of all documents, a site visit when applicable, and review, recommendation and decision by the CCO's Medical Director, Quality Committee and Credentialing Committee. The credentialing process for both MH/SUD and M/S providers averages no more than 90 days. Re-credentialing for both MH/SUD and M/S providers is conducted every three years, as required by OAR 410-141-3120 and recommended by NCQA guidelines. MH/SUD and M/S providers who fail to meet credentialing and re-credentialing requirements cannot participate in the CCO's network. Providers of MH/SUD and MS services may challenge credentialing/re-credentialing decisions through the appeals process. Based

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

Stringency of Strategy and Evidence: All MH/SUD and M/S providers are subject to meeting credentialing and re-credentialing requirements; there are no exceptions. In operation, MH/SUD have been less impacted through the CCO's application of credentialing and re-credentialing, with no MH/SUD providers denied or terminated from participating in network in the last contract year, and 4 M/S providers denied participation and 87 terminated from the network.

The CCO monitors similar metrics related to how stringently the CCO applies credentialing and re-credentialing requirements for MH/SUD and M/S providers, including: reviewing claims data, onsite audits, and grievance and appeal data. As a result, the strategies and evidentiary standards for credentialing and re-credentialing are no more stringently applied to MH/SUD providers than to M/S providers.

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

8. Compliance Determination for Benefit Packages CCO E and G

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

PROVIDER ADMISSION — PROVIDER EXCLUSIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Compliance Determination for Benefit Packages CCO A and B

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

8. Compliance Determination for Benefit Packages CCO E and G

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

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

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

1. To which benefits is the NQTL assigned?

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

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

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

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

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

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Except as otherwise required by OHA, non-emergency OON/OOS services are not covered unless 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 continuity of care for new	• Non-emergency OOS services are not covered unless the service meets the OAR criteria. • The OAR criteria for OOS coverage of non-emergency services include the service is not available in the State of Oregon or the client is OOS and requires covered services. • Requests for non-emergency OOS services are made	• Except as otherwise required by OHA, non-emergency OON/OOS services are not covered unless 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 continuity of care for new	• Non-emergency OOS services are not covered unless the service meets the OAR criteria. • The OAR criteria for OOS coverage of non-emergency services include the service is not available in the State of Oregon or the client is OOS and requires covered services. • Requests for non-emergency OOS services are made

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• If a request for a non-emergency OON/OOS benefit does not meet the CCO's OON/OOS criteria, it will not be prior authorized. • If a non-emergency OON/OOS benefit is not prior authorized, the service will not be covered, and payment for the service will be denied.	• If a request for a non-emergency OOS benefit does not meet the OAR criteria, it will not be prior authorized. • If a non-emergency OOS benefit is not prior authorized, the service will not be covered, and payment for the service will be denied. • Members/providers may appeal the denial of an OOS request.	• 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.	• If a request for a non-emergency OOS benefit does not meet the OAR criteria, it will not be prior authorized. • If a non-emergency OOS benefit is not prior authorized, the service will not be covered, and payment for the service will be denied. • Members/providers may appeal the denial of an OOS request.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Members/providers may appeal the denial of an OON/OOS request. • In CY 2017 the CCO received 275 non-emergency OON/OOS requests and zero requests were denied (0% appeal overturn rate). • 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.	• The State measures the stringency of the application of OOS requirements by reviewing OOS denial/appeal rates.	• Members/providers may appeal the denial of an OON/OOS request. • In CY 2017 the CCO received 545 non-emergency OON/OOS requests; 144 requests were denied (26%); and two (1.4%) denied requests were overturned on appeal. • 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.	• The State measures the stringency of the application of OOS requirements by reviewing OOS denial/appeal rates.

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

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

7. Compliance Determination for Benefit Packages CCO A and B

Comparability of Strategy and Evidence: The CCO seeks to maximize the use of in-network providers because in-network providers have alignment with care services for members and have been credentialed and contracted with the CCO. While the State has not established a network of MH/SUD providers, the State seeks to maximize the use of in-State providers for similar reasons. The CCO's purpose for providing OON/OOS coverage is to provide needed MH/SUD and M/S benefits when they are not available in-network or in-State. Similarly, for MH/SUD FFS benefits, the State provides OOS coverage to provide needed benefits when they are not available in-State.

For both non-emergency MH/SUD and M/S OON/OOS benefits, the CCO (and the State for FFS MH/SUD OOS benefits) requires prior authorization to determine medical necessity and to ensure no in-network/in-State providers are available to provide the benefit. OON/OOS coverage requirements are based on Federal and State requirements, including OAR (for both the State and the CCO) and the CCO contract (for the CCO). As a result, the strategy and evidence for OON/OOS coverage of non-emergency inpatient and outpatient benefits are comparable for MH/SUD and M/S benefits.

Comparability and Stringency of Processes: Requests for non-emergency OON/OOS CCO MH/SUD and M/S benefits are made through the CCO's prior authorization process and are reviewed for medical necessity and in-network/in-State coverage. The prior authorization timeframes (14 days for standard requests and 72 hours for urgent requests) apply. Similarly, the State reviews requests for non-emergency OOS MH/SUD services through its prior authorization process, and the prior authorization timeframes (14 days for standard requests and 72 hours for urgent requests) apply. OOS providers are reimbursed the Medicaid FFS rate. If the OOS MH/SUD provider is not enrolled in Oregon Medicaid, the provider must enroll in Oregon Medicaid. Similarly, the CCO requires OON/OOS providers to be enrolled with Oregon Medicaid. The CCO establishes a SCA with all OON/OOS MH/SUD providers and with OON/OOS M/S providers if they do not agree to the DMAP rate or request a SCA. While this is a difference between MH/SUD and M/S, since, as noted below, the CCO pays OON/OOS MH/SUD providers the CCO contract rate, which is generally higher than the DMAP rate, this is not a parity concern. The CCO's process for establishing a SCA is the same for MH/SUD and M/S providers and includes collecting the information necessary to complete the SCA and sending the completed SCA to the provider for signature. The average length of time to negotiate a SCA is one to three days. The CCO typically pays OON/OOS MH/SUD providers the CCO contract rate and pays OON/OOS M/S providers the Medicaid FFS rate, a percentage of the Medicaid FFS rate, or a negotiated rate. Since the CCO contract rate is generally higher than the Medicaid FFS rate, this difference in payment methodologies is not a

parity concern. Based on this, the processes for MH/SUD and M/S non-emergency OON/OOS benefits are comparable and applied no more stringently to MH/SUD non-emergency OON/OOS benefits.

Stringency of Strategy and Evidence: For both MH/SUD and M/S, if a request for a non-emergency OON/OOS benefit does not meet applicable criteria, which are based on Federal and State requirements, it will not be authorized, and payment for the service will be denied by the CCO/State. Members and providers may appeal the denial of OON/OOS authorization requests to the CCO/State as applicable. While the State does not have statistics regarding OOS requests, the CCO states that in CY 2017 0% of MH/SUD and approximately 26% of M/S OON/OOS requests were denied in 2017, with 0% of MH/SUD and 1.4% of M/S OON/OOS denials overturned on appeal. This indicates that OON/OOS standards are not applied more stringently to MH/SUD benefits. As a result, the strategies and evidentiary standards for OON/OOS are no more stringently applied to MH/SUD benefits than to M/S benefits.

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

8. Compliance Determination for Benefit Package CCO E and G

Comparability of Strategy and Evidence: For both MH/SUD and M/S benefits the State seeks to maximize the use of in-State providers because the State has determined that they meet applicable requirements and they have a provider agreement, which includes agreement to comply with Oregon Medicaid requirements and accept DMAP rates. Similarly, the CCO seeks to maximize the use of in-network providers because in-network providers have alignment with care services for members and have been credentialed and contracted with the CCO. The State provides OOS coverage to provide needed MH/SUD and M/S benefits when they are not available in-State. Similarly, the CCO provides OON/OOS coverage to provide needed MH/SUD benefits when they are not available in-network or in-State. For both non-emergency MH/SUD and M/S OOS benefits, the State (and the CCO for MH/SUD OON/OOS benefits) requires prior authorization to determine medical necessity and to ensure no in-State providers (and in-network providers for OON requests to the CCO) are available to provide the benefit. The State's OOS coverage requirements are based on OAR. The CCO's OON/OOS coverage requirements are based on OAR and the CCO contract. As a result, the strategy and evidence for OON/OOS coverage of non-emergency inpatient and outpatient benefits are comparable for MH/SUD and M/S benefits.

Comparability and Stringency of Processes: Requests for non-emergency OOS FFS MH/SUD and M/S benefits are made through the State's prior authorization process and are reviewed for medical necessity and in-State coverage. The prior authorization timeframes (14 days for standard requests and 72 hours for urgent requests) apply. Similarly, the CCO reviews requests for non-emergency OON/OOS MH/SUD services through its prior authorization process, and the prior authorization timeframes (14 days for standard requests and 72 hours for urgent

requests) apply. OOS FFS MH/SUD and M/S providers are reimbursed the Medicaid FFS rate. If the OOS provider is not enrolled in Oregon Medicaid, the provider must enroll in Oregon Medicaid. The CCO also requires OON/OOS MH/SUD providers to be enrolled with Oregon Medicaid. In addition, the CCO establishes a single case agreement (SCA) with all MH/SUD OON/OOS providers and generally pays them the CCO contract rate, not the Medicaid FFS rate. FFS M/S OOS providers are not required to complete a SCA in order to provide services; however, since the CCO pays MH/SUD OON/OOS providers the CCO contract rate, which is generally higher than the Medicaid FFS rate, this is not a parity concern. Based on this, the processes for MH/SUD non-emergency OON/OOS services are comparable and applied no more stringently to non-emergency MH/SUD OON/OOS benefits than to M/S benefits.

Stringency of Strategy and Evidence: For both MH/SUD and M/S FFS, if a request for a non-emergency OOS benefit does not meet applicable criteria, which are based on OAR, it will not be authorized, and payment for the service will be denied by the State. Similarly, if a request for a non-emergency MH/SUD OON/OOS benefit does not meet the CCO's criteria, which are based on OAR and the CCO contract, it will not be authorized, and payment for the service will be denied by the CCO. For both MH/SUD and M/S, members and providers may appeal the denial of an OON/OOS request. The strategies and evidentiary standards for OON/OOS are no more stringently applied to MH/SUD benefits than to M/S benefits

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