Oregon Health Authority

2020 Mental Health Parity Analysis Report

for

PacificSource Community Solutions –Columbia Gorge

February 2021

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Introduction

Overview of Oregon's Mental Health Parity Analysis

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

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

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

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

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

Components of the 2020 MHP Analysis

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

Figure 1-1—MHP: Four Prescribed Classifications

OHP Benefit Packages

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

Table 1-1—OHP Benefit Packages

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

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

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

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

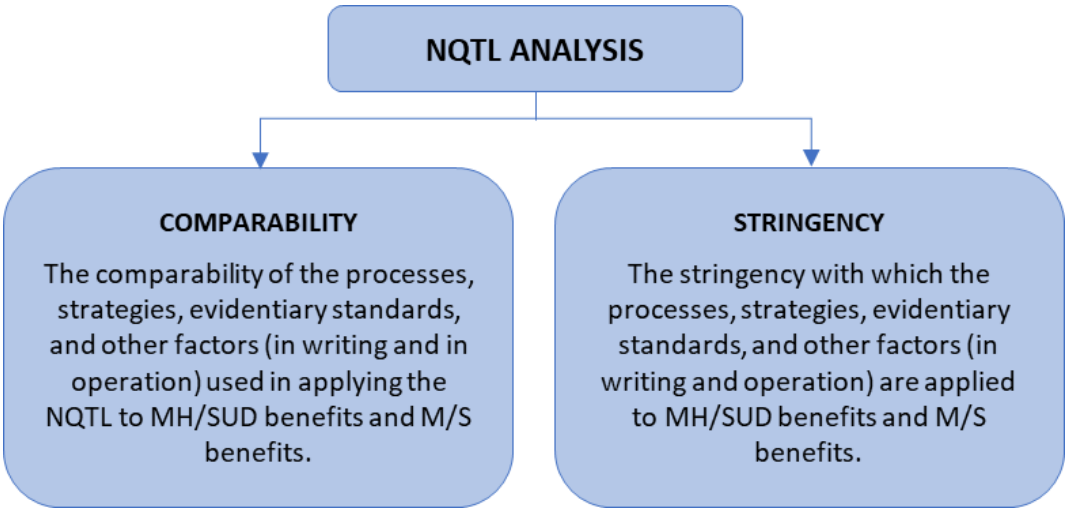
Non-Quantitative Treatment Limitations

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

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

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

Figure 1-2—MHP Analysis Comparability and Stringency



NQTL Categories

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

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

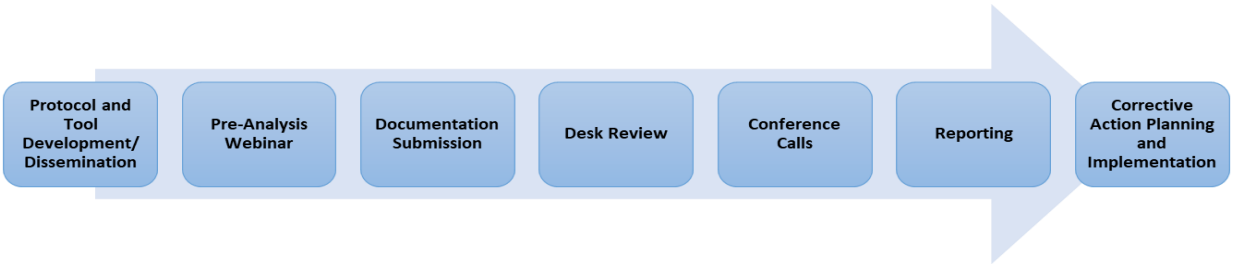
2. Process and Methodology

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

Analysis Activities for 2020

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

Figure 2-1—2020 MHP Analysis Activities



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

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

MHP Analysis Methodology

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

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

Table 2-1—Comparability and Stringency Standards

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

Analysis Results for 2020

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

3. MHP Analysis Results

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

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

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

Overall Assessment

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

Most of PSCS-CG's policies included standardized processes that applied to both MH/SUD and M/S benefits, including a service authorization handbook, UM and service determination policies, and a PA timeliness guideline. The CCO did not have separate policies for the management of benefits based on benefit package (i.e., CCOA, CCOB, CCOE, and CCOG).

For limits applied to IP and OP health benefits, PSCS-CG used UM processes to manage MH/SUD and M/S benefits. The purpose of the CCO's UM processes was to ensure coverage, medical necessity, appropriate treatment in the least restrictive environment that maintains the safety of the individual, compliance with federal and State requirements, and the prevention of unnecessary overutilization. PSCS-CG reported that the evidence used to apply UM to MH/SUD and M/S included Oregon Administrative Rules (OARs), Health Evidence Review Commission (HERC) Prioritized List (PL) and guidelines, and Milliman Care Guidelines (MCG). The application of authorization limits and the frequency and rigor in which they were applied to authorization requests was comparable across both MH/SUD and M/S benefits and to OHP FFS's application across both benefit types, but was determined to be less stringent than for M/S processes across CCOA and CCOG benefit packages. For CCOE and CCOG benefit packages, PSCS-CG's 30-day RR time frame allowance for IP and OP MH/SUD

authorization requests was more stringent than OHP FFS's RR time frame of 90 days for M/S authorization requests. Regarding interrater reliability (IRR), PSCS-CG conducted regular reviews using a 90 percent testing standard, which was determined to be in parity with OHP FFS's 80 percent testing standards for M/S authorizations. HSAG determined this discrepancy to be a quality issue rather than a parity concern.

HSAG's analysis of PSCS-CG processes and operations did not reveal any MHP concerns for the authorization of prescription drugs across the benefit packages. The application of PA for MH/SUD prescription drugs was comparable to PA for M/S prescription drugs. Prescription drug authorization requirements, guidelines, procedures, and 24-hour responses were determined to be no more stringently applied to MH/SUD benefit requests when compared to M/S requests. The denial rate for MH/SUD prescription drug requests was low, representing only 3.48 percent of total denials.

The analysis HSAG conducted of PSCS-CG also did not result in any findings of non-parity in either provider admission NQTL category or in the OON/OOS category. Because the CCO did not close its network to either MH/SUD or M/S providers, HSAG determined that the CCO's provider admission/network closure processes for MH/SUD providers were comparable to and no more stringently applied to M/S providers across all benefit packages. PSCS-CG shared PacificSource Health Plans' network of providers, with a reported average of 14,796 providers enrolled during the reporting period. HSAG's analysis of PSCS-CG's provider credentialing data did not reveal parity concerns due to low denial rates reported for providers seeking credentialing during the reporting period. For HSAG's analysis in the OON/OOS NQTL category, OHP FFS was not analyzed against PSCS-CG due to the State not credentialing providers but instead enrolling them in Medicaid. This difference in process did not present a parity concern.

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

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

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

Findings and Required Actions

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

Table 3-2 presents specific findings of non-parity organized by NQTL category. HSAG's MHP Analysis for PSCS-CG resulted in two findings across two NQTL categories.

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

#	NQTL Category	Finding	Required Action
1.	Category I—UM Limits Applied to Inpatient Services	For benefit packages CCOE and CCOG, PSCS-CG's 30-day RR time frame allowance for IP MH/SUD PAs was more stringent than the 90-day time frame allowed by OHP FFS and its subcontractor for IP M/S benefits under CCOE and CCOG benefit packages.	PSCS-CG should align its IP RR time frame allowance to be consistent with OHP FFS, allowing IP retrospective authorization requests up to 90 days from the date of service. Exceptions should still apply as determined through medical necessity.
2.	Category II—UM Limits Applied to Outpatient Services	For benefit packages CCOE and CCOG, PSCS-CG's 30-day RR time frame allowance for OP MH/SUD PAs was more stringent than the 90-day time frame allowed by OHP FFS and its subcontractor for OP M/S benefits under CCOE and CCOG benefit packages.	PSCS-CG should align its OP RR time frame allowance to be consistent with OHP FFS, allowing OP retrospective authorization requests up to 90 days from the date of service. Exceptions should still apply as determined through medical necessity.

Data Analysis Results

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

- Utilization Management for Inpatient/Outpatient Services (NQTL Categories I and II).

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

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

Utilization Management for Inpatient/Outpatient Services

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

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

Prior Authorizations by Benefit Type							
Benefit Type	# of PA Requests	# of PA Requests Denied	% of PA Requests Denied	# of PA Denials Appealed	% of PA Denials Appealed	# of PA Denials Overturned	% of PA Denials Overturned
MH/SUD	134	5	3.73%	0	0.00%	0	0.00%
M/S	5,792	219	3.78%	16	7.31%	1	0.46%
Total	**5,926**	**224**	**3.78%**	**16**	**7.14%**	**1**	**0.45%**

Observations

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

- Of the total 5,926 IP and OP PA requests reported, only 3.78 percent were denied.
- Of the five MH/SUD PA requests denied, representing 3.73 percent of the MH/SUD PA requests, none resulted in an appeal.
- Approximately 75 percent of MH/SUD denials were due to a "medical necessity" categorical denial reason.

Utilization Management for Prescription Drugs

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

Table 3-4—Prior Authorization Counts for Prescription Drugs

Prior Authorization Counts (Formulary and Non-Formulary)						
# of PA Requests	# of PA Requests Denied	% of PA Requests Denied	# of PA Denials Appealed	% of PA Denials Appealed	# of PA Denials Overturned	% of PA Denials Overturned
402	201	50.00%	34	16.92%	14	6.97%

Observations

HSAG's analysis of PSCS-CG's counts for prescription drug PA requests did not reveal any concerns related to parity due to a low denial rate for MH/SUD. The following data points were observed:

- Of the total 402 prescription drug PA requests reported, 50 percent were denied.
- MH/SUD denials represented only 3.48 percent of the total 201 denied prescription drug PA requests, none of which were appealed.
- The primary denial reason for prescription drug PA request denials was attributed to a "medical necessity" categorical reason.

Enrollment/Credentialing

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

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

Enrolment/Credentialing Counts by Provider Type						
Provider Type	Avg. # Enrolled Providers	# Providers Terminated	% Terminated	# of Cred. Requests	# of Cred. Requests Denied/Not Accepted	% of Cred. Requests Denied/Not Accepted
MH/SUD	3,661	13	0.36%	2,073	31	1.50%
M/S	11,135	47	0.42%	3,119	9	0.29%
Total	**14,796**	**60**	**0.41%**	**5,192**	**40**	**0.77%**

Observations

PSCS-CG shared PacificSource Health Plans' provider network. HSAG's analysis of PSCS-CG's provider credentialing data did not reveal any parity concerns due to low denial rates reported for providers seeking credentialing during the reporting period. The following data points were observed:

- Of the 14,796 reported average number of providers enrolled during the reporting period, 24.74 percent were MH/SUD providers.
- The total denial rate for all provider types was 0.77 percent, with MH/SUD providers representing 77.50 percent of total denials. While a significant percentage of MH/SUD providers were denied in comparison to M/S providers, the overall denial rate was extremely low, which resulted in a determination of parity.
- The majority of denials were due to a "criteria not met" categorical reason.

Additional Requirement Results

HSAG requested information from PSCS-CG on the required availability of medical necessity determinations regarding MH/SUD benefits to members, potential members, and contracting providers upon request, and how reasons for denial of reimbursement or payment for MH/SUD benefits were made available to members. PSCS-CG provided a Behavioral Health Desktop Reference describing procedural detail on how reasons for denials are populated into notices of adverse benefit determination. A review of PSCS-CG's website showed that the CCO had resources available on its website for members that included information on MH benefits available, a prescription drug formulary, and clinical practice guidelines. HSAG determined that PSCS-CG was compliant with the additional administrative MHP requirements.

4. Improvement Plan Process

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

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

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

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

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

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

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

Barb McConnell, Executive Director
bmcconnell@hsag.com
303.717.2105

Appendix A. MHP Evaluation Questionnaire

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

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

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

Provider Network Admission Changes in CCO—MH Parity Analysis Sections IV and V		
Question		**Yes/No**
1.	Did the CCO change its network status from open (accepting new provider applications) to closed (not accepting new provider applications for certain provider types) or from closed to open?	☐ Yes ☒ No
2.	Did the CCO add, remove, or change provider admission requirements (e.g., special training, education, experience), including as a result of State licensing changes, for any MH/SUD or M/S providers?	☐ Yes ☒ No

3.	Were any of the CCO's providers denied credentialing due to network closure (if applicable) or based on credentialing requirements? ***Documentation Required:*** *Provide a list of the number and percentage of providers denied credentialing (relative to those seeking credentialing, including the number of applications not accepted) or terminated from credentialing and provide the credentialing determination.* Documentation is in Required Documentation Report	☐ Yes ☒ No
4.	Did the CCO add or remove any MH/SUD or M/S provider types that are eligible for credentialing/reimbursement for services? *Required documents are in Supporting Documentation*	☒ Yes ☐ No

Appendix B. Finalized MHP NQTL Reporting Tables

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

Category I—Utilization Management Limits Applied to Inpatient Services

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

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

Classification: IP and emergency care

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
1. To which benefit is the NQTL assigned?			
• (1, 2, 3, 4, 6) PA and CR are required for planned non-emergency admissions to acute IP (in and OON), PRTS and subacute. • (1, 2, 3, 4, 6) Emergency admissions require notification within two business days of admission and subsequent CR. • (1, 4) Extra-contractual and experimental/investigational/ unproven benefit requests (i.e., exceptions) are submitted through a PA-like process.	• (1, 4) PA (only) for MH/SUD procedures performed in a medical facility (e.g., gender reassignment surgery authorizations, experimental/investigational, and extra-contractual benefits are conducted by OHA consistent with the information in column 2). • (2, 4) A level-of-care review is required for SCIP, SAIP and subacute care that is conducted by an OHA designee. • (1, 4) PA for SCIP, SAIP and subacute admission is obtained through a peer-to-peer review between a Comagine psychiatrist and the referring psychiatrist. • (1, 2, 4) CR Comagine RR for SCIP and SAIP are performed by Comagine. • (1, 2, 4) CR and RR for subacute care are conducted by Comagine. • (1, 2, 4) PA, inclusive of a Certificate of Need (CONS)	• (1, 2, 3, 4, 6) PA and CR are required for planned non-emergency admissions to acute IP (in and OON). • (1, 2, 3, 4, 6) Emergency admissions require notification within two business days of admission and subsequent CR. • (1, 2, 3, 4) Skilled nursing facility benefits (first 20 days) require PA. • (1, 4) Extra-contractual and experimental/investigational/ unproven benefit requests (i.e., exceptions) are submitted through a PA-like process.	• (1, 2, 4) PA and CR are required for in-state and OOS planned surgical procedures (including transplants) and associated imaging, rehabilitation and professional surgical services delivered in an inpatient setting and listed in OAR 410-130-0200, Table 130-0200-1; rehabilitation, and long term acute care (LTAC).(Notification is required for all IP admissions.) • (1, 2, 4) PA, CR and RR for Behavior Rehabilitation Services (BRS) are performed by OHA, DHS or OYA designee. • (1, 2, 4) PA and CR of skilled nursing facility (SNF) services. • (1, 4) Requests for extra-contractual and experimental/investigational /unproven benefits (i.e., exceptions) are submitted through a PA-like process.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	process, and CR, is conducted by Comagine for PRTS. • (1, 2, 4) PA, CR for AFH, SRTF, SRTH, YAP, RTF, and RTH are performed by Comagine.		
2. Why is the NQTL assigned to these benefits?			
• (1) To ensure coverage, medical necessity and prevent unnecessary overutilization (e.g., in violation of relevant OARs and associated Health Evidence Review Commission (HERC) guidelines2). • (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. • (3) Maximize use of INN providers to promote cost-effectiveness when appropriate. • (4) To comply with federal and State requirements • (6) To confirm the presence of certain service components required by relevant EBPs.	• (1) UM is assigned to ensure medical necessity of services and prevent overutilization. • (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual (e.g., matching the level of need to the least restrictive setting using the LOCUS – Level-of-Care Utilization System and LSI – Level of Service Inventory or PCSP – Person Centered Service Plan and IBL – Individually-Based Limitations). • (4) To comply with federal and State requirements.	• (1) To ensure coverage, medical necessity and prevent unnecessary overutilization (e.g., in violation of relevant OARs and associated Health Evidence Review Commission (HERC) guidelines). • (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. • (3) Maximize use of INN providers to promote cost-effectiveness when appropriate. • (4) To comply with federal and State requirements • (6) To confirm the presence of certain service components required by relevant EBPs.	• (1) PA and CR are assigned to ensure medical necessity of services and prevent overutilization (e.g., requests for care that are not medically necessary or in violation of relevant OARs, the Health Evidence Review Commission (HERC) PL and guidelines). • (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. • (4) To comply with federal and State requirements.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
3. What evidence supports the rationale for the assignment?			
• (1, 2 and 4) HERC PL and guidelines, MCG, and ASAM • (1) Every year PSCS conducts a claims analysis of MH/SUD and M/S claims data; reviews UM information, cost of services, costs of review and looks at the number services approved/denied to determine if UM should be added removed or adjusted. • (1, 2) The cost threshold is $100,000. The following data are reviewed as part of the strategy described above. – Utilization and Experience reports. – CCO Dashboards. – Quality Incentive Metrics Dashboards and analysis. • (1, 2) Behavioral Health Dashboards – Pre/post capitation analysis. – Out-of-area transfer review. – Hospital Capitation Dashboard.	• (1, 2, and 4) Health Evidence Review Commission (HERC) Prioritized List (PL) and guidelines. The HERC include 13 appointed members which include five physicians, a dentist, a public health nurse, a pharmacist and an insurance industry representative, a provider of complementary and alternative medicine, a behavioral health representative and two consumer representatives. The Commission is charged with maintaining a prioritized list of services, developing or identifying evidence-based health care guidelines and conducting comparative effectiveness research. HERC provides outcome evidence and clinical guidelines for certain diagnoses that may be translated into UM requirements. There are fewer guidelines for MH/SUD than for M/S. This is because 1) there are fewer technological procedures for MH/SUD (e.g.,	• (1, 2 and 4) HERC PL and guidelines and MCG • (1) Every year PSCS conducts a claims analysis of MH/SUD and M/S claims data; reviews UM information, cost of services, costs of review and looks at the number services approved/denied to determine if UM should be added removed or adjusted. • (1, 2) The cost threshold is $100,000. The following data are reviewed as part of the strategy described above. – Utilization and Experience reports. – CCO Dashboards. – Quality Incentive Metrics Dashboards and analysis. – Behavioral Health Dashboards. – Pre/post capitation analysis. – Out-of-area transfer review. – Hospital Capitation Dashboard. – OHP readmission report review.	• (1, 2 and 4) The HERC PL and guidelines. There are more guidelines for M/S than for MH/SUD because 1) there are more technological procedures (e.g., surgery, devices, procedures and diagnostic tests); and 2) the literature is more robust. • (1) InterQual. • (1) PA staff reports. If the UM team identifies any services for which utilization appears to be increasing (e.g., number of requests) or it appears that the State is paying for medically unnecessary care, the UM team consults with the health analytics team to analyze and evaluate adjustments to PA or CR. • (1) Health analytics reports. The health analytics team and policy analysts refer services that have been identified to have increasing utilization to the UM team for evaluation.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
– OHP readmission report review. – Cost of Care Committee review. – Ad-hoc reports. • (2) Oregon Performance Plan (OPP) requires that BH services be provided in least restrictive setting possible. The OPP is a DOJ-negotiated Olmsted settlement. Also see Roberts, E., Cumming, J & Nelson, K., A Review of Economic Evaluations of Community Mental Health Care, Sage Journals, Oct. 1, 2005, 1-13. Accessed May 25, 2018. http://journals.sagepub.com/doi/10.1177/1077558705279307. • (2) Inherent restrictiveness of residential settings and dangers associated with seclusion and restraint. Also see Cusack, K.J., Frueh, C., Hiers, T., et. al., Trauma within the Psychiatric Setting: A Preliminary Empirical Report, Human Services Press, Inc., 2003. 453-460.	cognitive behavioral therapy and psychodynamic therapy are billed using the same codes, no surgeries, few devices); 2) the MH/SUD literature is not as robust (e.g., fewer randomized trials, more subjective diagnoses (or the ICD-10-CM diagnoses represent a spectrum) and less standardization in interventions). • (1) InterQual.	– Cost of Care Committee review. – Ad-hoc reports. • (2) Medical errors in the hospital is the third leading cause of death in the US. Makary, M. & Daniel, M. Medical Error - The Third Leading Cause of Death in the US, BMJ, 2016;353:i2139. • (3) Network providers' credentials have been verified and they have contracted to accept the network rate. • (4) Applicable federal and State requirements. • (6) Specific EBPs.	

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• (3) Network providers' credentials have been verified and they have contracted to accept the network rate. • (4) Applicable federal and State requirements. • (6) Specific EBPs.			
4. What are the NQTL procedures?			
Timelines for authorizations: • Notification of urgent/emergent admission is required within 48 business hours of admission • PA is required to be submitted prior to the service being delivered. Determinations are made within 2 business days by LPCs and MDs for drugs, alcohol, and drug services in accordance with the CCO contract and OARs. • Authorizations are processed within 14 days for services that are not listed above, or as expeditiously as the member's condition requires. • PRTS decisions are made within 3 days during the CONS procedure.	**Timelines for gender reassignment surgery authorizations:** **(OHA)** • Standard requests are to be processed within 14 days. **Timelines for child residential authorizations**: **(OHA)** • OHA provides the initial authorization (level-of-care review) within three days of receiving complete requests for SCIP, SAIP or subacute. **(Comagine)** • Authorization requests for PRTS are submitted prior to admission or within 14 days of an emergency admission. An emergency admission is acceptable only under unusual	**Timelines for authorizations:** • Notification of urgent/emergent admission is required within 48 business hours of admission • PA is required to be submitted prior to the service being delivered. PA is required for pre-planned inpatient stays and a determination is made within 14 calendar days for standard requests. • Efforts are made to complete SNF determinations in the same day.	**Timelines for authorizations**: • All in-state and out-of-state (OOS) emergency admissions, LTAC, and IP rehabilitation require notification. Notification is preferred within 24 hours of admission, but there is no timeline requirement. Notification allows the State to conduct case management and discharge planning, but does not limit the scope or duration of the benefit. • PA is required before admission. • OARs require emergency requests be processed within one business day, urgent requests within three business days and standard requests within 14 days.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	and extreme circumstances, subject to RR by Comagine. **Timelines for adult residential and YAP authorizations**: **(Comagine Health)** • Emergency requests are processed within one business day, urgent within two business days, and standard requests within 10 business days.		
Documentation requirements: • Diagnosis code, service group and supporting clinical information are required. • Certificate of Need (CON) is required by the State for PRTS	**Documentation requirements (OHA):** • PA documentation requirements for non-residential MH/SUD benefits include a form that consists of a cover page. Diagnostic and CPT code information and a rationale for medical necessity must be provided, plus any additional supporting documentation. • The documentation requirement for level-of-care assessment for SCIP, SAIP and subacute is a psychiatric evaluation. Other information may be reviewed when available.	**Documentation requirements:** • Diagnosis code, service group and supporting clinical information are required. • Updated clinical information is submitted and reviewed by PacificSource's UM clinicians.	**Documentation requirements**: • PA documentation requirements include a form that consists of a cover page. Diagnostic and CPT code information and a rationale for medical necessity must be provided, plus any additional supporting documentation.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	Addiction Medicine (ASAM) Patient Placement Criteria second edition-revised (PPC-2R) to determine the appropriate level of SUD treatment of care. • There are no specific documentation requirements for CR of PRTS, SCIP or SAIP. **Documentation requirements (Comagine Health)**: • Documentation may include assessment, service plan, plan-of-care, Level-of-Care Utilization System (LOCUS), Level of Service Inventory (LSI), PCSP, IBL, or other relevant documentation.		
Method of document submission: • PA requests for IP hospital are made via InTouch Provider Portal or by fax prior to the service being delivered. • Residential SUD, PRTS, Sub-acute, and MH respite require online submission via InTouch provider portal or by fax prior to service delivery.	**Method of document submission (OHA):** • For non-residential MH/SUD services, paper (fax) or online PA requests are submitted prior to the delivery of services for which PA is required. • For SCIP, SAIP and subacute level-of-care review, the OHA designee may accept information via fax, mail or	**Method of document submission:** • PA requests for IP hospital and SNF are made via InTouch Provider Portal or by fax prior to the service being delivered. • Telephonic report between clinicians is also accepted.	**Method of document submission**: • Paper (fax) or online PA requests are submitted prior to the delivery of services for which PA is required.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Telephonic report between clinicians is also accepted.	secure email and has also picked up information. Supplemental information may be obtained by phone. **Method of document submission (Comagine):** • Packets are submitted to Comagine by mail, fax, email or web portal for review for child residential services. Telephonic clarification may be obtained. • Psychiatrist to psychiatrist review is telephonic. **Method of document submission (Comagine Health):** • Providers submit authorization requests for adult MH residential to Comagine Health by mail, fax, email or via portal, but documentation must still be faxed if the request is through portal. Telephonic clarification may be obtained.		
Qualifications of reviewers: • UM clinicians hold various credentials, including MSW, LPC, and RN. • Only MDs can make medical necessity denial determination.	**Qualifications of reviewers (OHA)**: • OHA M/S staff conduct PA and CR (if applicable) for gender reassignment surgery.	**Qualifications of reviewers:** • UM clinicians hold various credentials, including MSW, LPC, and RN. • Only MDs can make medical necessity denial determinations	**Qualifications of reviewers**: • Nurses may authorize and deny authorization requests relative to OAR, HERC PL guidelines and associated notes, and other

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	• The OHA designee is a licensed, master's-prepared therapist that reviews psychiatric evaluations to approve or deny the level-of-care requested. Psychiatric consultation is available if needed. **Qualifications of reviewers (Comagine)**: • Two reviewers with QMHP designation make residential authorization decisions. • Two psychiatrists make CONS determinations. **Qualifications of reviewers (Comagine Health)**: • Comagine Health QMHPs must meet minimum qualifications (see below) and demonstrate the ability to conduct and review an assessment, including identifying precipitating events, gathering histories of mental and physical health, substance use, past mental health services and criminal justice contacts, assessing family, cultural, social and work relationships, and		industry guidelines (e.g., AIM for radiology).

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	conducting/reviewing a mental status examination, complete a DSM diagnosis, and write and supervise the implementation of a PCSP. • A QMHP must meet one of the follow conditions: – Bachelor's degree in nursing and licensed by the State of Oregon; – Bachelor's degree in occupational therapy and licensed by the State of Oregon; – Graduate degree in psychology; – Graduate degree in social work; – Graduate degree in recreational, art, or music therapy; – Graduate degree in a behavioral science field; or – A qualified Mental Health Intern, as defined in 309-019-0105(61).		
Criteria: • Authorization decisions for SUD treatment are made using ASAM criteria	**Criteria (OHA)**: • Authorizations for non-residential MH/SUD services are based on the HERC PL and	**Criteria:** • PacificSource uses MCG, HERC PL and guidelines, OAR applicable to the OHP	**Criteria**: • Authorizations are based on the HERC PL and guidelines; Oregon Statute, OAR, and

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• PacificSource uses MCG, HERC PL and guidelines, OAR applicable to the OHP and CCOs, and the contract to make PA decisions.	guidelines; Oregon Statute, OAR, and federal regulations; InterQual guidelines; and evidence-based guidelines from private and professional associations. • OHA delegates review requests relative to least restrictive environment requirement. **Criteria (Comagine)**: • HERC PL, InterQual, and Comagine policy are used for residential CR. **Criteria (Comagine Health)**: • QMHPs review information submitted by providers relative to State plan and OAR requirements and develop a PCSP. • The PCSP components are entered into MMIS as an authorization.	and CCOs, and the contract to make PA decisions. • Medicare criteria are used for SNF.	federal regulations; InterQual guidelines; and evidence-based guidelines from private and professional associations, such as the Society of American Gastrointestinal and Endoscopic Surgeons and InterQual, where no State or federal guidelines exist.
Reconsideration/RR: • The CCO reserves the right to retrospectively review any service.	**Retrospective Review:** • Retrospective authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why	**Reconsideration/RR:** • The CCO reserves the right to retrospectively review any service.	**Retrospective Review:** • Retrospective authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	authorization could not have been obtained within the 90 days. **Reconsideration (OHA)**: • A provider may request review of an OHA denial decision for nonresidential MH/SUD services. The review occurs in weekly Medical Management Committee (MMC) meetings. • Exception requests for experimental and other non-covered benefits may be granted at the discretion of the MMC, which is led by the HSD medical director. • If a provider requests review of an OHA delegate level-of-care determination, KEPRO may conduct the second review. **Reconsideration (Comagine)**: • If the facility requests a reconsideration of a CONS 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.		authorization could not have been obtained within the 90 days. **Reconsideration**: • A provider may request review of a denial decision. The review occurs in weekly MMC meetings. • Exception requests for experimental and other non-covered benefits may be granted at the discretion of the MMC, which is led by the OHA's medical director.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	Reconsideration (Comagine Health): • Within 10 days of a denial, the provider may send additional documentation to Comagine Health for reconsideration. • A provider may request review of a denial decision, which occurs in weekly MMC meetings or Comagine Health's own comparable medical management meeting.		
Appeals: • Standard appeal processes apply.	**Appeals (OHA)**: • Members may request a hearing on any denial decision. **Appeals (Comagine)**: • Members may request a hearing on any denial decision. **Appeals (Comagine Health)**: • Members may request a hearing on any denial decision.	**Appeals:** • Standard appeal processes apply.	**Appeals**: • Standard appeal and fair hearing rights apply.
Consequences for failure to authorize: • Failure to PA/notify within timelines can result in non-payment.	**Consequences for failure to authorize (OHA)**: • Failure to obtain authorization for non-residential MH/SUD services can result in non-payment for benefits for which it is required. • Failure to obtain notification for non-residential MH/SUD	**Consequences for failure to authorize:** • Failure to PA/notify within timelines can result in non-payment.	**Consequences for failure to authorize**: • Failure to obtain authorization can result in non-payment for benefits for which it is required. • Failure to obtain notification does not result in a financial penalty.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	services does not result in a financial penalty. • For SCIP, SAIP and subacute, if coverage is retroactively denied, general funds will be used to cover the cost of care. **Consequences for failure to authorize (Comagine)**: • Non-coverage. **Consequences for failure to authorize (Comagine Health)**: • Failure to obtain authorization can result in non-payment for benefits for which it is required.		
5. How frequently or strictly is the NQTL applied?			
Frequency of review (and method of payment): • CR for acute IP is generally every 5 business days (7 calendar). • CR for MH subacute is a minimum of every 5 business days (7 calendar). • CR for PRTS is every 5 business days (7 calendar). • Residential SUD is reviewed every 5 business days (7 calendar).	**Frequency of review (and method of payment) (OHA)**: • Gender reassignment surgery is authorized as a procedure. • The initial authorization for SCIP, SAIP, and subacute is 30 days. **Frequency of review (and method of payment) (Comagine)**: • Child residential services are paid by per diem. • Child residential services authorizations are conducted every 30-90 days.	**Frequency of review (and method of payment):** • Average concurrent review frequency is 5-7 days for per diem paid care. • DRG length for IP paid by DRG. • CR is typically only needed for longer lengths of stay. PreManage is also utilized for determining if the member is still inpatient. The facilities provide updated UR if review of additional days is needed	**Frequency of review (and method of payment)**: • Most IP claims are paid DRG; as a result, CR is infrequently used. • CR is conducted monthly for LTAC and rehabilitation. • The State conducts CR for SNF at a frequency that is determined by the care manager, but not less than one time a year.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	Frequency of review (and method of payment) (Comagine Health): • Adult residential authorizations are conducted at least once per year. An independent and qualified agent (IQA) contacts MH provider quarterly for 1915i assessment accuracy. If member's status changes for more than 30 days, provider can contact IQA for a re-assessment.	beyond what was initially authorized. • SNF admissions are limited to 20 days per the benefit	• Authorization lengths are individualized by condition and are valid for up to a year. • Procedural authorizations are valid for three months.
RR conditions and timelines: • Requests for retrospective review of hospital admissions for which the CCO was not notified within two business days may be reviewed at the CCO's discretion. • CCO allows 30-day RR for non-emergent IP MH/SUD benefits. • Retrospective utilization may require review of the full medical records and may be reviewed by the Medical Director.	**Retrospective Review:** • Retrospective authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why authorization could not have been obtained within the 90 days. • Reconsideration (OHA): • A provider may request review of an OHA denial decision for nonresidential MH/SUD services. The review occurs in weekly Medical Management Committee (MMC) meetings.	**RR conditions and timelines:** • Requests for retrospective review of hospital admissions for which the CCO was not notified within two business days may be reviewed at the CCO's discretion. • Retrospective utilization may require review of the full medical records and may be reviewed by the Medical Director. • Non-emergent M/S RR is not considered.	**Retrospective Review:** • Retrospective authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why authorization could not have been obtained within the 90 days. **Reconsideration**: • A provider may request review of a denial decision. The review occurs in weekly MMC meetings. • Exception requests for experimental and other non-covered benefits may be

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	• Exception requests for experimental and other non-covered benefits may be granted at the discretion of the MMC, which is led by the HSD medical director. • If a provider requests review of an OHA delegate level-of-care determination, KEPRO may conduct the second review. • Reconsideration (Comagine): • If the facility requests a reconsideration of a CONS denial, a second psychiatrist (who did not make the initial decision) will review the documentation and discuss with the facility in a formal meeting. • No policy for CR denials. • Reconsideration (Comagine Health): • Within 10 days of a denial, the provider may send additional documentation to Comagine Health for reconsideration. • A provider may request review of a denial decision, which occurs in weekly MMC meetings or Comagine		granted at the discretion of the MMC, which is led by the OHA's medical director.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	Health's own comparable medical management meeting.		
Methods to promote consistent application of criteria: • The CCO conducts quarterly reviews using a 90% testing standard.	**Methods to promote consistent application of criteria (OHA)**: • Nurses are trained on the application of the HERC PL and guidelines, which is spot-checked through ongoing supervision. Whenever possible, practice guidelines from clinical professional organizations such as the American Medical Association or the American Psychiatric Association, are used to establish PA frequency for non-residential MH/SUD services. • There are only two OHA designee reviewers for level-of-care review for SCIP, SAIP, and subacute and no specific criteria, so N/A. **Methods to promote consistent application of criteria (Comagine):** • Parallel chart reviews for the two reviewers. (No criteria.)	**Methods to promote consistent application of criteria:** • The CCO conducts quarterly reviews using a 90% testing standard.	**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 (Comagine Health): • Monthly clinical team meetings in which randomly audited charts are reviewed/discussed by peers using Comagine Health compliance department-approved audit tool. • Results of the audit are compared, shared and discussed by the team and submitted to Compliance Department monthly for review and documentation. • Individual feedback is provided to each clinician during supervision on their authorization as well as plan-of-care reviews.		
6. What standard supports the frequency or rigor with which the NQTL is applied?			
Evidence for UM frequency: • Authorization decisions are based on Oregon's definition of medically necessary, MCG®, ASAM, the HERC PL and guidelines and CCO developed medical policy/guidelines. A policy is maintained regarding specific	**Evidence for UM frequency (OHA (and designee for level-of-care review), Comagine and KEPRO)**: • PA length and CR frequency are tied to HERC PL and guidelines, OAR, CFRs, InterQual, reviewer expertise	**Evidence for frequency:** • Authorization decisions are based on Oregon's definition of medically necessary, MCG®, ASAM, the HERC PL and guidelines and CCO developed medical policy/guidelines. A policy is maintained regarding specific	**Evidence for UM frequency**: • PA length and CR frequency are tied to HERC PL and guidelines, DRGs, OAR, CFRs, InterQual, reviewer expertise and timelines for expectations of improvement.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
guidelines used in decision-making (i.e., Clinical Criteria Used in UM Decisions). • Authorization of days is dependent on the clinical documentation reviewed in association with the IP stay.	and timelines for expectations of improvement.	guidelines used in decision-making (i.e., Clinical Criteria Used in UM Decisions). • Authorization of days is dependent on the clinical documentation reviewed in association with the IP stay.	
Data reviewed to determine UM application: • Utilization and Experience reports • CCO Dashboards. • Quality Incentive Metrics Dashboards and analysis. • Behavioral Health Dashboards. • Pre/post capitation analysis. • Out-of-area transfer review. • Hospital Capitation Dashboard. • OHP readmission report review. • Cost of Care Committee review. • Ad-hoc reports. • HERC, ASAM, MCG, OAR.	**Data reviewed to determine UM application**: • Denial/appeal overturn rates; number of PA requests; stabilization of cost trends; and number of hearings requested. These data are reviewed in subcontractor reports, on a quarterly basis by the State. (Applicable to non-residential MH/SUD services.) **Data reviewed to determine UM application (Comagine)**: • N/A **Data reviewed to determine UM application (Comagine Health):** • N/A	**Data reviewed to determine UM application:** • Utilization and Experience reports. • CCO Dashboards. • Quality Incentive Metrics Dashboards and analysis. • Pre/post corrective action plan analysis. • Out-of-area transfer review. • Hospital CAP Dashboard. • OHP readmission report review. • Cost of Care Committee review. • Ad-hoc reports. • HERC, OAR.	**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: • No IRR standard yet. Plans to target 90%by the end of the year. • Inter-rater reliability testing is performed on an annual basis between reviewers to ensure consistency in the review process, 90% testing standard.	**IRR standard (OHA):** • KEPRO has a formal policy including an 80% standard using InterQual criteria, conducting reviews at least annually. **IRR standard (Comagine Health):** • Spot-checks performed through supervision. Formal policy to be developed. **IRR standard (Comagine Health):** • Spot-checks performed through supervision.	**IRR standard:** • No IRR standard yet. Plans to target 90%by the end of the year. • Inter-rater reliability testing is performed on an annual basis between reviewers to ensure consistency in the review process, 90% testing standard.	**IRR standard (OHA):** • KEPRO has a formal policy including an 80% standard using InterQual criteria, conducting reviews at least annually.
Analysis			
PSCS-CG was responsible for delivering IP MH/SUD and M/S Medicaid benefits to members in all four benefit packages (CCOA, CCOB, CCOE, and CCOG), whereas OHP FFS was fully managing IP M/S benefits for CCOE and CCOG benefit packages. Emergency MH/SUD and M/S IP hospital admissions required notification, with most ongoing IP services requiring subsequent CR. Regarding nonemergent CCO MH/SUD and M/S IP admissions, PA or level-of-care approval was required. PA was also required for extra-contractual coverage requests (including experimental services); planned surgical procedures (including transplants); and associated imaging, rehabilitation, and professional surgical services delivered in an IP setting and listed in OAR 410-130-0200, Table 130-0200-1. For psychiatric residential treatment services (PRTS) benefits (e.g., Secure Children's Inpatient Programs [SCIP], Secure Adolescent Inpatient Programs [SAIP], and adult and youth residential services) delivered under all benefit packages, OHP FFS's subcontractor, Comagine Health, was conducting the CON and PA processes, with the CCO conducting CR for those services. The CCO was also conducting CR for MH/SUD subacute benefits. For M/S benefits under CCOA and CCOB benefit packages, the CCO was conducting PA and CR for SNF benefits for the first 20 days, with subsequent management being conducted by OHP FFS.			

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

HSAG's analysis of PSCS-CG's PA data for IP and OP benefits did not reveal any concerns related to MHP. Of the five MH/SUD PA requests denied, representing 3.73 percent of the MH/SUD PA requests, none resulted in an appeal. Approximately 75 percent of MH/SUD denials were due to a "medical necessity" categorical denial reason.

Comparability

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

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

Stringency

Qualified individuals conducted UM applying OARs, HERC, MCG, national guidelines, and ASAM for CCO SUD. The CCO and OP FFS subcontractors required all MH/SUD and M/S denials to be made by physicians and professional peers; however, nurses could deny benefits managed by OHP FFS. HSAG determined this difference to be an issue of quality rather than parity. OHP FFS's subcontractor, Comagine Health (a licensed MH professional), made denial determinations for level-of-care review for certain child residential services. PSCS-CG changed CR process for acute, subacute, PRTS, and SUD treatment to better align the frequency of reviews, which is now primarily conducted every five business days (seven calendar days). Both the CCO and OHP FFS allowed RR for MH/SUD and M/S when providers failed to obtain authorization. Although

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
exceptions to the time frames were allowed by both the CCO and OHP FFS, PSCS-CG's 30-day RR time frame allowance for IP MH/SUD PAs was more stringent than the 90-day time frame allowed by OHP FFS and its subcontractor for IP M/S authorizations under CCOE and CCOG benefit packages. For adult and youth residential services, Comagine Health allowed reconsideration of denials with the submission of additional documentation within 10 days of the denial. For OHP FFS and Comagine Health, the review of denial decisions occurred during MMC meetings. MH/SUD and M/S denial decisions could be appealed through appeals and/or State fair hearing processes. Failure to obtain authorization could result in noncoverage, although SCIP, SAIP, and subacute services could be covered by general fund dollars. Regarding IRR, the CCO was conducting regular reviews using a 90 percent testing goal, whereas OHP FFS's subcontractor had an 80 percent testing standard for M/S authorizations. HSAG did not determine this discrepancy to be a parity concern as the method to promote consistency was more structured for MH/SUD benefits.			
Outcome			
HSAG's analysis determined that the rationale, documentation requirements, processes, and frequency of UM applied to IP MH/SUD benefits were comparable to those applied to IP M/S benefits; however, it was determined that the rigor with which PSCS-CG's UM was applied to MH/SUD benefits was more stringent in relation to RR for CCOG and CCOG benefit packages as detailed in the finding below. **Finding #1:** For benefit packages CCOE and CCOG, PSCS-CG's 30-day RR time frame allowance for IP MH/SUD PAs was more stringent than the 90-day time frame allowed by OHP FFS and its subcontractor for IP M/S benefits under CCOE and CCOG benefit packages. **Required Action:** PSCS-CG should align its IP RR time frame allowance to be consistent with OHP FFS, allowing IP retrospective authorization requests up to 90 days from the date of service. Exceptions should still apply as determined through medical necessity.			

Category II—Utilization Management Limits Applied to Outpatient Services

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

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

Classification: OP

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

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

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
1. To which benefit is the NQTL assigned?				
• (2) Applied Behavior Analysis (ABA). • (2) OT, PT, ST for MH conditions are	The following services are managed by DHS: • (1) 1915(c) Comprehensive DD waiver.	• For all non-contracted and contracted providers not under a risk arrangement:	• (2, 3, 4, 5, 6) All out-of-network OP referrals and services • (2, 3, 4, 5) PT/ST/OT	The following services are managed by OHA: • (2, 3) Out of hospital births.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
managed through RR; PA is not required.	• (1) 1915(c) Support Services DD waiver. • (1) 1915(c) Behavioral DD Model waiver. • (1) 1915(c) Aged & Physically Disabled waiver. • (1) 1915(c) Hospital Model waiver. • (1) 1915(c) Medically Involved Children's NF waiver. • (1) 1915(k) Community First Choice State Plan option. • (1) 1915(j): Self-directed personal assistance.	• (2, 3, 4, 6) ABA • (2, 3, 4, 6) OP mental health • (2, 3, 4, 5, 6) Medication management • (2, 3,4, 6) Neuropsych eval • (2, 3, 4, 6) OP SUD • (2, 3, 4, 6) Medication Assisted Treatment • (2, 3, 4, 6) Urine Drug Screen • (2, 3, 4, 5, 6) Investigational and experimental services	• (exceptions: eval and re-evaluations) • (2, 3, 4, 5) Acupuncture • (2, 3, 4, 5) Chiropractic services • (2, 3, 4, 5, 6) OP surgery, elective/planned procedures in hospital or ambulatory surgery center, Bariatric evaluation • (2, 3, 5) Select DME • (6) Contact lenses • (2, 3, 4, 5) Potentially cosmetic services • (2, 3, 5) Select radiological services • (2, 3, 5) Investigational and experimental services • (2, 3, 5, 6) Genetic testing • (3, 4) Medication management • (2, 4, 5, 6) Urine Drug Screen (pain)	• (2) Home health services. • (2) OT, PT, ST for MH conditions are managed through RR; PA is not required. • (2, 3) Imaging. • (2) DME.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
2. Why is the NQTL assigned to these benefits?				
• (2) HERC PL. • (2) OAR 410-172-0650 for ABA services. • (2) PA requests with insufficient documentation to demonstrate MNC or HERC PL guidelines are not being followed.	• (1) The State requires PA of HCBS in order to meet federal requirements regarding PCSPs and ensure services are provided in accordance with a participant's PCSP and in the last restrictive setting.	• (2) To ensure coverage, medical necessity and prevent unnecessary overutilization. • (3) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. • (4) Maximize use of INN providers to promote cost-effectiveness when appropriate. • (5) To confirm the presence of specific components of an EBP. • (6) To comply with applicable State and federal guidelines.	• (2) To ensure coverage, medical necessity and prevent unnecessary overutilization. • (3) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. • (4) Maximize use of INN providers to promote cost-effectiveness when appropriate. • (5) To confirm the presence of specific components of an EBP. • (6) To comply with applicable State and federal guidelines.	• (2) To prevent services being delivered in violation of relevant OARs, associated HERC PL and guidelines and federal regulations. • (3) Services are associated with increased health or safety risks.
3. What evidence supports the rationale for the assignment?				
• (2) HERC PL. • (2) OAR 410-172-0650 for ABA services.	• (1) Federal requirements regarding PCSPs for 1915(c), 1915(k), and 1915(j) services (e.g.,	• (1) Every year PSCS conducts a claims analysis of MH/SUD and M/S claims data; reviews UM	• (1) Every year PSCS conducts a claims analysis of MH/SUD and M/S claims data; reviews UM	• (2) HERC PL and guidelines and clinical practice guidelines. • (2) PA requests with insufficient

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
• (2) PA requests with insufficient documentation to demonstrate medical necessity is not being met or HERC PL guidelines are not being followed.	42 CFR 441.301, 441.468, and 441.540) and the applicable approved 1915(c) waiver application/State plan amendment. • (1) Federal requirements regarding 1915(c) and 1915(i) services require that HCBS are provided in the least restrictive setting possible.	information, cost of services, costs of review and looks at the number services approved/denied to determine if UM should be added removed or adjusted. • The cost threshold is $100,000. • The following data are reviewed as part of the strategy described above. – Utilization and Experience reports. – CCO Dashboards. – Quality Incentive Metrics Dashboards and analysis. – Dental Dashboards. – Behavioral Health Dashboards. – Pre/post capitation analysis. – Out-of-area transfer review.	information, cost of services, costs of review and looks at the number services approved/denied to determine if UM should be added removed or adjusted. • The cost threshold is $100,000. • The following data are reviewed as part of the strategy described above. – Utilization and Experience reports. – CCO Dashboards. – Quality Incentive Metrics Dashboards and analysis. – Dental Dashboards. – Behavioral Health Dashboards. – Pre/post capitation analysis. – Out-of-area transfer review.	documentation to demonstrate medical necessity are not being met or HERC PL guidelines are not being followed. • (3) HERC Guidelines - Recommended limits on services for member safety.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
		– Hospital Capitation Dashboard. – OHP readmission report review. • (2, 6) OARs, HERC PL and guidelines, and federal guidelines. • (3) Oregon Performance Plan (OPP) requires that BH services be provided in least restrictive setting possible. The OPP is a DOJ-negotiated Olmsted settlement. • (3) HERC guidelines re safety concerns. • (4) Network providers' credentials have been verified and they have contracted to accept the network rate. • (5) Applicable EBPs • (6) Applicable State and federal regulation.	– Hospital Capitation Dashboard. – OHP readmission report review. • (2, 6) OARs, HERC PL and guidelines, and federal guidelines. • (3) HERC guidelines re safety concerns. • (4) Network providers' credentials have been verified and they have contracted to accept the network rate. • (5) Applicable EBPs. • (6) Applicable State and federal regulation.	

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
4. What are the NQTL procedures?				
Timelines for authorizations: • Urgent requests are processed in three business days and immediate requests in one business day. Routine requests are processed in 14 days. • OT, PT, ST for MH conditions are managed through RR; PA is not required.	**Timelines for authorizations**: • A PCSP must be approved within 90 days from the date a completed application is submitted.	**Timelines for authorizations:** • The CCO requires PA requests to be submitted prior to service provision.	**Timelines for authorizations:** • The CCO requires PA requests to be submitted prior to service provision.	**Timelines for authorizations**: • Urgent requests are processed in three business days and immediate requests in one business day. Routine requests are processed in 14 days. • OT, PT, ST for MH conditions are managed through RR; PA is not required.
Documentation requirements: • Form is one cover page. • Require diagnostic and CPT code and rationale for medical necessity plus any additional supporting documentation. • In addition, as part of the supporting documentation ABA must have an evaluation and referral for treatment from a	**Documentation requirements**: • The PCSP is based on a functional needs assessment and other supporting documentation. It is developed by the individual, the individual's team, and the individual's case manager.	**Documentation requirements:** • A one-page form and information supporting medical necessity.	**Documentation requirements:** • A one-page form and information supporting medical necessity.	**Documentation requirements**: • A cover page form is required. In addition, diagnostic information, a CPT code(s), a rationale for medical necessity plus any additional supporting documentation are required. • Documentation supporting medical necessity is required at

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

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
Qualifications of reviewers: • For ABA services, physicians review services. • For OT, PT, ST services, nurses may authorize and deny services. • Professional peers deny for other OP services.	**Qualifications of reviewers:** • A case manager must have at least: – A bachelor's degree (BA) in behavioral science, social science, or a closely related field; or – A BA in any field AND one year of human services related experience; or – An associate's degree (AA) in a behavioral science, social science, or a closely related field AND two years human services related experience; or – Three years of human services related experience.	**Qualifications of reviewers:** • PacificSource BH analysts and clinicians (i.e., LPC and MD) can approve. Only a MD can deny for medical necessity.	**Qualifications of reviewers:** • UM clinician completes clinical review. UM clinicians hold various credentials, including MSW, LPC, and RN.	**Criteria:** • Authorizations are based on applicable HERC PL and guidelines, Oregon Revised Statute, OAR, federal regulations, and evidence-based guidelines from private and professional associations such as the Society of American Gastrointestinal and Endoscopic Surgeons where no State or federal guidelines exist.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
Criteria: • Authorizations are based on applicable HERC guidelines, Oregon Statute, Oregon Administrative rules, federal regulations, and evidence-based guidelines from private and professional associations such as the American Psychiatric Association, where no State or federal guidelines exist.	**Criteria**: • Qualified case managers approve or deny services in the PCSP consistent with waiver/state plan and OAR requirements. • Once a PCSP is approved, itis entered into the payment management system as authorization by the CME staff.	**Criteria:** • Authorization decisions for SUD treatment are made using ASAM criteria. • PacificSource uses MCG, the HERC PL and guidelines, OARs applicable to the OHP and CCOs and the contract to make PA decisions.	**Criteria:** • PacificSource uses MCG, the HERC PL and guidelines, OARs applicable to the OHP and CCOs and the contract to make PA decisions.	
Reconsideration/RR: • A provider may request review of a denial decision, which occurs in weekly MMC meetings or Comagine's own comparable MMC meeting. • RR authorization requests can be made within 90 days of the date of service or after	**Reconsideration/RR:** • (c) NA	**Reconsideration/RR:** • Requests for retrospective review of hospital admissions for which the CCO was not notified within two business days may be reviewed at the CCO's discretion. • CCO allows 30-day RR for non-emergent IP MH/SUD benefits.	**Reconsideration/RR:** • Requests for retrospective review of hospital admissions for which the CCO was not notified within two business days may be reviewed at the CCO's discretion. • Retrospective utilization may require review of the full	**Reconsideration/RR:** • A review of a denial decision can be requested and is reviewed in weekly MMC meetings. • RR authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
the 90 days based on provider demonstration of a specific reason why authorization could not have been obtained within the 90 days. • OT, PT, ST are reviewed after the initial service prior to payment. Additionally, denial decisions can be requested and reviewed at weekly MMC meetings.		• Retrospective utilization may require review of the full medical records and may be reviewed by the Medical Director.	medical records and may be reviewed by the Medical Director. • Non-emergent M/S RR is not considered.	specific reason why authorization could not have been obtained within the 90 days. • OT, PT, ST are reviewed after the initial service prior to payment. Additionally, denial decisions can be requested and reviewed at weekly MCM meetings.
Consequences for failure to authorize: • Failure to obtain authorization may result in non-payment.	**Consequences for failure to authorize:** • Failure to obtain authorization may result in non-payment.	**Consequences for failure to authorize:** • Failure to obtain authorization can result in non-payment.	**Consequences for failure to authorize:** • Failure to obtain authorization can result in non-payment.	**Consequences for failure to authorize:** • Failure to obtain authorization may result in non-payment.
Appeals: • Notice and fair hearing rights apply.	**Appeals**: • Notice and fair hearing rights apply.	**Appeals:** • Standard appeal rights are available.	**Appeals:** • Standard appeal rights are available.	**Appeals**: • Notice and fair hearing rights apply.
5. How frequently or strictly is the NQTL applied?				
Frequency of review: • PA is granted for different LOS	**Frequency of review:** • PCSPs are reviewed and revised as needed,	**Frequency of review:**	**Frequency of review:** • Services that are self-limiting when the	**Frequency of review**: • PA is granted for different authorization

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
depending on the service and can be adjusted. PAs for extensive services usually range from 6 months to 1 year. • ABA is usually multiple service codes approved for 6 months. • Exceptions may be made at the discretion of the MMC, which is led by the HSD medical director.	but at least every 12 months.	• MH/SUD benefits are reviewed every 6 months.	purpose of the service is achieved (for example, OP surgery) are authorized for the number of units necessary for completion. • In general, frequency of review varies by type of services or program. Authorization is typically for one year. • CR for OP PT/OT/ST, DME, Chiropractic services, and Acupuncture.	periods depending on the service and can be adjusted. PAs for extensive services usually range from 6 months to 1 year. • Exceptions may be made at the discretion of the MMC, which is led by the HSD medical director.
Reconsideration/RR: • A provider may request review of a denial decision, which occurs in weekly MMC meetings or Comagine's own comparable MMC meeting. • RR authorization requests can be made within 90 days of the date of service or after the 90 days based on	**Reconsideration/RR:** • NA	**RR conditions and timelines:** • RR is allowed in urgent/emergent situations only, if submitted within six business days from the date of service or date of initiation of service.	**RR conditions and timelines:** • RR is allowed in urgent/emergent situations only, if submitted within six business days from the date of service or date of initiation of service.	**Reconsideration/RR:** • A review of a denial decision can be requested and is reviewed in weekly MMC meetings. • RR authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
provider demonstration of a specific reason why authorization could not have been obtained within the 90 days. • OT, PT, ST are reviewed after the initial service prior to payment. Additionally, denial decisions can be requested and reviewed at weekly MMC meetings.				authorization could not have been obtained within the 90 days. • OT, PT, ST are reviewed after the initial service prior to payment. Additionally, denial decisions can be requested and reviewed at weekly MCM meetings.
Methods to promote consistent application of criteria: • For ABA, a sample of cases are reviewed for ability to address assessed member needs and whether OARs were met.	**Methods to promote consistent application of criteria:** • DHS Quality Assurance Review teams review a representative sample of PCSPs as part of quality assurance and case review activities to assure that PCSPs meet program standards. • Additionally, OHA staff review a	**Methods to promote consistent application of criteria:** • IRR testing for MH/SUD clinicians was just introduced without a standard, which will be 90% going forward.	**Methods to promote consistent application of criteria:** • Utilization of IRR for M/S clinicians. Each is assigned 2 cases/quarter through • MCG®.	**Methods to promote consistent application of criteria**: • Nurses are trained on the application of the HERC guidelines, which is spot checked through ongoing supervision.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
	percentage of files to assure quality and compliance.			
6. What standard supports the frequency or rigor with which the NQTL is applied?				
Evidence for UM frequency: • HERC guidelines (for ABA and OT, PT, ST) of which there are more M/S than MH/SUD because 1) there are more technological procedures (e.g., surgery, devices, procedures and diagnostic tests); 2) the literature is more robust. • The amount of time a PA covers for services is limited by OAR 410-120-1320(7) which states that PAs can be approved and renewed up to one year at a time. • Whenever possible, practice guidelines from clinical professional	**Evidence for UM frequency**: • Federal requirements regarding PCSPs and 1915(c), 1915(k), and 1915(j) services (e.g., 42 CFR 441.301, 441.468, and 441.540) and the applicable approved 1915(c) waiver application/State plan amendment.	**Evidence for UM frequency:** • MCG® guidelines provide recommendations for ALOS, and are updated on a regular basis (annually). • HERC PL and guideline notes are updated based on State and federal schedules. • Clinical criteria policies are presented and approved through the Clinical Quality and Utilization Management Committee (CQUM) on a regular basis and then published for use. • ASAM criteria. • OAR	**Evidence for UM frequency:** • MCG® guidelines provide recommendations for ALOS, imaging and therapy requests and are updated on a regular basis (annually). • HERC PL and guideline notes are updated based on State and federal schedules. • Clinical criteria policies are presented and approved through the Clinical Quality and Utilization Management Committee (CQUM) on a regular basis and then published for use. • OAR	**Evidence for UM frequency**: • HERC guidelines of which there are more M/S than MH/SUD because 1) there are more technological procedures (e.g., surgery, devices, procedures and diagnostic tests); and 2) the literature is more robust. • The amount of time a PA covers for services is limited by OAR 410-120-1320(7) which states that PAs can be approved and renewed up to one year at a time. • Whenever possible, practice guidelines from clinical professional organizations such as the American Medical

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
organizations such as the American Medical Association or the American Psychiatric Association, are used to establish PA frequency.				Association or the American Psychiatric Association, are used to establish PA frequency.
Data reviewed to determine UM application: • A physician-led group of clinical professionals conduct an annual review to determine which services receive or retain a PA; items reviewed include: – Utilization. – Approval/denial rates. – Documentation/justification of services. – Cost data.	**Data reviewed to determine UM application:** • N/A	**Data reviewed to determine UM application:** • Utilization and Experience reports. • CCO Dashboards. • Quality Incentive Metrics Dashboards and analysis. • Behavioral Health Dashboards. • Pre/post capitation analysis. • Out-of-area transfer review. • Hospital CAP Dashboard. • OHP readmission report review. • Cost of Care Committee review. • Ad-hoc reports. • HERC, OAR.	**Data reviewed to determine UM application:** • Utilization and Experience reports. • CCO Dashboards. • Quality Incentive Metrics Dashboards and analysis. • Pre/post capitation analysis. • Out-of-area transfer review. • Hospital CAP Dashboard. • OHP readmission report review. • Cost of Care Committee review. • Ad-hoc reports. • HERC, OAR.	**Data reviewed to determine UM application:** • A physician-led group of clinical professionals conduct an annual review to determine which services receive or retain a PA; items reviewed include: – Utilization. – Approval/denial rates. – Documentation/justification of services. – Cost data.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
IRR standard (OHA): • KEPRO has a formal policy including an 80% standard using InterQual criteria. **IRR standard (Comagine):** • Spot-checks performed through supervision. Formal policy to be developed. **IRR standard (Comagine Health):** • Spot-checks performed through supervision.	**IRR standard:** • Spot-checks performed through supervision.	**IRR standard:** • Inter-rater reliability testing is performed on an annual basis between reviewers to ensure consistency in the review process, 90% testing standard.	**IRR standard:** • Inter-rater reliability testing is performed on an annual basis between reviewers to ensure consistency in the review process, 90% testing standard.	**IRR standard (OHA):** • KEPRO has a formal policy including an 80% standard using InterQual criteria.
Analysis				
UM was applied to FFS MH/SUD and M/S HCBS benefits, and CCO MH/SUD and FFS M/S OP benefits listed in comparability and stringency Standard #1. For HCBS, MH/SUD benefits were administered by the Oregon Department of Human Services (DHS) and OHA's subcontractor, Comagine Health, while HCBS M/S benefits were administered by DHS. Pursuant to the 2020 CCO 2.0 Health Care Services Contract, the CCO did not require PA for MH/SUD services with the exception of more intensive care benefits such as ABA and psychiatric day treatment. HSAG's analysis of PSCS-CG's PA data for IP and OP benefits did not reveal any concerns related to MHP. Of the five MH/SUD PA requests denied, representing 3.73 percent of the MH/SUD PA requests, none resulted in an appeal. Approximately 75 percent of MH/SUD denials were due to a "medical necessity" categorical denial reason. **Comparability** UM of MH/SUD and M/S HCBS benefits was required to meet federal HCBS requirements regarding PCSPs, providing benefits in the least restrictive environment, and applicable waiver applications/State plan amendments. Evidence for the application of UM to these benefits				

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

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

OARs require authorization decisions within 24 hours for emergencies, 72 hours for urgent requests, and 14 days for standard requests. Providers were encouraged to submit requests for authorization sufficiently in advance to be consistent with OAR time frames. Most CCO documentation requirements for MH/SUD included an admission note and records submitted via telephone, fax, or electronically. CCO M/S was electronically notified of an admission and care was reviewed via electronic health record (EHR). Alternatively, documentation could be submitted via fax. PCSPs for both M/S and MH/SUD must be developed within 90 days. The PCSP for both MH/SUD and M/S was based on an assessment and other relevant supporting documentation. It was developed by the individual, the individual's team, and the individual's case manager. Qualified individuals conducted UM applying OARs, HERC, MCG, national guidelines, and ASAM for CCO SUD. MH/SUD and M/S DHS reviewers were required to have a BA in a related field; a BA in any field plus one year of experience; an AA with two years' experience; or three years' experience. The CCO and Comagine required all MH/SUD and M/S denials to be made by professional peers; however, nurses could deny M/S benefits managed by OHP FFS. HSAG determined this difference to be an issue of quality rather than a parity concern. HSAG determined that the MH/SUD PA review time frames, documentation requirements, and qualification of reviewers were comparable to those applied to M/S benefits.

Stringency

Qualified individuals conducted UM applying OARs, HERC, MCG, national guidelines, and ASAM for CCO SUD. The CCO and OHA subcontractors required all MH/SUD and M/S denials to be made by physicians and professional peers; however, nurses could deny M/S benefits managed by OHP FFS. HSAG determined this difference to be an issue of quality rather than parity. Both the CCO and OHA allowed RR for MH/SUD and M/S when providers failed to obtain authorization. Although exceptions to these time frames were allowed by both the CCO and OHA, PSCS-CG's 30-day RR time frame allowance for IP MH/SUD PAs was more stringent than OHA's RR time frame of 90 days for M/S RR under benefit packages CCOE and CCOG. MH/SUD and M/S denial decisions could be appealed through appeals and/or State fair hearing processes. Failure to obtain authorization could result in noncoverage.

Regarding IRR, the CCO conducted regular reviews using a 90 percent testing goal, whereas the OHP FFS subcontractor had an 80 percent testing standard for M/S benefit authorizations. HSAG did not determine this discrepancy to be a parity concern as the method to promote consistency was more structured for MH/SUD benefits.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FFS M/S
Outcome				
HSAG's analysis determined that the rationale, documentation requirements, processes, and frequency of UM applied to OP MH/SUD benefits were comparable to those applied to OP M/S benefits; however, it was determined that the rigor with which PSCS-CG's UM was applied to MH/SUD benefits was more stringent in relation to RR for CCOG and CCOG benefit packages as detailed in the finding below. **Finding #2:** For benefit packages CCOE and CCOG, PSCS-CG's 30-day RR time frame allowance for OP MH/SUD PAs was more stringent than the 90-day time frame allowed by OHP FFS and its subcontractor for OP M/S benefits under CCOE and CCOG benefit packages. **Required Action:** PSCS-CG should align its OP RR time frame allowance to be consistent with OHP FFS, allowing OP retrospective authorization requests up to 90 days from the date of service. Exceptions should still apply as determined through medical necessity.				

Category III—Prior Authorization for Prescription Drug Limits

NQTL: PA for Prescription Drugs

Benefit Package: CCOA and CCOB for adults and children

Classification: Prescription Drugs

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

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
Committee based on best practices, professional guidelines and the Prioritized List.	guidelines, and P&T Committee review and recommendations. • Federal and state regulations/OAR and the Prioritized List.	Committee based on best practices, professional guidelines and the Prioritized List.
4. What are the NQTL procedures?		
• Prescribers request authorization by submitting the PA request form and clinical information. This may be completed through various routes -phone, online, or in some cases fax. • The standard PA request form is two pages long. Most authorization criteria require chart notes. Pharmacy department staff make every effort to obtain missing information via phone, online, or fax. • The CCO's call center is available 24 hours per day, every day, to answer questions. • All requests are responded to within 24 hours. • The PA criteria are developed by pharmacists and in consultation with the P&T Committee. • Failure to obtain PA with an absence of medical necessity results in lack of CCO coverage for requested medication above formulary limitations.	• PA requests are typically faxed to the Pharmacy Call Center, but requests can also be submitted through the online portal, by phone, or by mail. • The standard PA form is one page long, except for nutritional supplement requests. Most PA criteria require clinical documentation such as chart notes. • All PA requests are responded to within 24 hours. • The PA criteria are developed by pharmacists in consultation with the P&T Committee. • Failure to obtain PA in combination with an absence of medical necessity results in no provider reimbursement. • Notice of Benefit Determination sent to both Recipient and Provider. - Denials letters include information on required criteria, denial reasons, and how the provider can appeal and member hearing rights.	• Prescribers request authorization by submitting the PA request form and clinical information. This may be completed through various routes -phone, online, or in some cases fax. • The standard PA request form is two pages long. Most authorization criteria require chart notes. Pharmacy department staff make every effort to obtain missing information via phone, online, or fax. • The CCO's call center is available 24 hours per day, every day, to answer questions. • All requests are responded to within 24 hours. • The PA criteria are developed by pharmacists and in consultation with the P&T Committee. • Failure to obtain PA with an absence of medical necessity results in lack of CCO coverage for requested medication above formulary limitations.

CCO MH/SUD	FFS MH Carve Out	CCO M/S
5. How frequently or strictly is the NQTL applied?		
• Typically the frequency range is a year, depending on medical appropriateness and safety, and as recommended by the P&T Committee. • Approximately 89% of MH/SUD drugs are subject to PA, ST, QL criteria for clinical reasons. • If the request is denied the member/provider has appeal rights, and members can request a hearing. • The CCO assesses stringency through review of the number of PA requests, PA denial/approval rates, and pricing reports. • PA criteria are reviewed for appropriateness on an annual basis and as needed due to changes in formulary drugs and clinical appropriateness.	• The State approves PAs for up to 12 months, depending on medical appropriateness and safety, as recommended by the P&T Committee. • Approximately 19% of MH/SUD drugs are subject to PA criteria for clinical reasons. • The State allows providers to submit additional information for reconsideration of a denial. • Providers can appeal denials on behalf of a member, and members have fair hearing rights. • There were 10 client fair hearing requests for denied MH/SUD medications. None were reversed after agency reconsideration or hearing. • The State assesses stringency through review of PA denial/approval and appeal rates; number of drugs requiring PA; number of PA requests; and pharmacy utilization data/reports. • PA criteria are reviewed as needed due to clinical developments, literature, studies, and FDA medication approvals.	• Typically the frequency range is a year, depending on medical appropriateness and safety, and as recommended by the P&T Committee. • Approximately 89% of MH/SUD drugs are subject to PA, ST, QL criteria for clinical reasons. • If the request is denied the member/provider has appeal rights, and members can request a hearing. • The CCO assesses stringency through review of the number of PA requests, PA denial/approval rates, and pricing reports. • PA criteria are reviewed for appropriateness on an annual basis and as needed due to changes in formulary drugs and clinical appropriateness.

CCO MH/SUD	FFS MH Carve Out	CCO M/S
6. What standard supports the frequency or rigor with which the NQTL is applied?		
• Drug class reviews created by pharmacists and in consultation with the P&T Committee based on best practices, professional guidelines and the Prioritized List.	• FDA prescribing guidelines, medical evidence, best practices, professional guidelines, and P&T Committee review and recommendations. • Federal and state regulations/OAR and the Prioritized List.	• Drug class reviews created by pharmacists and in consultation with the P&T Committee based on best practices, professional guidelines and the Prioritized List.
Analysis		
PSCS-CG applied PA criteria to MH/SUD and M/S prescription drug benefits and applied PA to certain MH/SUD and M/S drugs to promote appropriate and safe treatment, and cost-effective use of prescription drugs. Since 2018, the CCO added and removed PA criteria to prescription drugs, and adjusted criteria for prescription drugs in the formulary. PA was consistent across all benefit packages (CCOA, CCOB, CCOE, and CCOG). HSAG's analysis of PSCS-CG's counts for prescription drug PA requests did not reveal any concerns related to parity due to a low denial rate for MH/SUD which represented only 3.48 percent of the total 201 denied prescription drug PA requests. No appeals or denial overturns on appeal were reported for MH/SUD prescription drug PA requests. **Comparability** The State applied PA to certain MH FFS carve-out drugs to promote appropriate and safe treatment. Evidence used by the CCO and OHP FFS to determine which MH/SUD and M/S drugs are subject to PA included Food and Drug Administration (FDA) prescribing guidelines, medical evidence, best practices, professional guidelines, and Pharmacy and Therapeutic (P&T) Committee review and recommendations. The PA criteria for both MH/SUD and M/S drugs were developed by pharmacists in consultation with the P&T Committee. PA requests for both MH/SUD and M/S drugs could be submitted by fax, phone, or online. **Stringency** For both MH/SUD and M/S drugs, most PA criteria required clinical documentation such as chart notes. Failure to obtain PA for MH/SUD and M/S drugs subject to PA in combination with an absence of medical necessity resulted in no reimbursement for the drug. Decisions were responded to within 24 hours, with decisions being made within 72 hours. For both MH/SUD and M/S drugs, the length of authorizations was dependent on medical appropriateness and safety, as recommended by the P&T Committee, based on clinical evidence such as FDA prescribing guidelines, best practices, and clinical practice guidelines. Both the CCO and OHA allowed exceptions to the formulary and preferred drug list		

CCO MH/SUD	FFS MH Carve Out	CCO M/S
based on medical necessity. For carve-out drugs covered by OHA, the CCO stated that it works with pharmacies and providers to redirect PA requests and claims to OHA.		
Outcome		
HSAG determined PSCS-CG's processes, strategies, and evidentiary standards for PA of MH/SUD prescription drugs to be comparable and no more stringently applied, in writing and in operation, to M/S prescription drugs.		

Category IV—Provider Admission—Closed Network

NQTL: Provider Admission

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

Classification: IP and OP

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
1. To which benefit is the NQTL assigned?		
• CCO does not close its network for new MH/SUD providers of inpatient or outpatient services.	• The State does not restrict new providers of inpatient or outpatient MH/SUD services from enrollment.	• N/A
2. Why is the NQTL assigned to these benefits?		
• N/A	• N/A	• N/A
3. What evidence supports the rationale for the assignment?		
• N/A	• N/A	• N/A
4. What are the NQTL procedures?		
• N/A	• N/A	• N/A
5. How frequently or strictly is the NQTL applied?		
• N/A	• N/A	• N/A

CCO MH/SUD	FFS MH/SUD	CCO M/S
6. What standard supports the frequency or rigor with which the NQTL is applied?		
• N/A	• N/A	• N/A
Analysis		
PSCS-CG did not close its network to providers of MH/SUD and M/S services. Developing a network based on network adequacy and sufficiency standards was supported by federal regulation, including the ability of a managed care organization (i.e., CCO) to limit contracting beyond the needs of its members to maintain quality and control costs (42 CFR §438.12). OAR 410-141-0220 also required the CCO to meet network sufficiency standards, which impacts the application of this NQTL category. In addition, provider network admission limits did not apply to FFS benefits, and the application of provider network admission NQTLs for benefits delivered under managed care as supported by 42 CFR §438.206 and §438.12. Accordingly, parity was not analyzed. **Comparability** N/A **Stringency** N/A		
Outcome		
Because PSCS-CG did not close its network to either MH/SUD or M/S providers, HSAG determined that the CCO's provider admission/network closure processes for MH/SUD providers were comparable to and no more stringently applied to M/S providers across all benefit packages.		

Category V—Provider Admission—Network Credentialing

NQTL: Provider Admission

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

Classification: IP and OP

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
– Ensure capabilities of provider to deliver high quality of care. – Ensure provider meets minimum competency standards.	health and safety and to reduce Medicaid provider fraud, waste, and abuse.	– Ensure capabilities of provider to deliver high quality of care. – Ensure provider meets minimum competency standards.	health and safety and to reduce Medicaid provider fraud, waste, and abuse.
3. What evidence supports the rationale for the assignment?			
• Credentialing/re-cred requirements are supported by the following evidence: – State law and Federal regulations, including 42 CFR 438.214. – State contract requirements. – National Committee for Quality Assurance (NCQA) accreditation guidelines.	• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E-Provider Screening and Enrollment.	• Credentialing/re-cred requirements are supported by the following evidence: – State law and Federal regulations, including 42 CFR 438.214. – State contract requirements. – National Committee for Quality Assurance (NCQA) accreditation guidelines.	• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E-Provider Screening and Enrollment.
4. What are the NQTL procedures?			
• The CCO requires that all independently licensed providers be credentialed in order to participate in network. • Providers must complete and provide the Oregon Practitioner Credentialing Application.	• 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	• The CCO requires that all independently licensed providers be credentialed in order to participate in network. • Providers must complete and provide the Oregon Practitioner Credentialing Application.	• 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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Providers may submit supporting documentation by USPS, email as secure PDF, fax, or hand delivered. • CCO's credentialing process involves primary source verification, license/certification review, board certification (if applicable) verification, NPI verification, tax ID review, malpractice evidence, hospital admitting privileges, sanctions and exclusions, work history and reviewing for completeness of the credentialing application. • CCO's credentialing process averages 36 days. • CCO's Medical Director and/or the Credentialing Committee are responsible for reviewing required information and making provider credentialing decisions. • CCO performs re-credentialing at least every 36 months/3 years. • Providers who do not meet credentialing/re-credentialing	type. This includes information demonstrating the provider meets provider enrollment requirements such as NPI, tax ID, disclosures, and licensure/certification. The provider enrollment forms vary from 1 to 19 pages, depending on the provider type. Supporting documentation includes the provider's IRS letter, licensure, SSN number, and/or Medicare enrollment as applicable to the provider type. The enrollment forms and documentation can be faxed in or completed and submitted electronically to the State's provider enrollment unit. The State's provider enrollment process includes checking the forms for completeness, running the provider name against exclusion databases, and verifying any licenses, certifications or equivalents. The State's enrollment process averages 7 to 14 days. State staff in the provider enrollment unit are	• Providers may submit supporting documentation by USPS, email as secure PDF, fax, or hand delivered. • CCO's credentialing process involves primary source verification, license/certification review, board certification (if applicable) verification, NPI verification, tax ID review, malpractice evidence, hospital admitting privileges, sanctions and exclusions, work history and reviewing for completeness of the credentialing application. • CCO's credentialing process averages 36 days. • CCO's Medical Director and/or the Credentialing Committee are responsible for reviewing required information and making provider credentialing decisions. • CCO performs re-credentialing at least every 36 months/3 years. • Providers who do not meet credentialing/re-credentialing	type. This includes information demonstrating the provider meets provider enrollment requirements such as NPI, tax ID, disclosures, and licensure/certification. The provider enrollment forms vary from 1 to 19 pages, depending on the provider type. Supporting documentation includes the provider's IRS letter, licensure, SSN number, and/or Medicare enrollment as applicable to the provider type. The enrollment forms and documentation can be faxed in or completed and submitted electronically to the State's provider enrollment unit. The State's provider enrollment process includes checking the forms for completeness, running the provider name against exclusion databases, and verifying any licenses, certifications or equivalents. The State's enrollment process averages 7 to 14 days. State staff in the provider enrollment unit are

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
requirements may be denied or terminated from the network. • Providers who are adversely affected by credentialing or re-credentialing decisions may challenge the decision by submitting a reconsideration request to the CCO. If the denial is still upheld through the appeal process, the practitioner has the opportunity for a hearing. This information is communicated to the practitioner in a Notice of Denial letter. • Providers must complete and provide: – DEA/CDS, or prescribe plan (if applicable). – Hospital admitting privilege, or admit plan (if applicable). – Occurrence and aggregate malpractice coverage. – Work history. – Malpractice claims history. – CMS opt-out. – Sanctions and exclusions.	responsible for reviewing information and making provider enrollment decisions.	requirements may be denied or terminated from the network. • Providers who are adversely affected by credentialing or re-credentialing decisions may challenge the decision by submitting a reconsideration request to the CCO. If the denial is still upheld through the appeal process, the practitioner has the opportunity for a hearing. This information is communicated to the practitioner in a Notice of Denial letter. • Providers must complete and provide: – DEA/CDS, or prescribe plan (if applicable). – Hospital admitting privilege, or admit plan (if applicable). – Occurrence and aggregate malpractice coverage. – Work history. – Malpractice claims history. – CMS opt-out. – Sanctions and exclusions.	responsible for reviewing information and making provider enrollment decisions.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
– Board certification (MD, DO and DPM). – Attestation questions and signature to verify that application contents are current and true.		– Board certification (MD, DO and DPM). – Attestation questions and signature to verify that application contents are current and true.	
5. How frequently or strictly is the NQTL applied?			
• All providers/provider types must be credentialed. • There are no exceptions to meeting these requirements for providers participating in network.	• All providers/provider types are subject to enrollment/re-enrollment requirements. • There are no exceptions to meeting provider enrollment/re-enrollment requirements.	• All providers/provider types must be credentialed. • There are no exceptions to meeting these requirements for providers participating in network.	• All providers/provider types are subject to enrollment/re-enrollment requirements. • There are no exceptions to meeting provider enrollment/re-enrollment requirements.
6. What standard supports the frequency or rigor with which the NQTL is applied?			
• Requirement to conduct credentialing for all new providers is established by State law and Federal regulations. • The frequency with which CCO performs re-credentialing is based upon: – State law and Federal regulations. – State contract requirements. – OAR 410.	• 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 – OAR 410. – Monitoring of provider performance. Including	• 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. Including State license sanctions, Federal sanctions, adverse events, and site visits. – NCQA accreditation standards. • CCO monitors the following data/information to determine how strictly to apply credentialing/re-credentialing criteria: – Denial/termination rates for providers as a result of credentialing/re-credentialing reviews. – Provider appeals/disputes. – Network adequacy data, such as access to care, provider specialties.		State license sanctions, Federal sanctions, adverse events, and site visits. – NCQA accreditation standards. • CCO monitors the following data/information to determine how strictly to apply credentialing/re-credentialing criteria: – Denial/termination rates for providers as a result of credentialing/re-credentialing reviews. – Provider appeals/disputes. – Network adequacy data, such as access to care, provider specialties.	
Analysis			
All IP and OP providers of MH/SUD and M/S services were subject to CCO credentialing and recredentialing requirements. PSCS conducted credentialing and recredentialing for both providers of MH/SUD and M/S services to meet State and federal requirements, ensure providers are capable of delivering high-quality care, and ensure providers meet minimum competency standards. The CCO's processes were the same across all benefit packages (CCOA, CCOB, CCOE, and CCOG). PSCS-CG shared PacificSource Health Plans' provider network, with a reported average number of 14,796 providers enrolled during the reporting period. The total denial rate for all provider types was 0.41 percent, with MH/SUD providers representing 77.50 percent of total denials. While a significant percentage of MH/SUD providers were denied in comparison to M/S providers, the overall denial rate was extremely low, which resulted in a determination of parity. The majority of denials were due to a "criteria not met" categorical reason.			

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Comparability PSCS-CG required providers of MH/SUD and M/S services to successfully meet credentialing and recredentialing requirements in order to be admitted to and continue to participate in the CCO's network. Providers were required to complete and submit a credentialing application and provide supporting documentation as part of the credentialing process. Both MH/SUD and M/S providers had several methods of submitting their application and supporting documentation, including by fax, by mail, electronically, or hand-delivered. Nonlicensed MH care providers (e.g., qualified mental health providers/assistants and traditional health care works) were vetted similarly, with verifications completed according to qualifications and certifications related to specific provider type. PSCS-CG shared a validation policy specific to the process for validating nonlicensed providers. The CCO's credentialing process for MH/SUD providers included the primary source verification of licensing, board certification, Medicare Excluded Providers (Office of Inspector General), Medicare sanction (Excluded Parties List System/System for Award Management), Medicare opt-out (if applicable), and a National Practitioner Database query match to look for unexplained gaps in work history greater than six months. The process for M/S providers involved a similar review of each application to determine whether standards are met. **Stringency** The credentialing process for both MH/SUD and M/S providers averaged 36 days depending on the completeness of the application and timeliness of primary source verification documents. The CCO's credentialing committee was responsible for reviewing required information and making provider credentialing decisions for both MH/SUD and M/S providers. Recredentialing for both MH/SUD and M/S providers was conducted every three years, or as needed based on self-disclosure of certain kinds of incidents or background checks. Failure for MH/SUD and M/S providers to meet credentialing and recredentialing requirements could result in a denial to join the CCO's network. MH/SUD and M/S providers who are adversely affected by credentialing or recredentialing decisions may challenge the decision through an appeal process.			
Outcome			
HSAG's analysis found PSCS-CG's credentialing processes and data for MH/SUD providers to be comparable and no more stringently applied to, in writing and in operation, than for M/S providers.			

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

NQTL: OON and OOS limits

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

Classification: IP and OP

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
1. To which benefit is the NQTL assigned?			
• Out of Network (OON) and Out of State (OOS) Benefits	• OOS Benefits	• Out of Network (OON) and Out of State (OOS) Benefits	• OOS Benefits
2. Why is the NQTL assigned to these benefits?			
• CCO seeks to maximize use of in-network providers because our provider network consists of local providers that have been credentialed and contracted with the CCO. • The purpose of providing OON/OOS coverage is to provide needed services when they are not available in-network/in-State.	• The State seeks to maximize use of in-State providers because the State has determined that they meet applicable requirements, and they have a provider agreement with the State, which includes agreement to comply with Oregon Medicaid requirements and accept DMAP rates.	• CCO seeks to maximize use of in-network providers because our provider network consists of local providers that have been credentialed and contracted with the CCO. • The purpose of providing OON/OOS coverage is to provide needed services when they are not available in-network/in-State.	• The State seeks to maximize use of in-State providers because the State has determined that they meet applicable requirements, and they have a provider agreement with the State, which includes agreement to comply with Oregon Medicaid requirements and accept DMAP rates.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• The purpose of prior authorizing non-emergency OON/OOS benefits is to determine the medical necessity of the requested benefit and the availability of an in-network/in-State provider.	• The purpose of providing OOS coverage is to provide needed services when the service is not available in the State of Oregon or the client is OOS and requires covered services. • The purpose of PA for non-emergency OOS services is to ensure the criteria in OAR 410-120-1180 are met.	• The purpose of prior authorizing non-emergency OON/OOS benefits is to determine the medical necessity of the requested benefit and the availability of an in-network/in-State provider.	• The purpose of providing OOS coverage is to provide needed services when the service is not available in the State of Oregon or the client is OOS and requires covered services. • The purpose of PA for non-emergency OOS services is to ensure the criteria in OAR 410-120-1180 are met.
3. What evidence supports the rationale for the assignment?			
• The CCO covers OON/OOS benefits in accordance with Federal and State requirements, including OAR and the CCO contract.	• The State covers OOS benefits in accordance with OARs.	• The CCO covers OON/OOS benefits in accordance with Federal and State requirements, including OAR and the CCO contract.	• The State covers OOS benefits in accordance with OARs.
4. What are the NQTL procedures?			
• Except as otherwise required by OHA, non-emergency OON/OOS services are not covered unless medically necessary services are not available within network/within State. • The CCO's criteria for non-emergency OON/OOS coverage includes: the special coverage needs of the member,	• Non-emergency OOS services are not covered unless the service meets the OAR criteria. • The OAR criteria for OOS coverage of non-emergency services include the service is not available in the State of Oregon or the client is OOS and requires covered services.	• Except as otherwise required by OHA, non-emergency OON/OOS services are not covered unless medically necessary services are not available within network/within State. • The CCO's criteria for non-emergency OON/OOS coverage includes: the special coverage needs of the member,	• Non-emergency OOS services are not covered unless the service meets the OAR criteria. • The OAR criteria for OOS coverage of non-emergency services include the service is not available in the State of Oregon or the client is OOS and requires covered services.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
member traveling outside the service area; member temporarily residing outside the service area (e.g., foster children, residential treatment). • 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 for other prior authorizations (14 days for standard requests). • The CCO establishes one-time agreements (OTAs) with an OON/OOS provider if the provider will not accept the DMAP rate. • The CCO's process for establishing a OTA includes a communication between the CCO Health Services department and the CCO Provider Contracting department to express the need for a OTA. Provider Contracting then negotiates the terms of the OTA with the provider, for full execution of the OTA.	• Requests for non-emergency OOS services are made through the State PA process. • The timeframe for approving or denying a non-emergency OOS request is the same as for other PAs (14 days for standard and three business days for urgent). • OOS providers must enroll with Oregon Medicaid. • The State pays OOS providers the Medicaid FFS rate.	member traveling outside the service area; member temporarily residing outside the service area (e.g., foster children, residential treatment). • 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 for other prior authorizations (14 days for standard requests). • The CCO establishes an OTA with an OON/OOS provider if the provider will not accept the DMAP rate. • The CCO's process for establishing a OTA includes a communication between the CCO Health Services department and the CCO Provider Contracting department to express the need for a OTA. Provider Contracting then negotiates the terms of the OTA with the provider, for full execution of the OTA.	• Requests for non-emergency OOS services are made through the State PA process. • The timeframe for approving or denying a non-emergency OOS request is the same as for other PAs (14 days for standard and three business days for urgent). • OOS providers must enroll with Oregon Medicaid. • The State pays OOS providers the Medicaid FFS rate.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• The average length of time to negotiate an OTA is 1-5 days. • Only providers enrolled in Oregon Medicaid 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.		• The average length of time to negotiate an OTA is 1-5 days. • Only providers enrolled in Oregon Medicaid can qualify as an OON/OOS provider. • The CCO pays OON/OOS providers: – The Medicaid FFS rate; – A percentage of the Medicaid FFS rate; or – A negotiated rate.	
5. How frequently or strictly is the NQTL applied?			
• If a request for a non-emergency • OON/OOS benefit does not meet the CCO's OON/OOS criteria, it will not be prior authorized. • If a non-emergency OON/OOS benefit is not prior authorized, the service will not be covered, and payment for the service will be denied. • Members/providers may appeal the denial of an OON/OOS request. • The CCO evaluates the number of OTAs on a monthly basis (this may vary depending on increasing/decreasing OTA	• If a request for a non-emergency OOS benefit does not meet the OAR criteria, it will not be authorized. • If a non-emergency OOS benefit is not authorized, the service will not be covered, and payment for the service will be denied. • Members/providers may appeal the denial of an OOS request. • The State measures the stringency of the application of OOS requirements by reviewing OOS denial/appeal rates.	• If a request for a non-emergency • OON/OOS benefit does not meet the CCO's OON/OOS criteria, it will not be prior authorized. • If a non-emergency OON/OOS benefit is not prior authorized, the service will not be covered, and payment for the service will be denied. • Members/providers may appeal the denial of an OON/OOS request. • The CCO evaluates the number of OTAs on a monthly basis (this may vary depending on increasing/decreasing OTA	• If a request for a non-emergency OOS benefit does not meet the OAR criteria, it will not be authorized. • If a non-emergency OOS benefit is not authorized, the service will not be covered, and payment for the service will be denied. • Members/providers may appeal the denial of an OOS request. • The State measures the stringency of the application of OOS requirements by reviewing OOS denial/appeal rates.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
volume) to determine whether the network should be expanded or a particular OON/OOS should be recruited to be a network provider.		volume) to determine whether the network should be expanded or a particular OON/OOS should be recruited to be a network provider.	
6. What standard supports the frequency or rigor with which the NQTL is applied?			
• Federal and State requirements, including OAR and the CCO contract.	• The State covers OOS benefits in accordance with OAR.	• Federal and State requirements, including OAR and the CCO contract.	• The State covers OOS benefits in accordance with OAR.
Analysis			
PSCS-CG ensured OON/OOS coverage to provide needed MH/SUD and M/S benefits when they were not available INN or in-state. Similarly, for MH/SUD FFS benefits, the State provided OOS coverage to provide needed benefits when they were not available in-state. The same PA processes and evidentiary standards described in NQTL categories I, II, and III were applied to OOS coverage of MH/SUD and M/S benefits across all benefit packages (CCOA, CCOB, CCOE, and CCOG). PSCS-CG established OTAs with OON providers in the absence of INN providers to ensure the provision of medically necessary services, while OHP FFS ensured OON providers were enrolled with Medicaid. **Comparability** For both nonemergency MH/SUD and M/S OON/OOS benefits, the CCO (and the State for FFS MH/SUD OOS benefits) requires prior authorization to determine medical necessity and to ensure no INN/in-state providers are available to provide the benefit. The same PA processes and evidentiary standards described in NQTL categories I, II, and III were applied to OOS coverage of MH/SUD and M/S requests. For OON coverage requests, the CCO would determine if an INN provider was available or work with the OON provider to establish a OTA with payment of applicable Medicaid FFS rates. This process was applied equitably to both MH/SUD and M/S providers across all benefit packages. **Stringency** Requests for nonemergency OON/OOS CCO MH/SUD and M/S benefits were made through the CCO's PA process and reviewed for medical necessity and INN/in-state coverage. The PA time frames (14 days for standard requests and 72 hours for urgent requests) applied. Similarly, the State reviewed requests for nonemergency OOS MH/SUD services through its PA process, adhering to its PA time frames identified at 14 days for standard requests and 72 hours for urgent requests. The CCO described a process for handling a complex OON/OOS MH/SUD member case, identifying how it would appropriately apply the PA and OTA process to ensure benefits were provided in relation to the member's needs.			

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
PSCS-CG also provided an OTA template for review that identified compliant agreement information and confirmed the CCO's processes related to its use of OON providers.			
Outcome			
HSAG determined that PSCS-CG's processes, strategies, and evidentiary standards for OON/OOS limits applied to MH/SUD were comparable and no more stringently applied, in writing and in operation, to M/S OON/OOS limits across all benefit packages.			

Appendix C. Improvement Plan Template

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