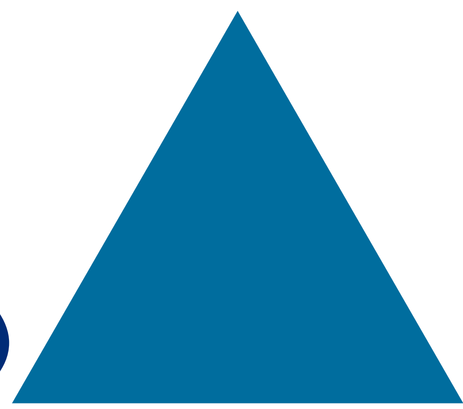
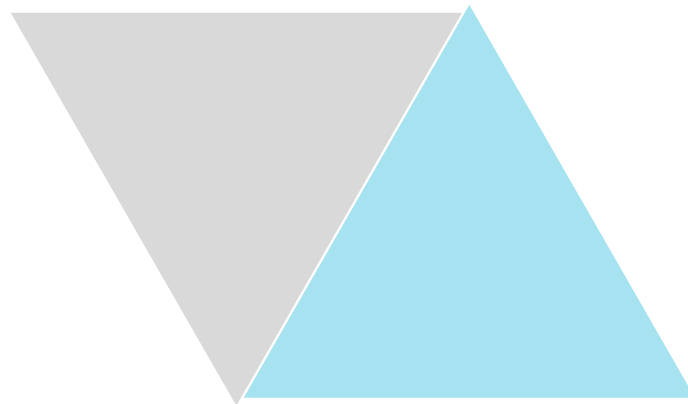
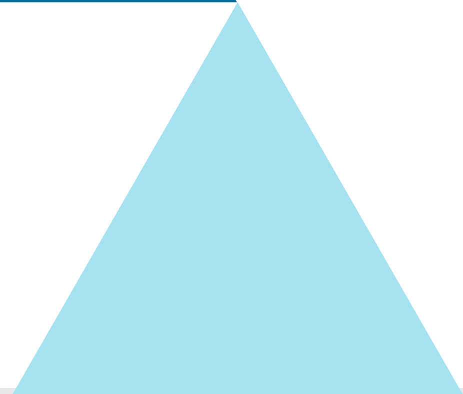


HEALTH WEALTH CAREER

TRILLIUM COMMUNITY HEALTH PLAN (TRILLIUM)

NQTL ANALYSIS





MAKE TOMORROW, TODAY

CONTENTS

Introduction 3
Inpatient Utilization Management 5
Outpatient Utilization Management 34
Prior Authorization for Prescription Drugs 56
Provider Admission — Closed Network 60
Provider Admission — Network Credentialing and Requirements in Addition to State Licensing 66
Provider Admission — Provider Exclusions 73
Out of Network (OON)/Out of State (OOS) 75

INTRODUCTION

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

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

OHA analyzed the following four NQTLs for each CCO:

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

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

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

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

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

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

INPATIENT UTILIZATION MANAGEMENT

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

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

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

1. To which benefits is the NQTL assigned?

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

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

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

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

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

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
White River Junction VT, Center for Outcomes Research and Evaluation, Maine Medical Center, & Institute for the Evaluative Clinical Sciences, Toronto, Canada, Financial support was provided by grants from the Robert, Wood Johnson Foundation, the National Institutes of Health (Grant Number CA52192) and the National Institute of Aging (Grant Number 1PO1AG19783-01), 2002, pp 1-32. • (2) Oregon Performance Plan (OPP) requires that BH services be provided in least restrictive setting possible. The OPP is a DOJ-negotiated Olmsted settlement. Also see Roberts, E., Cumming, J & Nelson, K., A Review of Economic Evaluations of Community Mental Health Care, Sage Journals, Oct. 1, 2005, 1-13. Accessed May 25, 2018. http://journals.sagepub.com/d	Research and Evaluation, Maine Medical Center, & Institute for the Evaluative Clinical Sciences, Toronto, Canada, Financial support was provided by grants from the Robert, Wood Johnson Foundation, the National Institutes of Health (Grant Number CA52192) and the National Institute of Aging (Grant Number 1PO1AG19783-01), 2002, pp 1-32. • (2) The Oregon Performance Plan (OPP) requires that BH services be provided in the least restrictive setting possible. The OPP is a DOJ-negotiated Olmsted settlement.	Research and Evaluation, Maine Medical Center, & Institute for the Evaluative Clinical Sciences, Toronto, Canada, Financial support was provided by grants from the Robert, Wood Johnson Foundation, the National Institutes of Health (Grant Number CA52192) and the National Institute of Aging (Grant Number 1PO1AG19783-01), 2002, pp 1-32. • (2) Medical errors in the hospital is the third leading cause of death in the US. Makary, M. & Daniel, M. Medical Error - The Third Leading Cause of Death in the US, BMJ, 2016;353:i2139.	

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
oi/10.1177/107755870527930 7 • (2) Inherent restrictiveness of residential settings and dangers associated with seclusion and restraint. Also see Cusack, K.J., Frueh, C., Hiers, T., et. al., *Trauma within the Psychiatric Setting: A Preliminary Empirical Report,* Human Services Press, Inc., 2003. 453-460. • (3) Network providers' credentials have been verified and they have contracted to accept the network rate. • (4) Applicable federal and State requirements.	• (4) PRTS CONS: OAR 410-172-0690 and 42 CFR 441.156. • (4) OARs and other applicable federal and State requirements. • (5) Cost and utilization reports	• (3) Network providers' credentials have been verified and they have contracted to accept the network rate. • (4) Applicable federal and State requirements.	• (4) Applicable federal and State requirements.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Timelines for authorizations: • Reviews are completed in the care management program within 24 hours of receipt of the necessary information. If needed information is not received within 24 hours, the provider is given another 24 hours to complete it. If not, coverage may be denied for inadequate information.	**Timelines for gender reassignment surgery authorizations (for benefit packages E and G):** **(OHA)** • Standard requests are to be processed within 14 days. **Timelines for child residential authorizations**: **(OHA)** • OHA provides the initial authorization (level-of-care review) within 3 days of requests for SCIP, SAIP or subacute. **(HIA)** • Authorization requests for PRTS are submitted prior to admission or within 14 days of an emergency admission. An emergency admission is acceptable only under unusual and extreme circumstances, subject to RR by HIA. **Timelines for adult residential and YAP authorizations**:	**Timelines for authorizations:** • Reviews are completed in the care management program within 24 hours of receipt of the necessary information. If needed information is not received within 24 hours, the provider is given another 24 hours to complete it. If not, coverage may be denied for inadequate information.	**Timelines for authorizations**: • All in-state and out-of-state (OOS) emergency admissions, LTAC, and IP rehabilitation require notification. Notification is preferred within 24 hours of admission, but there is no timeline requirement. Notification allows the State to conduct case management and discharge planning, but does not limit the scope or duration of the benefit. • PA is required before admission. • OARs require emergency requests be processed within 24 hours, urgent requests within 72 hours and standard requests within 14 days; although a backlog may develop.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	(KEPRO) • OARs require emergency requests be processed within 24 hours, urgent within 72 hours, and standard requests within 14 days.		
Documentation requirements: • One page authorization form. • Reviews require chart notes or clinical information, but only the minimum necessary is requested to determine medical necessity per HIPAA.	**Documentation requirements (OHA):** • PA documentation requirements for non-residential MH/SUD benefits in benefit packages E and G include a form that consists of a cover page. Diagnostic and CPT code information and a rationale for medical necessity must be provided, plus any additional supporting documentation. • The documentation requirement for level-of-care assessment for SCIP, SAIP and subacute is a psychiatric evaluation. Other information may be reviewed when available.	**Documentation requirements:** • One page authorization form. • Reviews require chart notes or clinical information, but only the minimum necessary is requested to determine medical necessity per HIPAA.	**Documentation requirements**: • PA documentation requirements include a form that consists of a cover page. Diagnostic and CPT code information and a rationale for medical necessity must be provided, plus any additional supporting documentation.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	(ASAM) Patient Placement Criteria second edition-revised (PPC-2R) to determine the appropriate level of SUD treatment of care. • There were no reported specific documentation requirements for CR of SCIP or SAIP. **Documentation requirements (KEPRO)**: • Documentation may include assessment, service plan, plan-of-care, Level-of-care Utilization System (LOCUS), Level of Service Inventory (LSI) or other relevant documentation.		
Method of document submission: • Requests can be submitted via fax, phone call or provider portal.	**Method of document submission (OHA):** • For non-residential MH/SUD services in benefit packages E and G, paper (fax) or online PA requests are submitted prior to the delivery of services for which PA is required.	**Method of document submission:** • Requests can be submitted via fax, phone call or provider portal.	**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
	• For SCIP, SAIP and subacute level-of-care review, the OHA designee may accept information via fax, mail or email and has also picked up information. Supplemental information may be obtained by phone. **Method of document submission (HIA):** • Packets are submitted to HIA by mail, fax, email or web portal for review for child residential services. Telephonic clarification may be obtained. • Psychiatrist to psychiatrist review is telephonic. **Method of document submission (KEPRO):** • Providers submit authorization requests for adult MH residential to KEPRO by mail, fax, e-mail or via portal, but documentation must still be faxed if the request is through the portal. Telephonic clarification may be obtained.		

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Qualifications of reviewers: • MH/SUD clinical UM staff definition: Licensed or meet credentialing criteria for Qualified Mental Health Professional (QMHP). Clinical BH UM staff conduct authorization of services via Level I medical necessity reviews, and consult with the Licensed BH Practitioner (LBHP), TBH Medical Director who is a psychiatrist or licensed doctoral-level clinical psychologist, as needed regarding UM decisions. When needed, LBHP conducts authorization of services via Level II medical necessity reviews. • Potential denials are referred for physician review; only physicians can issue denials.	**Qualifications of reviewers (OHA)**: • OHA M/S staff conduct PA and CR (if applicable) for gender reassignment surgery (for benefit packages E and G). (See processes, strategies and evidentiary standards in column 4.) • The OHA designee is a licensed, masters'-prepared therapist that reviews psychiatric evaluations to approve or deny the level-of-care requested. Psychiatric consultation is available if needed. **Qualifications of reviewers (HIA)**: • Two LCSWs with QMHP designation make residential authorization decisions. • Two psychiatrists make CONS determinations. **Qualifications of reviewers (KEPRO)**: • KEPRO QMHPs must meet minimum qualifications (see below) and demonstrate the	**Qualifications of reviewers:** • Nurses can authorize services but only physicians issue denials.	**Qualifications of reviewers**: • Nurses may authorize and deny authorization requests relative to OAR, HERC PL guidelines and associated notes, and other industry guidelines (e.g., AIM for radiology).

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	ability to conduct and review an assessment, including identifying precipitating events, gathering histories of mental and physical health, substance use, past mental health services and criminal justice contacts, assessing family, cultural, social and work relationships, and conducting/reviewing a mental status examination, complete a DSM diagnosis, and write and supervise the implementation of a PCSP. • A QMHP must meet one of the follow conditions: – Bachelor's degree in nursing and licensed by the State or Oregon; – Bachelor's degree in occupational therapy and licensed by the State of Oregon; – Graduate degree in psychology; – Graduate degree in social work;		

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	– Graduate degree in recreational, art, or music therapy; – Graduate degree in a behavioral science field; or – A qualified Mental Health Intern, as defined in 309-019-0105(61).		
Criteria: • Eligibility and benefit coverage are confirmed and clinical information is required to review for medical necessity of the request. • Benefit coverage is limited to medically necessary services by contract. • Clinical UM staff can authorize services relative to OARs, HERC PL and guidelines, InterQual Criteria, and Centene's Clinical Policy and Guidelines to evaluate medical necessity and determine frequency of review. • There are no differences in the procedures for children or	**Criteria (OHA)**: • Authorizations for non-residential MH/SUD services in benefit packages E and G are based on the HERC PL and guidelines, Oregon Statute, OAR, federal regulations, and evidence-based guidelines from private and professional associations. • The OHA designee reviews requests relative to the least restrictive environment requirement. **Criteria (HIA)**: • HERC PL and HIA policy are used for residential CR. **Criteria (KEPRO)**:	**Criteria:** • Eligibility and benefit coverage are confirmed and clinical information is required to review for medical necessity of the request. • Benefit coverage is limited to medically necessary services by contract. • Clinical UM staff can authorize services relative to OARs, HERC PL and guidelines, InterQual Criteria, and Centene's Clinical Policy and Guidelines to evaluate medical necessity and frequency of review. • There are no differences in the procedures for children or	**Criteria**: • Authorizations are based on the HERC PL and applicable guidelines, Oregon Statute, OAR, federal regulations, evidence-based guidelines from private and professional associations such as the Society of American Gastrointestinal and Endoscopic Surgeons and InterQual, where no State or federal guidelines exist.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
adults that are not tied to relevant practice guidelines.	• 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.	adults that are not tied to relevant practice guidelines.	
Reconsideration/RR: • Potential denials are referred for physician review. • A treating physician/provider can request a physician-to-physician call within 48 hours of notification of the potential denial to discuss the requested services with the health plan's physician. • RR is available.	**Reconsideration/RR (OHA)**: • A provider may request review of an OHA denial decision. The review occurs in weekly Medical Management Committee (MMC) meetings. (Applies to non-residential MH/SUD services in benefit packages E and G.) • Exception requests for experimental and other non-covered benefits (for benefit packages E and G) may be granted at the discretion of the MMC, which is led by the HSD medical director. • If a provider requests review of an OHA designee level-of-care determination, HIA may conduct the second review.	**Reconsideration/RR:** • Potential denials are referred for physician review. • A treating physician/provider can request a physician-to-physician call within 48 hours of notification of the potential denial to discuss the requested services with the health plan's physician. • RR is available.	**Reconsideration/RR**: • A provider may request review of a denial decision. The review occurs in weekly MMC meetings. • Exception requests for experimental and other non-covered benefits may be granted at the discretion of the MMC, which is led by the HSD medical director.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Denials can result in non-payment. **Appeals:** • Members have a right to an appeal and a fair hearing**.** • A letter is sent if there is a determination to deny, including information regarding the provider's right to appeal on behalf of the member, along with the member's right to a fair hearing.	• Failure to obtain notification for non-residential MH/SUD services in benefit packages E and G does not result in a financial penalty. • For SCIP, SAIP and subacute, if coverage is retroactively denied, general funds may be used to cover the cost of care. **Consequences for failure to authorize (HIA)**: • Non-coverage. **Consequences for failure to authorize (KEPRO)**: Failure to obtain authorization can result in non-payment for benefits for which it is required. **Appeals (OHA)**: • Members may request a hearing on any denial decision. **Appeals (HIA)**: • Documentation has not included the fair hearing process. **Appeals (KEPRO)**:	• Denials can result in non-payment. **Appeals:** • Members have a right to an appeal and a fair hearing**.** • A letter is sent if there is a determination to deny, including information regarding the provider's right to appeal on behalf of the member, along with the member's right to a fair hearing.	• Failure to obtain notification does not result in a financial penalty. **Appeals**: • Members may request a hearing on any denial decision.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	• Members may request a hearing on any denial decision.		

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Frequency of review (and method of payment): • Most MH/SUD IP stays are paid on a per diem basis. Working on case rate development. • PA: Required of all MH/SUD IP admissions after receiving the notification and authorization request from the provider. • CR: Required when the initial number of days requested is exhausted and additional IP days are needed/requested. Authorization lengths are individualized by condition and are every 5 to 7 days during CR. • Subacute is reviewed every 7 days, PRTS is authorized for up to 14 days at a time days. (No PA for SUD INN	**Frequency of review (and method of payment) (OHA)**: • Gender reassignment surgery (for benefit packages E and G) is authorized as a procedure. • The initial authorization for SCIP, SAIP and subacute is 30 days. **Frequency of review (and method of payment) (HIA)**: • Child residential services are paid by per diem. • Child residential services authorizations are conducted every 30-90 days. **Frequency of review (and method of payment) (KEPRO)**: • Adult residential and YAP authorizations are conducted at least once per year. In practice reviews average every 6 months.	**Frequency of review (and method of payment):** • M/S IP stays are paid by DRG, per diems and percentage of billed charges (CAHs). • PA: Required of all IP admissions after receiving the notification and authorization request from the provider. • CR: Required when the initial number of days requested is exhausted and additional IP days are needed/requested. • Authorization lengths are individualized by condition. Following the initial 7 day authorization, care is reviewed every six days. • The reviewing medical director can make exceptions to the PA process.	**Frequency of review (and method of payment)**: • Most IP claims are paid DRG; as a result, CR is infrequently used. • CR is conducted monthly for LTAC and rehabilitation. • The State conducts CR for SNF after the first 20 days (which are managed by the CCO) at a frequency that is determined by the care manager, but not less than one time a year. • Authorization lengths are individualized by condition and are valid for up to a year. • Procedural authorizations are valid for 3 months.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
residential and OON is reviewed every 30.) • The reviewing medical director can make exceptions to the PA process. **RR conditions and timelines:** • RR authorizations are completed within 30 days of receipt of a RR request; and then the provider is notified via a fax or mailed letter; and the provider portal and/or telephonically.	**RR conditions and timelines (OHA)**: • RR for non-residential MH/SUD services in benefit packages E and G is only available for retro eligibility situations (e.g., the person became eligible during the stay). **RR conditions and timelines (HIA):** • No policy **RR conditions and timelines (KEPRO)**: • The request for authorization is received within 30 days of the date of service. • Any requests for authorization after 30 days from date of service require documentation from the provider that authorization could not have been obtained	• SNF is reviewed every 7 days. **RR conditions and timelines:** • RR authorizations are completed within 30 days of receipt of a RR request; and then the provider is notified via a fax or mailed letter; and the provider portal and/or telephonically.	**RR conditions and timelines**: • RR is only available for retro eligibility situations (e.g., the person became eligible during the stay).

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	within 30 days of the date of service.		
Methods to promote consistent application of criteria: • Reviewers participate in IRR training to promote consistent criteria application. Hypothetical cases are reviewed and criteria application discussed in a group. Plans to move to IRR testing by the end of the year.	**Methods to promote consistent application of criteria (OHA)**: • Nurses are trained on the application of the HERC PL and guidelines, which is spot-checked through ongoing supervision. Whenever possible, practice guidelines from clinical professional organizations such as the American Medical Association or the American Psychiatric Association, are used to establish PA frequency for services in the FFS system. (Applicable to non-residential MH/SUD services in benefit packages E and G.) • There is only one OHA designee reviewer for level-of-care review for SCIP, SAIP, and subacute and no specific criteria, so N/A.	**Methods to promote consistent application of criteria:** • Reviewers participate in IRR testing to promote consistent criteria application. Failure to meet threshold results in more training. A second fail would result in a corrective action plan.	**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 (HIA): • Parallel chart reviews for the two reviewers. (No criteria.) **Methods to promote consistent application of criteria (KEPRO)**: • Monthly clinical team meetings in which randomly audited charts are reviewed/discussed by peers using the KEPRO compliance department-approved audit tool. • Results of the audit are compared, shared and discussed by the team and submitted to the Compliance Department monthly for review and documentation. • Individual feedback is provided to each clinician during supervision on their authorization as well as plan-of-care reviews.		

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Evidence for UM frequency: • Claims data re ALOS, OARs, the HERC PL and guidelines, InterQual, Centene's clinical policy and guidelines that are reviewed annually and based on national best practice and professional guidelines. • Also, comorbidities and average length of stay impact frequency.	**Evidence for UM frequency (OHA (and designee for level-of-care review), HIA and KEPRO)**: • PA length and CR frequency are tied to HERC PL and guidelines, OAR, CFRs, reviewer expertise and timelines for expectations of improvement. • The Commission that develops HERC consists of 13 appointed members, which include five physicians, a dentist, a public health nurse, a pharmacist and an insurance industry representative, a provider of complementary and alternative medicine, a behavioral health representative and two consumer representatives. The Commission is charged with maintaining a priority list of services, developing or identifying evidence-based health care guidelines and conducting comparative effectiveness research. • HERC guidelines of which there are fewer for MH/SUD than M/S. This is because 1)	**Evidence for UM frequency:** • OARs, the HERC PL and guidelines, InterQual, Centene's clinical policy and guidelines that are reviewed annually and based on best practice and professional guidelines. • Also, comorbidities and average length of stay impact frequency	**Evidence for UM frequency**: • PA length and CR frequency are tied to HERC PL and guidelines, DRGs, OAR, CFRs, reviewer expertise and timelines for expectations of improvement. • The Commission that develops HERC consists of 13 appointed members, which include five physicians, a dentist, a public health nurse, a pharmacist and an insurance industry representative, a provider of complementary and alternative medicine, a behavioral health representative and two consumer representatives. The Commission is charged with maintaining a priority list of services, developing or identifying evidence-based health care guidelines and conducting comparative effectiveness research. • HERC guidelines of which there are more M/S than

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	there are fewer technological procedures for MH/SUD (e.g., cognitive behavioral therapy and psychodynamic therapy are billed using the same codes, no surgeries, few devices); 2) the MH/SUD literature is not as robust (e.g., fewer randomized trials, more subjective diagnoses (or the ICD-10-CM diagnoses represent a spectrum) and less standardization in interventions).		MH/SUD because 1) there are more technological procedures (e.g., surgery, devices, procedures and diagnostic tests); and 2) the literature is more robust.
Data reviewed to determine UM application: • Monthly department audits of PA requests and concurrent review requests, quarterly corporate audits, and PA denial/approval rates.	**Data reviewed to determine UM application (OHA)**: • Denial/appeal overturn rates; number of PA requests; stabilization of cost trends; and number of hearings requested. These data are reviewed in contractor reports, on a quarterly basis by the State. (Applicable to non-residential MH/SUD services in benefit packages E and G.) **Data reviewed to determine UM application (HIA)**: N/A **Data reviewed to determine UM application (KEPRO):** N/A	**Data reviewed to determine UM application**: • Monthly department audits of PA requests and concurrent review requests, quarterly corporate audits, and PA denial/approval rates.	**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: • Plans to implement a 90% standard. **Results of criteria application:** • In 2017, MH/SUD received 21 appeals. Of those 21, 3 were overturned, resulting in a 14% overturn rate.	**IRR standard:** • OHA: N/A • HIA: N/A • KEPRO: N/A **Results of criteria application**: • OHA: 0 appeal overturns. • HIA: 0 appeal overturns. • KEPRO: 0 appeal overturns.	**IRR standard:** • IRR standard is 90%. **Results of criteria application:** • In 2017, M/S received 247 appeals (including DME). Of those 106 were overturned, resulting in a 43% overturn rate.	**IRR Standard**: • N/A **Results of criteria application**: • 0 appeal overturns.

7. Compliance Determination for Benefit Packages CCO A and B

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

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

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

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

Qualified individuals conduct UM applying OARs, HERC, InterQual, and Centene policy for CCO MH/SUD and M/S. The OHA designee reviews authorization requests to determine if the level-of-care is the least restrictive environment. HIA reviews care relative to policy. KEPRO develops PCSPs based on State plan and OAR requirements. *OHA plans to enhance the evidence base for child residential authorization decisions through additional research, resulting in admission and CR criteria development.* Physicians make all CCO MH/SUD and M/S denials. The OHA designee, who is a licensed MH professional, makes denial determinations for level-of-care review for certain child residential services. HIA denials are made by psychiatrists. KEPRO QMHPs develop PCSPs. *OHA plans to ensure that all denial decisions are made by professional peers*. The CCO makes physician-to-physician calls available within 48 hours of notice of a potential denial in addition to RR for MH/SUD and M/S. Upon provider request, the OHA designee obtains RR by HIA. HIA allows reconsideration of CONS determinations, but reported they do not have an RR policy for HIA's CR denials for child residential services. For adult residential and YAP services, KEPRO allows reconsideration of denials with the submission of additional documentation within 10 days of the denial. For OHA and KEPRO, the review of a denial decision occurs in a weekly MMC meeting. *OHA intends to standardize RR processes when feasible*. Providers may appeal a MH/SUD and M/S denial decision by the CCO. OHA FFS reviews denials through the fair hearing process, but HIA and the OHA designee have not encouraged use of this process. *OHA plans to confirm all notices of action, appeal and fair hearing processes are consistent with federal requirements.* Failure to

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

obtain authorization may result in non-coverage, although SCIP, SAIP and subacute services may be covered by general fund dollars. Inclusive of OHA action plans, the MH/SUD and M/S processes are comparable and no more stringently applied to MH/SUD benefits.

Stringency of Strategy and Evidence: Concurrent review is conducted every 5-7 days for MH/SUD IP hospital, which is paid by per diem, while M/S acute IP hospital services paid primarily by DRG are reviewed every 6 days. MH/SUD sub-acute and M/S SNF are reviewed every7 days for the 20 day benefit. PRTS is reviewed every 14 days and INN SUD residential does not require PA, although OON SUD residential is reviewed every 30 days. FFS child residential is reviewed every 30-90 days while FFS adult residential and YAP are reviewed no less than annually, but in practice averages 6 months. OARs, HERC, InterQual and Centene policy for CCO MH/SUD and M/S. *OHA plans to task the FFS residential subcontractors with review of CR frequencies relative to the most recent research to confirm MH/SUD review frequency is directly tied to evidence rather than historical standard practice.* CCO MH/SUD and M/S offer RR. KEPRO makes RR available for 30 days post-admission. The OHA designee and HIA do not have standard policies describing when RR is available. In addition, it was discovered that there are conflicting State rules regarding RR timelines. *OHA plans to standardize the availability of RR, including the conditions under which it is permissible and the timeframes. OHA will align OAR requirements and RR offerings by contractors.* The CCO and State review utilization data to determine if PA or CR should be added or adjusted for MH/SUD and M/S IP benefits. MH/SUD is conducting IRR training prior to IRR testing to promote consistency of criteria application. M/S conducts IRR testing to a standard of 90%. *MH/SUD plans to implement a standard of 90% by the end of the year.* HIA conducts parallel chart reviews for its two reviewers and KEPRO team meetings include random chart audits using a compliance tool followed by team discussion. There is no formal oversight of criteria application for the OHA designee level-of-care review process for certain child residential services. *OHA plans to institute a more formalized measurement of criteria application when feasible.* The CCO reported a 43% appeal overturn rate for M/S and 14% for MH/SUD. FFS MH/SUD had 0 appeal overturns in 2017. Inclusive of OHA and CCO action plans, the strategy and evidence are no more stringently applied to MH/SUD than to M/S in writing or in operation.

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

Below are the OHA action plans:

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

Below is the CCO-specific action plan:

1. *The CCO plans to implement MH/SUD IRR testing to a standard of 90% (same as M/S) by the end of 2018.*

8. Compliance Determination for Benefit Packages CCO E and G:

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

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

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

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

Stringency of Strategy and Evidence: Concurrent review is conducted every 3-5 days for MH/SUD IP hospital (which is paid by per diem), while FFS M/S rarely conducts CR because most IP services are paid by DRG. CCO MH/SUD subacute is reviewed weekly. PRTS frequency of review averages up to 14 days. INN SUD residential does not require PA, although OON SUD residential is reviewed every 30 days. FFS child residential is reviewed every 1-3 months while FFS adult residential and YAP are reviewed no less than annually but in practice average 6 month reviews. SNF is also reviewed no less than annually after the first 20 days. LTAC and rehab hospital (M/S IP) are reviewed monthly. Evidence for the frequency of review for CCO MH/SUD is InterQual, Centene policy, expected length of stay and denial frequency. *OHA plans to task the FFS residential subcontractors with review of CR frequencies relative to the most recent research to confirm MH/SUD review frequency is directly tied to evidence rather than historical standard practice*. CCO MH/SUD offers RR. KEPRO makes RR available for 30 days post-admission. FFS MH/SUD only allows RR for retro-eligibility circumstances. The OHA designee and HIA do not have standard policies describing when RR is available. In addition, it was discovered that there are conflicting State rules regarding RR timelines. *OHA plans to standardize the availability of RR, including the conditions under which it is permissible and the timeframes. OHA will align OAR requirements and RR offerings by contractors*. The CCO and State review utilization data to determine if PA or CR should be added or adjusted for MH/SUD and M/S IP benefits. For MH/SUD the CCO is conducting IRR training prior to IRR testing to promote consistency of criteria application. HIA conducts IRR and parallel chart reviews for its two reviewers and KEPRO team meetings include random chart audits using a compliance tool followed by team discussion. HIA and the OHA designee do not have specific criteria against which decisions are made. FFS M/S conducts

spot-checks through supervision to assess criteria application. *OHA plans to institute a more formalized measurement of criteria application when feasible even though this is not a parity issue in these benefit packages.* The CCO reported a 14% appeal overturn rate for MH/SUD in 2017. FFS M/S appeal overturn rate was 0. Inclusive of OHA and CCO action plans, the strategy and evidence are no more stringently applied to MH/SUD than to M/S in writing or in operation.

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

OUTPATIENT UTILIZATION MANAGEMENT

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

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

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

1. To which benefits is the NQTL assigned?

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
• (1) 1915(c) Comprehensive DD waiver (operated/managed by DHS) • (1) 1915(c) Support Services DD waiver (operated/managed by DHS) • (1) 1915(c) Behavioral DD Model waiver (operated/managed by DHS)	The following services are managed by DHS: • (1) 1915(c) Comprehensive DD waiver • (1) 1915(c) Support Services DD waiver • (1) 1915(c) Behavioral DD Model waiver • (1) 1915(c) Aged & Physically Disabled waiver • (1) 1915(c) Hospital Model waiver	• (2, 3) Specialty services such as psychological testing, ABA, TMS and ECT • (2) Higher levels of care including IOP, PHP, Psychiatric Day Treatment • (Most OP BH services (i.e. individual therapies, group therapy, skill building) including ICTS/IOSS	• (2) OP services on the prioritized list—PT, OT, ST, Allergy testing, Chiropractic services, Sleep disorder evaluation and treatment, • (2) Home health services, nutritionist services, some surgical procedures. • (2, 3) Imaging • (2) DME	The following services are managed by OHA: • (2, 3) Out of hospital births • (2) Home health services • (2) OT, PT, ST, and audiology for M/S conditions (and autistic disorder, which is also managed according to the processes, strategies and

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
• (1)1915(i)(HK) services for adults (home-based habilitation, behavioral habilitation and psychosocial rehab for persons with CMI) (managed by KEPRO under contract with OHA)	• (1) 1915(c) Medically Involved Children's NF waiver • (1) 1915(k) Community First Choice State Plan option • (1) 1915(j): Self-directed personal assistance	and MAT do not require UM) • (2, 3) All experimental and OON services require a PA and are subject to medical necessity review per applicable OARs.	• (2) Hospice, and Palliative Care • (2) OP office visits to Specialists (cardiologists, radiologist, neurologist) • (2, 3) All experimental and out of network services require a PA and are subject to medical necessity review per applicable OARs.	evidentiary standards described for FFS/MS OP) • (2, 3) Imaging • (2) DME

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

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
		increased health or safety risks.	increased health or safety risks.	

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

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
		Implications of Regional Variations in Medicare Spending: Part 2. Health Outcomes and Satisfaction with Care, Center for the Evaluative Clinical Sciences, Dartmouth Medical School, VA Outcomes Group, White River Junction VT, Center for Outcomes Research and Evaluation, Maine Medical Center, & Institute for the Evaluative Clinical Sciences, Toronto, Canada, Financial support was provided by grants from the Robert, Wood Johnson Foundation, the National Institutes of Health (Grant Number CA52192) and the National Institute of Aging (Grant Number	Implications of Regional Variations in Medicare Spending: Part 2. Health Outcomes and Satisfaction with Care, Center for the Evaluative Clinical Sciences, Dartmouth Medical School, VA Outcomes Group, White River Junction VT, Center for Outcomes Research and Evaluation, Maine Medical Center, & Institute for the Evaluative Clinical Sciences, Toronto, Canada, Financial support was provided by grants from the Robert, Wood Johnson Foundation, the National Institutes of Health (Grant Number CA52192) and the National Institute of Aging (Grant Number	

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
		1PO1AG19783-01), 2002, pp 1-32. • (2) Oregon Performance Plan (OPP) requires that BH services are provided in least restrictive setting possible. The OPP is a DOJ-negotiated Olmsted settlement. • (3) HERC guidelines re safety concerns.	1PO1AG19783-01), 2002, pp 1-32. • (3) HERC guidelines re safety concerns.	• (3) HERC guidelines - Recommended limits on services for member safety.

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Timelines for authorizations: • A PCSP must be approved within 90 days from the date a completed application is submitted.	**Timelines for authorizations**: • A PCSP must be approved within 90 days from the date a completed application is submitted.	**Timelines for authorizations:** • Providers are expected to request PA prior to services being administered and may not attempt to collect payment from the member for a service that was not authorized.	**Timelines for authorizations:** • Providers are expected to request PA prior to services being administered and may not attempt to collect payment from the member for a service that was not authorized.	**Timelines for authorizations**: • Urgent requests are processed in 72 hours and immediate requests in 24 hours. Routine requests are processed in 14 days.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
		• Reviews are completed within 14 days of receipt of the standard request and within 72 hours for preservice urgent requests and 24 hours for concurrent urgent requests.	• Reviews are completed within 14 days of receipt of the standard request and within 72 hours for preservice urgent requests and 24 hours for concurrent urgent requests.	
Documentation requirements: • (c)The PCSP is based on a functional needs assessment and other supporting documentation. It is developed by the individual, the individual's team and the individual's case manager. • (i)The PCSP is based on an assessment, service plan, plan-of-care, Level-of-care Utilization System (LOCUS), Level of Service Inventory (LSI) or other relevant	**Documentation 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:** • The auth form is one page. • Reviews require chart notes or clinical information provided via telephone, and only the minimum is required to determine medical necessity as per HIPAA.	**Documentation requirements:** • The auth form is one page. • Reviews require chart notes, and only the minimum is required to determine medical necessity as per HIPAA.	**Documentation requirements**: • A cover page form is required. In addition, diagnostic information, a CPT code(s), a rationale for medical necessity plus any additional supporting documentation are required.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
documentation. The PCSP is developed by the member's treatment team in consultation with the member.				
Method of document submission: • All 1915(c) services must be included in a participant's PCSP and approved by a qualified case manager at the local case management entity (CME) prior to service delivery. • Information is obtained during a face-to-face meeting, often at the individual's location. • (i) Providers submit authorization requests to KEPRO by mail, fax email or via portal, but documentation must still be faxed if the	**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:** • Fax, portal, or telephone call. • The provider is notified via a fax or mailed letter; and the provider portal and/or telephonically.	**Method of document submission:** • Fax or portal. • The provider is notified via a fax or mailed letter; and the provider portal and/or telephonically.	**Method of document submission**: • Paper (fax) or online PA/POC submitted prior to the delivery of services.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
request is submitted via portal. **Qualifications of reviewers**: • (c) A case manager must have at least: – A bachelor's degree (BA) in behavioral science, social science, or a closely related field; or – A BA in any field AND one year of human services related experience; or – An associate's degree (AA) in a behavioral science, social science, or a closely related field AND two	**Qualifications of reviewers**: • A case manager must have at least: – A BA in behavioral science, social science, or a closely related field; or – A BA in any field AND one year of human services related experience; or – An associate's degree (AA) in a behavioral science, social science, or a closely related field AND two years human	**Qualifications of reviewers:** • MH/SUD clinical UM staff definition: Licensed or meeting credentialing criteria for Qualified Mental Health Professional (QMHP). Clinical BH UM staff conduct authorization of services via Level I medical necessity reviews, and consult with the Licensed BH Practitioner (LBHP), TBH Medical Director who is a psychiatrist or licensed doctoral-level clinical psychologist, as needed regarding UM decisions. When needed, LBHP conducts authorization	**Qualifications of reviewers:** • M/S Clinical UM staff definition: Unencumbered licensed nurse or therapist can review and approve. Reviews that do not meet criteria for approval are sent to a Medical Reviewer (Medical Doctor) for determination of denial based on medical necessity. • PA & RR: Potential denials are referred for physician review (within 48 hours for PA).	**Qualifications of reviewers:** • Nurses may authorize and deny services.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
years human services related experience; or – Three years of human services-related experience. (i) **Qualifications of reviewers**: • KEPRO QMHPs must meet minimum qualifications (see below) and demonstrate the ability to conduct and review an assessment, including identifying precipitating events, gathering histories of mental and physical health, substance use, past mental health services and criminal justice contacts, assessing family, cultural, social and work relationships, and conducting/reviewing	services related experience; or – Three years of human services-related experience.	of services via Level II medical necessity reviews. • PA & RR: Potential denials are referred for physician review (within 48 hours for PA).		

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
a mental status examination, complete a DSM diagnosis, write and supervise the implementation of a PCSP. • A QMHP must meet one of the following conditions: – Bachelor's degree in nursing and licensed by the State or Oregon; – Bachelor's degree in occupational therapy and licensed by the State of Oregon; – Graduate degree in psychology; – Graduate degree in social work; – Graduate degree in recreational, art, or music therapy;				

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
– Graduate degree in a behavioral science field; or – A qualified Mental Health Intern, as defined in 309-019-0105(61).				
Criteria: • (c) Qualified case managers approve or deny services in the PCSP consistent with waiver and OAR requirements. • Once a PCSP is approved, services in the PCSP are entered into the payment management system by the CME staff as authorizations. • (i) QMHPs approve or deny services in the PCSP consistent with State plan and OAR requirements. • QMHPs enter prior authorizations into the	**Criteria**: • Qualified case managers approve or deny services in the PCSP consistent with waiver/state plan and OAR requirements. • Once a PCSP is approved, it is entered into the payment management system as authorization by the CME staff.	**Criteria:** • Authorizations are based on ASAM, OARs, HERC PL and guidelines, and federal guidelines.	**Criteria:** • Authorizations are based on InterQual, OARs, HERC PL and guidelines, federal guidelines.	**Criteria:** • Authorizations are based on the HERC PL and guidelines, Oregon Statute, Oregon Administrative rules, federal regulations, and evidence-based guidelines from private and professional associations such as the Society of American Gastrointestinal and Endoscopic Surgeons where no State or federal guidelines exist.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
MMIS based on the member's PCSP. **Reconsideration/RR**: • (c) N/A • (i) Within 10 days of a denial, the provider may send additional documentation to KEPRO for reconsideration. • (i) A provider may request review of a denial decision, which occurs in weekly MMC meetings or KEPRO's own comparable MMC meeting. **Consequences for failure to authorize**: • Failure to obtain authorization may result in non-payment.	**Reconsideration/RR**: • N/A **Consequences for failure to authorize**: • Failure to obtain authorization may result in non-payment.	**Reconsideration/RR:** • A treating physician/provider can request a physician to physician call within 48 hours of notification of the potential denial to discuss the requested services with the health plan's physician. • Potential denials are referred for physician review. The reviewing medical director can make exceptions to the PA process. **Consequences for failure to authorize:** • Failure to obtain authorization or a request for RR in combination with the absence of medical necessity results in a referral for physician	**Reconsideration/RR:** • A treating physician/provider can request a physician to physician call within 48 hours of notification of the potential denial to discuss the requested services with the health plan's physician. • Potential denials are referred for physician review. The reviewing medical director can make exceptions to the PA process. **Consequences for failure to authorize:** • Failure to obtain authorization or a request for RR in combination with the absence of medical necessity results in a referral for physician	**Reconsideration/RR**: • A review of a denial decision can be requested and is reviewed in weekly MMC meetings. **Consequences for failure to authorize**: • Failure to obtain authorization may result in non-payment.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Appeals: Notice and fair hearing rights apply.	**Appeals**: Notice and fair hearing rights apply.	review with a potential for a denial. • Denials may result in non-payment. **Appeals:** • Standard appeal and hearing processes apply.	review with a potential for a denial. • Denials may result in non-payment. **Appeals:** • Standard appeal and hearing processes apply.	**Appeals**: Members may request a hearing on any denial decision.

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Frequency of review: • PCSPs are reviewed and revised as needed, but at least every 12 months.	**Frequency of review:** • PCSPs are reviewed and revised as needed, but at least every 12 months.	**Frequency of review:** • Average length of stay for MH/SUD OP services varies based upon medical necessity. • Concurrent review frequency depends upon level-of-care. ABA, ECT, MH IOP/PHP, and Neuropsychological/Psychological Testing services authorized for	**Frequency of review:** • Average length of PA for M/S services varies based upon medical necessity with a range of 30-90 days.	**Frequency of review**: • PA is granted for different authorization periods depending on the service and can be adjusted. Authorizations for extensive services usually range from 6 months to 1 year. • PT, ST, OT authorizations are usually for one year (i.e., 30 visits). • Exceptions may be made at the discretion of the MMC which is

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
		up to 6 months at a time. • Initial TMS services authorized for up to 25 visits and concurrent requests authorized for up to 16 visits within initial authorization date range. • Psychiatric Day Treatment Services authorized for up to 30 days at a time.		led by the HSD medical director.
RR conditions and timelines: • (c) N/A • (i) Within 10 days of a denial, the provider may send additional documentation to KEPRO for reconsideration • (i) A provider may request review of a denial decision, which occurs in weekly Medical Management meetings or KEPRO's	**RR conditions and timelines:** • N/A	**RR conditions and timelines:** • RR is available. • Peer to peer is offered within 48 hours of a potential denial.	**RR conditions and timelines:** • RR is available. • Peer to peer is offered within 48 hours of a potential denial.	**RR conditions and timelines:** • RR available for retro eligibility circumstances.

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

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

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Evidence for UM frequency: • Federal requirements regarding PCSPs and 1915(c) and 1915(i) services (e.g., 42 CFR 441.301 and 441.725) and the applicable approved 1915(c) waiver application/1915(i) State plan amendment.	**Evidence for UM frequency**: • Federal requirements regarding PCSPs and 1915(c), 1915(k), and 1915(j) services (e.g., 42 CFR 441.301, 441.468, and 441.540) and the applicable approved 1915(c) waiver application/State plan amendment.	**Evidence for UM frequency:** • OARs (e.g., timelines for treatment plan updates for OP and day treatment), the HERC PL, InterQual, Centene's clinical policy and guidelines, which are reviewed annually and are based on best practice (e.g., SAMHSA), and professional guidelines.	**Evidence for UM frequency:** • OARs, the HERC PL, InterQual, Centene's clinical policy and guidelines, which are reviewed annually and are based on best practice, and professional guidelines.	**Evidence for UM frequency**: • HERC guidelines of which there are more M/S than MH/SUD because 1) there are more technological procedures (e.g., surgery, devices, procedures and diagnostic tests); and 2) the literature is more robust. • The amount of time a PA covers for services is limited by OAR 410-120-1320(7) which states that PAs can be approved and renewed up to 1 year at a time. • Whenever possible, practice guidelines from clinical professional organizations such as the American Medical Association or the

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
				American Psychiatric Association, are used to establish PA frequency.
Data reviewed to determine UM application: • N/A	**Data reviewed to determine UM application**: • N/A	**Data reviewed to determine UM application:** • Measures that assess UM: Monthly department audits of PA requests and concurrent review requests, quarterly corporate audits, and PA denial/approval rates.	**Data reviewed to determine UM application:** • Measures that assess UM: Monthly department audits of PA requests and concurrent review requests, quarterly corporate audits, and PA denial/approval rates.	**Data reviewed to determine UM application**: • A physician-led group of clinical professionals conducts an annual review to determine which services receive or retain a PA; items reviewed include: – Utilization – Approval/denial rates – Documentation/ justification of services – Cost data
IRR standard: • N/A	**IRR standard:** • N/A	**IRR standard:** • NA	**IRR standard:** • 90%	**IRR standard:** • N/A

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Results of criteria application (appeal overturn rates): • (c): 0 appeal overturns • (i) (KEPRO) 11% appeal overturn rate (1 out of 9 hearings)	**Results of criteria application (appeal overturn rates):** • (c) for I/DD: 0 appeal overturns • (c) for APD plus (k) and (j): 0.8% appeal overturn rate	**Results of criteria application (appeal overturn rates):** MH/SUD OP: • Number of Denials = 66 • Appeal Overturn Rate = 3%	**Results of criteria application (appeal overturn rates):** M/S OP: • Number of Denials = 120 • Number of Appeal Overturns = 0	**Results of criteria application (appeal overturn rates):** • 0 appeal overturns

7. Compliance Determination for Benefit Packages CCO A and B

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

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

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

Comparability and Stringency of Processes: HCBS MH/SUD benefits are administered by DHS and KEPRO while HCBS M/S benefits are administered by DHS. PCSPs for both M/S and MH/SUD must be developed within 90 days. The PCSP for both MH/SUD and M/S is based on an assessment and other relevant supporting documentation. It is developed by the individual, the individual's team and the individual's case manager. MH/SUD and M/S DHS reviewers must have a BA in a related field; a BA in any field plus one year experience; an AA with two years' experience; or three years' experience. KEPRO reviewers for 1915(i) services must have a nursing or OT license, a graduate degree in a related field or be a qualified MH intern. KEPRO's higher education requirements do not present a parity concern because they impact quality not the stringency of criteria application. MH/SUD and M/S review documentation relative to waiver application/State plan amendment

requirements, and the approved PCSP is entered as service authorization. KEPRO offers reconsideration and RR, although DHS does not offer RR when services are not authorized. Failure to obtain authorization may result in non-payment for MH/SUD and M/S. Notice and fair hearing rights apply. Accordingly, UM processes are comparable and no more stringently applied to HCBS MH/SUD benefits than to M/S benefits.

Non-HCBS CCO MH/SUD and M/S OP benefit reviews are conducted by qualified clinicians who evaluate clinical information that is submitted via fax or web-portal, relative to InterQual, ASAM, HERC, or OARs. CCO MH/SUD and M/S requires submission of an authorization form and information supportive of medical necessity such as chart notes. Timelines for authorization decisions are the same for MH/SUD and M/S and defined in OARs. Failure to obtain authorization may result in non-payment for MH/SUD and M/S services; although an exception process allows RR and physician-to-physician review, and standard appeal processes apply. There are no differences in processes for children and adults that are not tied to practice guidelines. Accordingly, UM processes are comparable to, and no more stringently applied, to non-HCBS CCO MH/SUD benefits than to M/S benefits.

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

Non-HCBS CCO MH/SUD service authorizations vary but range from 30 days for PDTS to 6 months (for ABA, ECT, IOP, and testing) of service. M/S reported authorization lengths that vary from 30 – 90 days. Service authorization lengths are based on InterQual, ASAM, OARs, HERC and Centene policy. CCO M/S conducts IRR testing to a standard of 90%. CCO MH/SUD is conducting IRR training *with the intent of moving to IRR testing to a standard of 90%.* The CCO reviews utilization and other data to determine if UM requires adjustment. MH/SUD and M/S report appeal overturn rates of 3% and 0 respectively. Inclusive of the CCO action plan, the UM strategy and evidence are no more stringently applied to MH/SUD than to M/S OP benefits in operation or in writing.

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

8. Compliance Determination for Benefit Packages E and G

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

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

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

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

Non-HCBS CCO MH/SUD benefit reviews are conducted by qualified clinicians who evaluate clinical information that is submitted via phone, fax or web-portal, relative to InterQual and ASAM, HERC, and OARs. CCO MH/SUD requires submission of an authorization form and information supportive of medical necessity such as chart notes. Similarly, FFS M/S benefit reviews are conducted by qualified clinicians that evaluate clinical information that supports medical necessity (which may include POCs) submitted via paper (fax) or online relative to OARs and HERC. Timelines for authorization decisions are the same for MH/SUD and M/S and defined in OARs. Failure to obtain authorization may result in non-payment for MH/SUD and M/S services; although an exception process allows RR for CCO MH/SUD and FFS M/S benefits. Appeal processes

apply for both CCO MH/SUD and FFS M/S. There are no differences in processes for children and adults that are not tied to practice guidelines. Accordingly, UM processes are comparable to, and no more stringently applied, to non-HCBS MH/SUD benefits than to M/S benefits.

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

Non-HCBS CCO MH/SUD service authorizations vary, but range from 30 days for PDTS to 6 months (for ABA, ECT, IOP, and testing) of service. Service authorization lengths are based on InterQual, ASAM, OARs, HERC and Centene policy. FFS M/S authorization lengths range from 6 months to one year. These lengths are tied to HERC. The CCO allows RR for MH/SUD while FFS offers RR for retroactive eligibility. CCO MH/SUD MNC application is evaluated during IRR training. FFS M/S application is spot-checked through supervision and chart review. At a minimum, the CCO and State review utilization and other data to determine if UM requires adjustment. MH/SUD and M/S reported appeal overturn rates of 3% and 0 respectively. As a result, the UM strategy and evidence are no more stringently applied to MH/SUD than to M/S OP benefits in operation or in writing.

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

PRIOR AUTHORIZATION FOR PRESCRIPTION DRUGS

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

1. To which benefits is the NQTL assigned?

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

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• To 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. Comparability of Evidentiary Standard: What evidence supports the rationale for the assignment?

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• PA criteria are created by pharmacists and in consultation with the CCO's 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.	• PA criteria are created by pharmacists and in consultation with the CCO's P&T Committee based on best practices, professional guidelines and the Prioritized List.

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• Prescribers request prior authorization (PA) by completing a one page request form. Most PA criteria require chart notes. Forms and notes may be mailed, but are typically faxed. • All requests are responded to within 24 hours. • The PA criteria are developed by pharmacists and approved by the P&T Committee. • Failure to obtain PA in combination with an absence of medical necessity results in the member not receiving the medication and the request being denied.	• 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.	• Prescribers request prior authorization (PA) by completing a one page request form. Most PA criteria require chart notes. Forms and notes may be mailed, but are typically faxed. • All requests are responded to within 24 hours. • The PA criteria are developed by pharmacists and approved by the P&T Committee. • Failure to obtain PA in combination with an absence of medical necessity results in the member not receiving the medication and the request being denied.

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• PA approval can be for the length of the therapy request or up to 5 years, depending on medical appropriateness and safety, as recommended by the CCO's P&T Committee. • Approximately 18% of MH/SUD drugs are subject to PA criteria for clinical reasons.	• The State approves PAs for up to 12 months, depending on medical appropriateness and safety, as recommended by the P&T Committee. • Approximately 17% of MH drugs are subject to PA criteria for clinical reasons.	• PA approval can be for the length of the therapy request or up to 5 years, depending on medical appropriateness and safety, as recommended by the CCO's P&T Committee. • Approximately 6% of M/S drugs are subject to PA criteria for clinical reasons.

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• Providers and members may both appeal, and members have fair hearing rights. • The appeal overturn rate for CY 2017 was 44%. The main reason for overturn was additional information was provided. • The CCO assesses stringency through therapeutic class reviews. Each therapeutic class is reviewed at least annually. When a therapeutic class is reviewed, the medications with PA in that class are reviewed to determine if PA should continue to be required. • The CCO conducts inter-rater reliability testing to ensure consistency in the review process. • PA criteria are reviewed for appropriateness on an annual basis.	• The State allows providers to submit additional information for reconsideration of a denial. • Providers can appeal denials on behalf of a member, and members have fair hearing rights. • The appeal overturn rates for MH carve out drugs was 8:2 (25%). • The State assesses stringency through review of PA denial/approval and appeal rates; number of drugs requiring PA; number of PA requests; and pharmacy utilization data/report. • PA criteria are reviewed as needed due to clinical developments, literature, studies, and FDA medication approvals.	• Providers and members may both appeal, and members have fair hearing rights. • The appeal overturn rate for CY 2017 was 44%. The main reason for overturn was additional information was provided. • The CCO assesses stringency through therapeutic class reviews. Each therapeutic class is reviewed at least annually. When a therapeutic class is reviewed, the medications with PA in that class are reviewed to determine if PA should continue to be required. • The CCO conducts inter-rater reliability testing to ensure consistency in the review process. • PA criteria are reviewed for appropriateness on an annual basis.

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• In consultation with the P&T Committee, pharmacists review medication and create criteria and policies utilizing evidence-based medicine, best practices, clinical guidelines, and the Prioritized List.	• FDA prescribing guidelines, medical evidence, best practices, professional guidelines, and P&T Committee review and recommendations. • Federal and state regulations/OAR and the Prioritized List.	• In consultation with the P&T Committee, pharmacists review medication and create criteria and policies utilizing evidence-based medicine, best practices, clinical guidelines, and the Prioritized List.

7. Compliance Determination for Benefit Packages CCO A and B

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

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

Stringency of Strategy and Evidence: Both the CCO and the State approve PAs for up to 12 months. However, the CCO approves certain long-term medications with diagnoses that do not change for up to five years, so that the provider does not have to seek approval for each prescription renewal. This applies to both CCO MH/SUD and M/S medications so it is not a parity concern within the CCO. And while this is less stringent than authorization periods for FFS MH carve out drugs, pursuant to State rule, the State cannot authorize any FFS service for more than 12 months. For both MH/SUD (FFS and CCO) and M/S drugs, the length of prior authorization depends on medical appropriateness and safety, as recommended by the applicable P&T Committee based on evidence such as FDA prescribing guidelines, best practices, and professional guidelines. The State assesses the stringency of strategy through review of PA denial/approval and appeal rates, and the CCO assess stringency of strategy through therapeutic class reviews. The percent of MH/SUD drugs subject to PA requirements is comparable to M/S drugs. In addition, the appeal overturn rates are comparable. As a result, the strategies and evidentiary standards for prior authorization of prescription drugs are applied no more stringently to MH/SUD drugs than to M/S drugs.

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

PROVIDER ADMISSION — CLOSED NETWORK

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• CCO may close its network for new MH/SUD providers of inpatient services. • CCO may close its network for new MH/SUD providers of outpatient services.	• The State does not restrict new providers of inpatient or outpatient MH/SUD services from enrollment.	• CCO may close its network for new M/S providers of inpatient services. • CCO may close its network for new M/S providers of outpatient services.	• The State does not restrict new providers of inpatient or outpatient MH/SUD services from enrollment.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• When CCO closes its network to new MH/SUD providers, it is done to: – Balance member access needs with safety and quality concerns. – Balance member access needs with cost effectiveness/cost control.	• N/A	• When CCO closes its network to new M/S providers, it is done to: – Balance member access needs with safety and quality concerns. – Balance member access needs with cost effectiveness/cost control.	• N/A

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

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• New providers that are denied admission into the network due to network closure will not be able to participate in the CCO network and may not be	• N/A	• New providers that are denied admission into the network due to network closure will not be able to participate in the CCO network and may not be	• N/A

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
reimbursed for services provided to CCO members. • CCO reviews every application submitted by new providers and reviews against the CCO's network adequacy evaluation. The CCO behavioral health section conducts the initial review of provider applications against MH/SUD network sufficiency and provides a recommendation to deny an application based upon a closed network. • CCO's Provider Network Management is responsible for the decision-making process to close the network. • CCO considers the need for particular service/provider types, geographic-specific needs, provider to enrollee ratios, and provider specialties in making the determination to close the network. • Providers that are denied the opportunity to participate in CCO's network may		reimbursed for services provided to CCO members. • CCO reviews every application submitted by new providers and reviews against the CCO's network adequacy evaluation. The CCO behavioral health section conducts the initial review of provider applications against M/S network sufficiency and provides a recommendation to deny an application based upon a closed network. • CCO's Provider Network Management is responsible for the decision-making process to close the network. • CCO considers the need for particular service/provider types, geographic-specific needs, provider to enrollee ratios, and provider specialties in making the determination to close the network. • Providers that are denied the opportunity to participate in CCO's network may challenge CCO's decision by	

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
challenge CCO's decision by requesting a re-review of the application, including additional information if available. • Exceptions to the CCOs decision to close the network to particular provider types may be made if the provider offers additional information to the CCO to demonstrate a specialty that would add value to the network.		requesting a re-review of the application, including additional information if available. • Exceptions to the CCOs decision to close the network to particular provider types may be made if the provider offers additional information to the CCO to demonstrate a specialty that would add value to the network.	

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• When the CCO decides to close the network to particular specialties/ provider types, all new providers applying for those particular providers/provider types are subject to this NQTL. • Four providers were impacted by CCO's decision to close all or part of its network to new providers in the last contract year.	• N/A	• When the CCO decides to close the network to particular specialties/ provider types, all new providers applying for those particular providers/provider types are subject to this NQTL. • Eighteen providers were impacted by CCO's decision to close all or part of its network to new providers in the last contract year.	• N/A

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• The CCO reviews the following data/information to determine how strictly to apply the criteria/considerations to close the CCO network to new providers: – Member access to care measures (e.g., timely access, distance) – Provider to member ratios – Provider availability – Number of out of network requests and/or single case agreements	• N/A	• The CCO reviews the following data/information to determine how strictly to apply the criteria/considerations to close the CCO network to new providers: – Member access to care measures (e.g., timely access, distance) – Provider to member ratios – Provider availability – Number of out of network requests and/or single case agreements	• N/A

7. Compliance Determination for Benefit Packages CCO A and B

Comparability of Strategy and Evidence: The CCO may close its network to new providers of MH/SUD and M/S inpatient and outpatient services. When the CCO closes its network to new MH/SUD and M/S providers, it is done to balance access needs with safety and quality concerns and to balance member access needs with cost effectiveness/cost control. The CCO follows established Federal and State regulations when imposing limitations upon new MH/SUD and M/S providers applying to participate in network.

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

Comparability and Stringency of Processes: When the CCO determines that particular provider types are not needed, requests to join the CCO's network are declined and the provider may not be reimbursed for provided services. The CCO reviews every MH/SUD and M/S

application submitted by new providers and reviews against the CCO's network adequacy evaluation. The CCO behavioral health section conducts the initial review of provider applications against MH/SUD network sufficiency and provides a recommendation to deny an application based upon a closed network. For both MH/SUD and M/S providers, the CCO evaluates the need for particular service/provider types, geographic-specific needs, provider to enrollee ratios, and provider specialties in making the determination to close the network. MH/SUD and M/S providers denied the opportunity to participate in the CCO's network may challenge the CCO's decision by requesting a re-review of the application, including additional information if available.

Exceptions may be made if the MH/SUD or M/S provider offers additional information to the CCO to demonstrate a specialty that would add value to the network. Based upon these findings, the CCO's network closure processes for providers of MH/SUD services are comparable and applied no more stringently than for providers of M/S.

Stringency of Strategy and Evidence: When the CCO decides to close the network to particular specialties/provider types, all new MH/SUD and M/S providers applying for those particular specialties/provider types are subject to the NQTL. In operation, The CCO's decision to close all or part of its network has had a greater impact on M/S providers than to MH/SUD providers; 4 MH/SUD providers were denied participation in network due to the CCO's decision to close all or part of its network, whereas 18 M/S providers were impacted.

The CCO monitors similar metrics related to decisions to close the network across MH/SUD and M/S, reviewing information such as access standards, provider to member ratios, provider availability, and number of out of network requests and/or single case agreements. As a result, the strategies and evidentiary standards for network closure are no more stringently applied to MH/SUD providers than to M/S providers.

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

8. Compliance Determination for Benefit Packages CCO E and G

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

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

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

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

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

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

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

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

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• All providers must meet credentialing and recredentialing requirements. • Providers must complete and provide CAQH or OPCA application, liability insurance, ownership and disclosure form. • Providers may submit supporting documentation by fax, e-mail, US mail or through CAQH's web portal. • CCO's credentialing process involves:	• All providers are eligible to enroll as a provider and receive reimbursement provided they meet all relevant Federal and State licensing and other rules and are not on an exclusionary list. • Providers must complete forms and documentation required for their provider type. This includes information demonstrating the provider meets provider enrollment requirements such	• All providers must meet credentialing and recredentialing requirements. • Providers must complete and provide CAQH or OPCA application, liability insurance, ownership and disclosure form. • Providers may submit supporting documentation by fax, e-mail, US mail or through CAQH's web portal. • CCO's credentialing process involves:	• All providers are eligible to enroll as a provider and receive reimbursement provided they meet all relevant Federal and State licensing and other rules and are not on an exclusionary list. • Providers must complete forms and documentation required for their provider type. This includes information demonstrating the provider meets provider enrollment requirements,

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
– Review to ensure application is complete, – Primary source verification of licensure, board certification, Education/training, State/Federal exclusion/debarment lists, and NPDB. – Secondary source verification of work history and hospital privileges. • CCO's credentialing process averages 15.2 days. • CCO's Medical Director/Credentialing Committee is responsible for reviewing required information and making provider credentialing decisions. • CCO performs recredentialing every 36 months. • Providers who do not meet credentialing/re-credentialing requirements are denied from participation in network. • Providers who are adversely affected by credentialing or recredentialing decisions may	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.	– Review to ensure application is complete, – Primary source verification of licensure, board certification, Education/training, State/Federal exclusion/debarment lists, and NPDB. – Secondary source verification of work history and hospital privileges. • CCO's credentialing process averages 15.2 days. • CCO's Medical Director/Credentialing Committee is responsible for reviewing required information and making provider credentialing decisions. • CCO performs recredentialing every 36 months. • Providers who do not meet credentialing/re-credentialing requirements are denied from participation in network. • Providers who are adversely affected by credentialing or recredentialing decisions may	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.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
challenge the decision through a formal appeal process as outlined in CC.Cred.08 (same process that is followed for providers of M/S services).	• State staff in the provider enrollment unit are responsible for reviewing information and making provider enrollment decisions. • The State reviews all provider enrollment every three years, as required by Federal regulations. • Providers who are not enrolled/re-enrolled are not eligible for Medicaid reimbursement. • Providers who are denied enrollment or re-enrollment may appeal the decision to the State.	challenge the decision through a formal appeal process as outlined in CC.Cred.08 (same process that is followed for providers of M/S services).	• State staff in the provider enrollment unit are responsible for reviewing information and making provider enrollment decisions. • The State reviews all provider enrollment every three years, as required by Federal regulations. • Providers who are not enrolled/re-enrolled are not eligible for Medicaid reimbursement. • Providers who are denied enrollment or re-enrollment may appeal the decision to the State.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• All providers/provider types must be credentialed. • There are no exceptions to meeting these requirements. • Providers in exceptional circumstances may be able to be reimbursed for services as OON providers.	• All providers/provider types are subject to enrollment/re-enrollment requirements. • There are no exceptions to meeting provider enrollment/re-enrollment requirements. • Less than 1% of providers were denied admission, and	• All providers/provider types must be credentialed. • There are no exceptions to meeting these requirements. • Providers in exceptional circumstances may be able to be reimbursed for services as OON providers.	• All providers/provider types are subject to enrollment/re-enrollment requirements. • There are no exceptions to meeting provider enrollment/re-enrollment requirements. • Less than 1% of providers were denied admission, and

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Less than 1% of providers were denied admission or terminated from the network in the last contract year as a result of credentialing and recredentialing.	.005% of providers were terminated last CY for failure to meet enrollment/re-enrollment requirements.	• Less than 1% of providers were denied admission or terminated from the network in the last contract year as a result of credentialing and recredentialing.	.005% of providers were terminated last CY for failure to meet enrollment/re-enrollment requirements.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Requirement to conduct credentialing for all new providers is established by State law and Federal regulations. • The frequency with which CCO performs recredentialing is based upon: – State law and Federal regulations – State contract requirements – Monitoring of provider performance, such as quality monitoring and licensing information – National accreditation standards (NCQA) • CCO monitors the following data/information to determine how strictly to apply	• 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 recredentialing is based upon: – State law and Federal regulations – State contract requirements – Monitoring of provider performance, such as quality monitoring and licensing information – National accreditation standards (NCQA) • CCO monitors the following data/information to determine how strictly to apply	• 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
credentialing/ recredentialing criteria**:** – Quarterly reports that measure the volume of denied and approved credentialing/ recredentialing decisions – Complaints and grievances on credentialing decisions – Network adequacy data, such as access to care, provider specialties.		credentialing/ recredentialing criteria**:** – Quarterly reports that measure the volume of denied and approved credentialing/ recredentialing decisions – Complaints and grievances on credentialing decisions – Network adequacy data, such as access to care, provider specialties.	

7. Compliance Determination for Benefit Packages CCO A and B

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

Comparability and Stringency of Processes: All providers of MH/SUD and M/S services must successfully meet credentialing and re-credentialing requirements in order to be admitted to and continue to participate in the CCO's network. The information and documentation new providers are required to complete and submit as part of the credentialing process is substantially the same. Providers complete the CAQH or OPCA application, liability insurance, ownership and disclosure form**.**

Both MH/SUD and M/S providers are offered several methods of submitting their application and supporting documentation, including fax, e-mail, US mail or through CAQH's web portal. The CCO's credentialing process involves ensuring the application is complete, primary source

verification of licensure, board certification, education/training, State/Federal exclusion/debarment lists, and NPDB, and secondary source verification of work history and hospital privileges.

The CCO's credentialing process for both MH/SUD and M/S providers includes the Medical Director/Credentialing Committee, who are responsible for reviewing required information and making provider credentialing decisions. The credentialing process for both MH/SUD and M/S providers averages 15.2 days. Re-credentialing for both MH/SUD and M/S providers is conducted every 36 months, as required by OAR and the national accreditation standards used by the CCO (NQCA). MH/SUD and M/S providers who fail to meet credentialing and re-credentialing requirements cannot participate in the CCO's network. Both MHSUD and MS may appeal negative credentialing and re-credentialing decisions.

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

Stringency of Strategy and Evidence: All MH/SUD and M/S providers are subject to meeting credentialing and re-credentialing requirements; there are no exceptions. In operation, MH/SUD and M/S providers have been comparably impacted by the application of credentialing and re-credentialing requirements, with fewer than 1% of MH/SUD and M/S providers terminated from the network or denied admission in the last contract year.

The CCO monitors similar metrics related to applying credentialing and re-credentialing requirements for MH/SUD and M/S providers, including reviewing quarterly reports that measure the volume of denied and approved credentialing/recredentialing decisions, complaints and grievances, and network adequacy data such as access to care and provider specialties. As a result, the strategies and evidentiary standards for credentialing and re-credentialing are no more stringently applied to MH/SUD providers than to M/S providers.

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

8. Compliance Determination for Benefit Packages CCO E and G

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

PROVIDER ADMISSION — PROVIDER EXCLUSIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Compliance Determination for Benefit Packages CCO A and B

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

8. Compliance Determination for Benefit Packages CCO E and G

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

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

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

1. To which benefits is the NQTL assigned?

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

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

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

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

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

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• 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 include special needs of the member and availability of a qualified	• 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 include special needs of the member and availability of a qualified	• 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
provider within contract access standards. • The CCO developed its criteria for non-emergency OON/OOS coverage to include consideration of continuity of care, complexity of the case, and lack of in network provider of same specialty and expertise. • 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 a single case agreement (SCA) with an OON/OOS provider if the provider does not agree to the DMAP rate. • The CCO's process for establishing a SCA includes processing a request from a provider for a special rate that comes in through the UM	• Requests for non-emergency OOS services are made through the State prior authorization process. • The average length of time to receive an approval or denial of a non-emergency OON request is the same as for other prior authorizations (14 days for standard and 72 hours for urgent). • OOS providers must enroll with Oregon Medicaid. • The State pays OOS providers the Medicaid FFS rate.	provider within contract access standards. • The CCO developed its criteria for non-emergency OON/OOS coverage to include consideration of continuity of care, complexity of the case, and lack of in network provider of same specialty and expertise. • 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 a single case agreement (SCA) with an OON/OOS provider if the provider does not agree to the DMAP rate. • The CCO's process for establishing a SCA includes processing a request from a Provider for a special rate that comes in through the UM	• Requests for non-emergency OOS services are made through the State prior authorization process. • The average length of time to receive an approval or denial of a non-emergency OON request is the same as for other prior authorizations (14 days for standard and 72 hours for urgent). • OOS providers must enroll with Oregon Medicaid. • The State pays OOS providers the Medicaid FFS rate.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
team during the PA process and is given to Contracting to follow up on business demographics, Medicaid and Provider numbers, and then negotiate the terms of the agreement. • The average length of time to negotiate a SCA is 3 days. The CCO's standard practice is to complete the SCA within the PA timeframes. • 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.		team during the PA process and is given to Contracting to follow up on business demographics, Medicaid and Provider numbers, and then negotiate the terms of the agreement. • The average length of time to negotiate a SCA is 3 days. The CCO's standard practice is to complete the SCA within the PA timeframes. • 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. Stringency of Strategy: How frequently or strictly is the NQTL applied?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• In cases where services cannot be reasonably obtained by a network/in-State provider, OON/OOS services can be rendered if the services are medically necessary, a covered service, and authorized by the CCO. • The decision to authorize use of an OON/OOS provider will be based on continuity of care, complexity of the case and the lack of availability of an in-network/in-State provider of the same specialty and expertise. • Services will be authorized as long as the service is needed or until the service can be provided by an in-network/in-State provider. • The CCO will coordinate payment with the OON/OOS provider and ensure the cost to the member is not greater than it would be if the services were furnished by an in-network provider.	• If a request for a non-emergency OOS benefit does not meet the OAR criteria, it will not be prior authorized. • If a non-emergency OOS benefit is not prior authorized, the service will not be covered, and payment for the service will be denied. • Members/providers may appeal the denial of an OOS request. • The State measures the stringency of the application of OOS requirements by reviewing OOS denial/appeal rates.	• In cases where services cannot be reasonably obtained by a network/in-State provider, OON/OOS services can be rendered if the services are medically necessary, a covered service, and authorized by the CCO. • The decision to authorize use of an OON/OOS provider will be cased on continuity of care, complexity of the case and the lack of availability of an in-network/in-State provider of the same specialty and expertise. • Services will be authorized as long as the service is needed or until the service can be provided by an in-network/in-State provider. • The CCO will coordinate payment with the OON/OOS provider and ensure the cost to the member is not greater than it would be if the services were furnished by an in-network provider. • The CCO will coordinate with the OON/OOS provider with	• If a request for a non-emergency OOS benefit does not meet the OAR criteria, it will not be prior authorized. • If a non-emergency OOS benefit is not prior authorized, the service will not be covered, and payment for the service will be denied. • Members/providers may appeal the denial of an OOS request. • The State measures the stringency of the application of OOS requirements by reviewing OOS denial/appeal rates.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• The CCO will coordinate with the OON/OOS provider with regard to payment and communication with member's primary care physician (PCP). • 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 was unable to determine the number of OON/OOS requests that were received, denied, appealed, or overturned on appeal for CY 2017. • The CCO measures the stringency of the application of OON requirements by reviewing OON denial/appeal rates. • The CCO evaluates the number of SCAs twice a year to determine whether the network should be expanded or a particular OON should be		regard to payment and communication with member's primary care physician (PCP). • 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 was unable to determine the number of OON/OOS requests that were received, denied, appealed, or overturned on appeal for CY 2017. • The CCO measures the stringency of the application of OON requirements by reviewing OON denial/appeal rates. • The CCO evaluates the number of SCAs twice a year to determine whether the network should be expanded or a particular OON should be recruited to be a network provider.	

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
recruited to be a network provider.			

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

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

7. Compliance Determination for Benefit Packages CCO A and B

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

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

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

the Medicaid FFS rate, a percentage of the Medicaid FFS rate, or a negotiated rate. Based on this, the processes for MH/SUD and M/S non-emergency OON/OOS benefits are comparable and applied no more stringently to MH/SUD non-emergency OON/OOS benefits.

Stringency of Strategy and Evidence: For both MH/SUD and M/S, if a request for a non-emergency OON/OOS benefit does not meet applicable criteria, which are based on Federal and State requirements, it will not be authorized, and payment for the service will be denied by the CCO/State. Members and providers may appeal the denial of OON/OOS authorization requests to the CCO/State as applicable. Neither the State nor the CCO was able to provide statistics regarding OON/OOS requests. The strategies and evidentiary standards for OON/OOS are no more stringently applied to MH/SUD benefits than to M/S benefits.

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

8. Compliance Determination for Benefit Packages CCO E and G

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

Comparability and Stringency of Processes: Requests for non-emergency OOS FFS MH/SUD and M/S benefits are made through the State's prior authorization process and are reviewed for medical necessity and in-State coverage. The prior authorization timeframes (14 days for standard requests and 72 hours for urgent requests) apply. Similarly, the CCO reviews requests for non-emergency OON/OOS MH/SUD services through its prior authorization process, and the prior authorization timeframes (14 days for standard requests and 72 hours for urgent requests) apply. OOS FFS MH/SUD and M/S providers are reimbursed the Medicaid FFS rate. If the OOS provider is not enrolled in Oregon Medicaid, the provider must enroll in Oregon Medicaid. The CCO also requires OON/OOS MH/SUD providers to be enrolled with Oregon

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

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

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