Oregon Health Authority

2020 Mental Health Parity Analysis Report

for

Umpqua Health Alliance, LLC

February 2021

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Introduction

Overview of Oregon's Mental Health Parity Analysis

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

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

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

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

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

Components of the 2020 MHP Analysis

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

Figure 1-1—MHP: Four Prescribed Classifications

OHP Benefit Packages

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

Table 1-1—OHP Benefit Packages

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

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

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

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

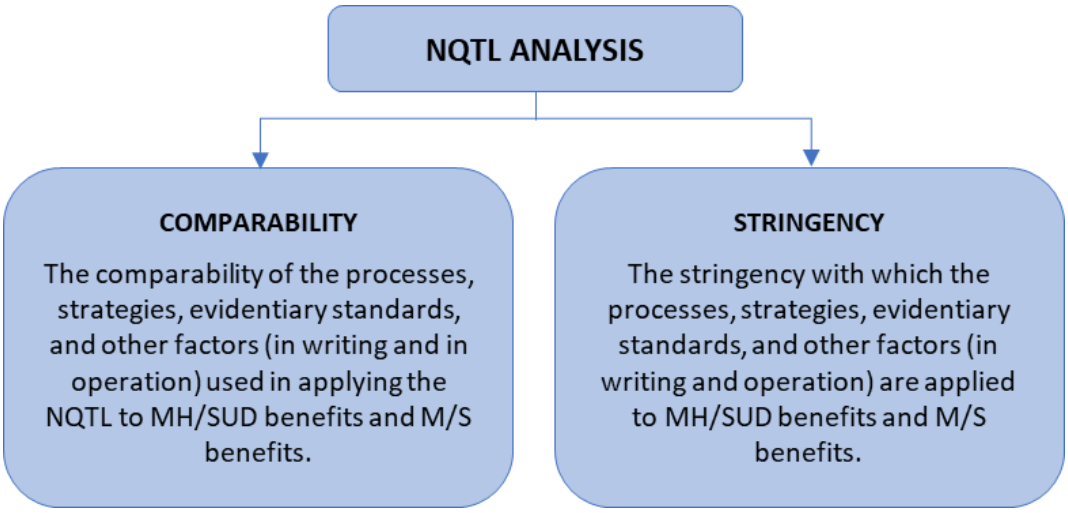
Non-Quantitative Treatment Limitations

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

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

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

Figure 1-2—MHP Analysis Comparability and Stringency



NQTL Categories

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

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

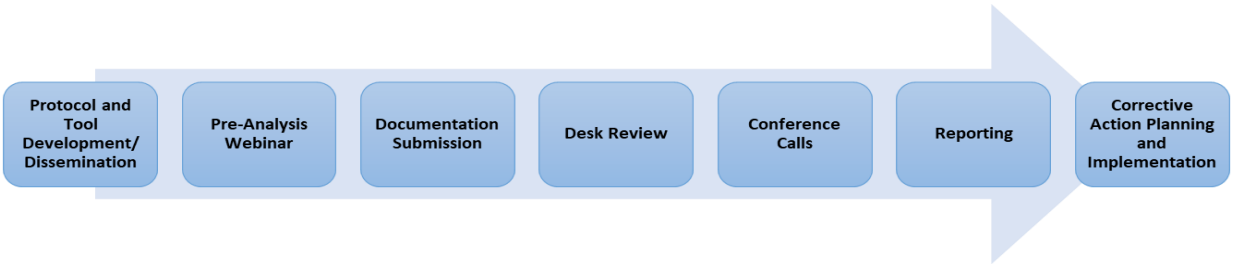
2. Process and Methodology

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

Analysis Activities for 2020

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

Figure 2-1—2020 MHP Analysis Activities



1. **Protocol and Tool Development and Dissemination:** HSAG developed and disseminated an MHP Analysis Protocol that presented details and guidance to OHA and the CCOs on the analysis process and included tools in which to conduct the 2020 MHP Analysis activity. The tools utilized for the analysis, identified below, were based on OHA's initial analysis of MHP and were developed using guidance outlined in the CMS *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*.
   - **MHP Evaluation Questionnaire**—Questions referencing the six NQTL categories, to identify changes that may impact parity.
   - **MHP Reporting Template**—Documentation of changes and additions to NQTLs previously reported in 2018, organized by the six NQTL categories.
   - **MHP Required Documentation Template**—UM and credentialing data across MH/SUD and M/S benefits and providers.

   Pre-Analysis Webinar: HSAG conducted a pre-analysis webinar on July 15, 2020, with OHA and the CCOs to provide an overview of MHP regulations, details of the protocol and tools, specifics of the analysis timeline, and examples of MHP scenarios for reference.
2. **Documentation Submission:** OHA and the CCOs were required to submit documentation that included responses to the MHP Evaluation Questionnaire and completed templates, along with supporting documentation, by August 31, 2020.

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

MHP Analysis Methodology

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

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

Table 2-1—Comparability and Stringency Standards

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

Analysis Results for 2020

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

3. MHP Analysis Results

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

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

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

Overall Assessment

UHA was responsible for delivering MH/SUD and M/S Medicaid benefits to members in all four benefit packages (CCOA, CCOB, CCOE, and CCOG), whereas OHP FFS was fully managing M/S benefits for CCOE and CCOG benefit packages. In 2019, UHA terminated its delegation agreement with Adapt and conducted all PA within the CCO. The CCO had agreements with community mental health programs (CMHPs) for the management of some MH/SUD benefits. HSAG evaluated UHA's application of NQTLs to MH/SUD and M/S benefits in terms of comparability and stringency across the six NQTL categories.

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

For limits applied to IP and OP health benefits, UHA used UM processes to manage MH/SUD and M/S benefits. The purpose of the CCO's UM processes was to ensure coverage, medical necessity, appropriate treatment in the least restrictive environment that maintains the safety of the individual, compliance with federal and State requirements, and the prevention of unnecessary overutilization. UHA reported that the evidence used to apply UM to MH/SUD and M/S included Oregon Administrative Rules (OARs), Health Evidence Review Commission (HERC) Prioritized List (PL) and guidelines, and InterQual guidelines. The application of authorization limits and the frequency and rigor in which they were applied to authorization requests was comparable across both MH/SUD and M/S benefits and to OHP FFS's application across both benefit types and all four benefit packages. Both UHA and OHP FFS allowed a 90-day time frame for submission of retrospective authorizations from the date of service, with exceptions considered. Regarding interrater reliability (IRR), UHA conducted biannual reviews of

authorization decisions using an 80 percent testing standard, which was in alignment with OHP FFS's IRR process conducted at least annually with an 80 percent testing standard.

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

The analysis HSAG conducted of UHA also did not result in any findings of non-parity in either provider admission NQTL category or in the OON/OOS category. The CCO did not close its network to either MH/SUD or M/S providers, but instead prioritized behavioral health providers to maximize the use of certain providers (e.g., qualified mental health professionals, integrated primary care providers, and providers with integrated pharmacy prescribing capabilities). HSAG determined that the CCO's provider admission/network closure processes for MH/SUD providers were comparable to and no more stringently applied to M/S providers across all benefit packages. Analysis of the CCO's credentialing data revealed a 20.83 percent total denial rate for all provider types with 13.33 percent of MH/SUD providers denied as compared to 24.24 percent of M/S providers denied. HSAG's analysis of UHA's provider credentialing data did not reveal parity concerns due to low denial rates reported for providers seeking credentialing during the reporting period. For HSAG's analysis in the Network Credentialing NQTL category, OHP FFS was not analyzed against UHA due to the State not credentialing providers but instead enrolling them in Medicaid. This difference in process did not present a parity concern. HSAG's analysis of OON/OOS NQTLs also did not result in any findings as NQTLs were consistently applied and single case agreements utilized for OON providers were needed.

Based on the strategy and evidence provided by UHA, including reported changes in operations and practices, PA and credentialing data, and discussions during prescheduled conference calls, HSAG analyzed the parity of MH/SUD benefits as compared to M/S benefits. HSAG's analysis resulting in no findings for UHA. The CCO was fully compliant with all parity provisions, in operation and in writing, across all benefit packages.

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

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

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

Findings and Required Actions

HSAG's analysis of UHA's processes, strategies, and evidentiary standards resulted in no findings.

Data Analysis Results

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

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

Utilization Management for Inpatient/Outpatient Services

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

Table 3-2—Prior Authorization Counts for Inpatient and Outpatient Services

Prior Authorization Counts by Benefit Type							
Benefit Type	**# of PA Requests**	**# of PA Requests Denied**	**% of PA Requests Denied**	**# of PA Denials Appealed**	**% of PA Denials Appealed**	**# of PA Denials Overturned**	**% of PA Denials Overturned**
MH/SUD	970	75	7.73%	7	9.33%	1	1.33%
M/S	13,250	1,567	11.83%	68	4.34%	11	0.70%
Total	**14,220**	**1,642**	**11.55%**	**75**	**4.57%**	**12**	**0.73%**

Observations

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

- Of the total 14,220 IP and OP PA requests reported, 11.55 percent were denied, with only 75 appeals.
- Of the 75 MH/SUD PA requests denied, representing 4.57 percent of the 1,642 MH/SUD PA requests, seven denials resulted in an appeal.
- Approximately 60 percent of MH/SUD PA denials were requests for OP services.

Utilization Management for Prescription Drugs

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

Table 3-3—Prior Authorization Counts for Prescription Drugs.

Prior Authorization Counts (Formulary and Non-Formulary)						
# of PA Requests	# of PA Requests Denied	% of PA Requests Denied	# of PA Denials Appealed	% of PA Denials Appealed	# of PA Denials Overturned	% of PA Denials Overturned
3,558	1,688	47.44%	22	1.30%	4	0.24

Observations

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

- Of the total 3,558 prescription drug PA requests reported, 47.44 percent were denied.
- Less than 2 percent (1.30 percent) of the 1,688prescription drug PA request denials were appealed, with only four PA denials resulting in an overturned decision.
- The majority of denied prescription drug PA requests were denied for "not covered" and "not medically necessary" categorical reasons.

Enrollment/Credentialing

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

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

Enrollment/Credentialing Counts by Provider Type						
Provider Type	Avg. # Enrolled Providers	# Providers Terminated	% Terminated	# of Cred. Requests	# of Cred. Requests Denied/Not Accepted	% of Cred. Requests Denied/Not Accepted
MH/SUD	60	6	10.00%	15	2	13.33%
M/S	259	11	4.25%	33	8	24.24%
Total	**319**	**17**	**5.33%**	**48**	**10**	**20.83%**

Observations

HSAG's analysis of UHA's provider credentialing data revealed parity concerns related to high denial rates reported for providers seeking credentialing during the reporting period. The following data points were observed:

- Of the 319 reported average number of providers enrolled during the reporting period, 18.81 percent were MH/SUD providers.
- The total denial rate for all provider types was 20.83 percent, with 13.33 percent of MH/SUD providers denied as compared to 24.24 percent of M/S providers denied.
- Of the MH/SUD providers seeking credentialing during the reporting period, 13.33 percent were denied credentialing.
- Seven of the 10 denials were due to a "provider type not needed" denial reason.

Additional Requirement Results

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

4. Improvement Plan Process

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

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

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

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

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

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

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

Barb McConnell, Executive Director
bmcconnell@hsag.com
303.717.2105

Appendix A. MHP Evaluation Questionnaire

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

General Questions for CCOs		
Question		**Yes/No**
1.	Did the CCO add, change, or eliminate delegated administrative functions to a new or for an existing subcontractor (e.g., UM, provider admission, etc.)? ***Documentation Required:*** *Provide contractual requirements (e.g., scope of work) for delegated administrative functions.*	☒ Yes ☐ No
2.	Did the CCO add or exclude any specific classifications of drugs from its formulary?	☒ Yes ☐ No

Utilization Management (IP, OP, and Rx) Changes in CCO—MH Parity Analysis Sections I, II, and III		
Question		**Yes/No**
1.	Did the CCO change payment arrangements with some/all providers (e.g., FFS to sub-capitation, per diem to DRG, reduction in payment levels to specific provider types or for specific benefits)?	☒ Yes ☐ No
2.	Did the CCO add or remove numerical limits (e.g., number of units) to MH/SUD or M/S benefits?	☐ Yes ☒ No
3.	Did the CCO add or remove non-numerical benefit limits (e.g., scope or duration of benefits, medical necessity criteria, etc.) to MH/SUD or M/S benefits?	☒ Yes ☐ No
4.	Did the CCO change timelines for authorization requests for MH/SUD or M/S benefits?	☒ Yes ☐ No

5.	Did the CCO change documentation requirements for UM requests for MH/SUD or M/S benefits (e.g., evidence of medical necessity, documentation submission requirements)?	☐ Yes ☒ No
6.	Did the CCO change qualifications for reviewers that can authorize or deny requests?	☐ Yes ☒ No
7.	Did the CCO develop or add medical necessity/level of care criteria for MH/SUD or M/S benefits?	☒ Yes ☐ No
8.	Did the CCO change the method for monitoring consistency of MNC application for MH/SUD or M/S benefits (e.g., standards for consistency of MNC, reliability adherence criteria)?	☒ Yes ☐ No
9.	Did the CCO change/modify penalties for failure to request/receive authorization for MH/SUD or M/S benefits (e.g., payment reductions, exceptions or waivers of penalties)?	☐ Yes ☒ No
10.	Did the CCO change frequency, time frames, or conditions of utilization review for MH/SUD or M/S benefits (e.g., RR or CR time frames or conditions)?	☐ Yes ☒ No
11.	What is the number of coverage requests, denials, appeals, appeal overturns, hearings, and hearing overturns experienced during the last full calendar year separately for MH/SUD and M/S for each classification (IP, OP, and Rx)? ***Documentation Required:*** *Provide lists that identify the number of coverage requests, denials, appeals, appeal overturns, hearings, and hearing overturns for the last full calendar year separately for MH/SUD and M/S for each classification (i.e., IP, OP, and Rx). For Rx, include a list identifying the number of drugs subject to PA.*	☐ Yes ☐ No
Provider Network Admission Changes in CCO—MH Parity Analysis Sections IV and V		
Question		**Yes/No**
1.	Did the CCO change its network status from open (accepting new provider applications) to closed (not accepting new provider applications for certain provider types) or from closed to open?	☐ Yes ☒ No
2.	Did the CCO add, remove, or change provider admission requirements (e.g., special training, education, experience), including as a result of State licensing changes, for any MH/SUD or M/S providers?	☐ Yes ☒ No
3.	Were any of the CCO's providers denied credentialing due to network closure (if applicable) or based on credentialing requirements?	☐ Yes

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

Appendix B. Finalized MHP NQTL Reporting Tables

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

Category I—Utilization Management Limits Applied to Inpatient Services

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

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

Classification: IP and emergency care

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FF M/S
1. To which benefit is the NQTL assigned?			
• (1, 2, 3) PA and CR are required for planned non-emergency admissions to acute IP (in and out-of-network (OON)), PRTS, subacute. • (1, 2, 3) Emergency admissions require notification within 48 hours of admission and subsequent CR. • (1, 2, 3) Extra-contractual and experimental/investigational/ unproven benefit requests (i.e., exceptions) are submitted through a PA-like process.	• (1, 4) PA (only) for MH/SUD procedures performed in a medical facility (e.g., gender reassignment surgery authorizations, experimental/investigational, and extra-contractual benefits are conducted by OHA consistent with the information in column 2). • (2, 4) A level-of-care review is required for SCIP, SAIP and subacute care that is conducted by an OHA designee. • (1, 4) PA for SCIP, SAIP and subacute admission is obtained through a peer-to-peer review between a Comagine psychiatrist and the referring psychiatrist. • (1, 2, 4) CR Comagine RR for SCIP and SAIP are performed by Comagine. • (1, 2, 4) CR and RR for subacute care are conducted by Comagine. • (1, 2, 4) PA, inclusive of a Certificate of Need (CONS)	• (1, 2, 3) PA and CR are required for planned non-emergency admissions to acute IP (in and out-of-network (OON)). • (1, 2, 3) Emergency admissions require notification within 48 hours of admission and subsequent CR. • (1, 2, 3) Skilled nursing facility benefits (first 20 days) require PA. • (1, 2, 3) Extra-contractual and experimental/investigational/ unproven benefit requests (i.e., exceptions) are submitted through a PA-like process.	• (1, 2, 4) PA and CR are required for in-state and OOS planned surgical procedures (including transplants) and associated imaging, rehabilitation and professional surgical services delivered in an inpatient setting and listed in OAR 410-130-0200, Table 130-0200-1; rehabilitation, and long term acute care (LTAC).(Notification is required for all IP admissions.) • (1, 2, 4) PA, CR and RR for Behavior Rehabilitation Services (BRS) are performed by OHA, DHS or OYA designee. • (1, 2, 4) PA and CR of skilled nursing facility (SNF) services. • (1, 4) Requests for extra-contractual and experimental/investigational /unproven benefits (i.e., exceptions) are submitted through a PA-like process.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FF M/S
3. What evidence supports the rationale for the assignment?			
• (1 and 2) ASAM, HERC PL and guidelines3. • (1) UM and claims reports are reviewed for trends in overutilization on a quarterly basis relative to own data and InterQual benchmarks. Data are reviewed for outliers (UM) and disease states that might require intervention (CM). Forwarded to quality committee or a benefit workgroup to review requirements. May also be forwarded to network if needed. • (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.	• (1) UM is assigned to ensure medical necessity of services and prevent overutilization • (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual (e.g., matching the level of need to the least restrictive setting using the LOCUS – Level-of-Care Utilization System and LSI – Level of Service Inventory or PCSP – Person Centered Service Plan and IBL – Individually-Based Limitations). • (4) To comply with federal and State requirements.	• (1 and 2) HERC PL and guidelines. • (1) IP is high cost service. Inpatient utilization and over and underutilization reports are reviewed at UM committee. • (1 and 2) InterQual • (2) Benefit has multiple interventions of varying costs that may be successful. • (3) Applicable State and federal requirements.	• (1, 2 and 4) The HERC PL and guidelines. There are more guidelines for M/S than for MH/SUD because 1) there are more technological procedures (e.g., surgery, devices, procedures and diagnostic tests); and 2) the literature is more robust. • (1) InterQual • (1) PA staff reports. If the UM team identifies any services for which utilization appears to be increasing (e.g., number of requests) or it appears that the State is paying for medically unnecessary care, the UM team consults with the health analytics team to analyze and evaluate adjustments to PA or CR. • (1) Health analytics reports. The health analytics team and policy analysts refer services that have been identified to have increasing utilization to the UM team for evaluation.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FF M/S
• http://journals.sagepub.com/doi/10.1177/1 077558705279307 • (2) Inherent restrictiveness of residential settings and dangers associated with seclusion and restraint. Also see Cusack, K. J., Frueh, C., Hiers, T., et. al., Trauma within the Psychiatric Setting: A Preliminary Empirical Report, Human Services Press, Inc., 2003. 453-460. • (3) Applicable State and federal requirements.			
4. What are the NQTL procedures?			
Timelines for authorizations: • PA form should be submitted prior to service delivery for elective admissions and provider should wait for authorization before delivering the service. • Notification of emergency admissions is required 48 hours from admission date (or as soon as possible following admission). • CR is conducted telephonically by an RN or LPC with collaborating	**Timelines for gender reassignment surgery authorizations:** **(OHA)** • Standard requests are to be processed within 14 days. **Timelines for child residential authorizations**: **(OHA)** • OHA provides the initial authorization (level-of-care review) within three days of receiving complete requests for SCIP, SAIP or subacute. **(Comagine Health)**	**Timelines for authorizations:** • PA form should be submitted prior to service delivery for elective admissions and provider should wait for authorization before delivering the service. • Notification of emergency admissions is required 48 hours from admission date (or as soon as possible following admission). • CR documentation can be completed by fax, telephone or online, RN or LP makes an	**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.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FF M/S
documentation as needed. Authorization is made within 2 business days once supporting documentation has been received. • For youth residential, most referrals originate with CCO and require a Certificate of Need (CON) be completed by Comagine (usually takes 1 week to complete). (See column 2.) • CON is completed by CMHP and submitted to UHA for psychiatrist determination. • CR decisions are made within 72 hours (IP, Residential) or 2 business days (SUD) or as expeditiously as the member's health requires.	• 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 Comagine. **Timelines for adult residential and YAP authorizations**: **(Comagine Health)** • Emergency requests are processed within one business day, urgent within two business days, and standard requests within 10 business days.	authorization decision usually within 2 business days when clinical information is provided. • SNF requests are processed within 2 business days.	• PA is required before admission. • OARs require emergency requests be processed within one business day, urgent requests within three business days and standard requests within 14 days.
Documentation requirements: • A PA request form, online or hospital face sheet is required along with supporting documentation for rational are required.	**Documentation requirements (OHA):** • PA documentation requirements for non-residential MH/SUD benefits include a form that consists of a cover page. Diagnostic and CPT code information and a rationale for medical necessity must be provided, plus any	**Documentation requirements:** • A PA request form, online or hospital face sheet is required along with supporting documentation for rational are required. Diagnosis codes are not required for un-planned admissions.	**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	FF M/S
	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 for PRTF CONS and CR for PRTF, SCIP and SAIP (Comagine Health)**: • PRTS CONS requires documentation that supports the justification for child residential services, including: – A cover sheet detailing relevant provider and recipient – Medicaid numbers; – Requested dates of service; – HCPCS or CPT Procedure code requested; and – Amount of service or units requested; – A behavioral health assessment and service plan meeting the requirements described in		

CCO MH/SUD	FFS MH/SUD	CCO M/S	FF M/S
	OAR 309-019-0135 through 0140; or – Any additional supporting clinical information supporting medical justification for the services requested; – For substance use disorder services (SUD), the Division uses the American Society of Addiction Medicine (ASAM) Patient Placement Criteria second edition-revised (PPC-2R) to determine the appropriate level of SUD treatment of care. • There are no specific documentation requirements for CR of PRTS, SCIP or SAIP. **Documentation requirements (Comagine Health)**: • Documentation may include assessment, service plan, plan-of-care, Level-of-Care Utilization System (LOCUS), Level of Service Inventory (LSI), PCSP, IBL, or other relevant documentation.		

CCO MH/SUD	FFS MH/SUD	CCO M/S	FF M/S
Method of document submission: • Fax or online.	**Method of document submission (OHA):** • For non-residential MH/SUD services, paper (fax) or online PA requests are submitted prior to the delivery of services for which PA is required. • For SCIP, SAIP and subacute level-of-care review, the OHA designee may accept information via fax, mail or secure email and has also picked up information. Supplemental information may be obtained by phone. **Method of document submission (Comagine Health):** • Packets are submitted to Comagine by mail, fax, email or web portal for review for child residential services. Telephonic clarification may be obtained. • Psychiatrist to psychiatrist review is telephonic. **Method of document submission (Comagine Health):** • Providers submit authorization requests for adult MH residential to Comagine Health	**Method of document submission:** • Fax or online.	**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	FF M/S
	by mail, fax, email or via portal, but documentation must still be faxed if the request is through portal. Telephonic clarification may be obtained.		
Qualifications of reviewers: • PA and CR is completed by an individual who has clinical expertise in addressing the member's medical, behavioral, or oral health needs or in consultation with a health care professional with clinical expertise in treating the member's condition or disease staff make a CR authorization decision. • Denials are reviewed by a board certified psychiatrist or the Medical Director.	**Qualifications of reviewers (OHA)**: • OHA M/S staff conduct PA and CR (if applicable) for gender reassignment surgery. • The OHA designee is a licensed, master's-prepared therapist that reviews psychiatric evaluations to approve or deny the level-of-care requested. Psychiatric consultation is available if needed. **Qualifications of reviewers (Comagine Health)**: • Two reviewers with QMHP designation make residential authorization decisions. • Two psychiatrists make CONS determinations. **Qualifications of reviewers (Comagine Health)**: • Comagine Health QMHPs must meet minimum qualifications (see below) and	**Qualifications of reviewers:** • PA and CR is completed by an individual who has clinical expertise in addressing the member's medical, behavioral, or oral health needs or in consultation with a health care professional with clinical expertise in treating the member's condition or disease staff make a CR authorization decision. • Denials are reviewed by a Medical Director.	**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	FF M/S
	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 a mental status examination, complete a DSM diagnosis, and write and supervise the implementation of a PCSP. • A QMHP must meet one of the follow conditions: – Bachelor's degree in nursing and licensed by the State of Oregon; – Bachelor's degree in occupational therapy and licensed by the State of Oregon; – Graduate degree in psychology; – Graduate degree in social work; – Graduate degree in recreational, art, or music therapy;		

CCO MH/SUD	FFS MH/SUD	CCO M/S	FF M/S
	– Graduate degree in a behavioral science field; or • A qualified Mental Health Intern, as defined in 309-019-0105(61).		
Criteria: • Authorization decisions are based on guidelines such as InterQual, UpToDate, HERC PL, HERC guidelines, and OARs.	**Criteria (OHA)**: • Authorizations for non-residential MH/SUD services are based on the HERC PL and guidelines; Oregon Statute, OAR, and federal regulations; InterQual guidelines; and evidence-based guidelines from private and professional associations. • OHA delegates review requests relative to least restrictive environment requirement. **Criteria (Comagine Health)**: • HERC PL, InterQual, and Comagine policy are used for residential CR. **Criteria (Comagine Health)**: • QMHPs review information submitted by providers relative to State plan and OAR requirements and develop a PCSP.	**Criteria:** • Authorization decisions are based on guidelines such as InterQual, UpToDate, HERC PL, HERC guidelines, and OARs.	**Criteria**: • Authorizations are based on the HERC PL and guidelines; Oregon Statute, OAR, and federal regulations; InterQual guidelines; and evidence-based guidelines from private and professional associations, such as the Society of American Gastrointestinal and Endoscopic Surgeons and InterQual, where no State or federal guidelines exist.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FF M/S
	• The PCSP components are entered into MMIS as an authorization.		
Reconsideration/RR: • UR staff can waive PA requirements for residential, but this is very rare due to CCO initiating most referrals. • Medical Director can make exceptions to the process including determining if RR will be considered.	**Retrospective Review:** • Retrospective authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why authorization could not have been obtained within the 90 days. **Reconsideration (OHA)**: • A provider may request review of an OHA denial decision for nonresidential MH/SUD services. The review occurs in weekly Medical Management Committee (MMC) meetings. • Exception requests for experimental and other non-covered benefits may be granted at the discretion of the MMC, which is led by the HSD medical director. • If a provider requests review of an OHA delegate level-of-care determination, KEPRO	**Reconsideration/RR:** • Medical Director can make exceptions to the process including determining if RR will be considered.	**Retrospective Review:** • Retrospective authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why authorization could not have been obtained within the 90 days. **Reconsideration**: • A provider may request review of a denial decision. The review occurs in weekly MMC meetings. • Exception requests for experimental and other non-covered benefits may be granted at the discretion of the MMC, which is led by the OHA's medical director.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FF M/S
	• Members may request a hearing on any denial decision. **Appeals (Comagine Health)**: • Members may request a hearing on any denial decision.		
Consequences for failure to authorize: • Failure to obtain authorization can result in non-payment.	**Consequences for failure to authorize (OHA)**: • Failure to obtain authorization for non-residential MH/SUD services can result in non-payment for benefits for which it is required. • Failure to obtain notification for non-residential MH/SUD services does not result in a financial penalty. • For SCIP, SAIP and subacute, if coverage is retroactively denied, general funds will be used to cover the cost of care. **Consequences for failure to authorize (Comagine Health)**: • Non-coverage. **Consequences for failure to authorize (Comagine Health)**: • Failure to obtain authorization can result in non-payment for benefits for which it is required.	**Consequences for failure to authorize:** • Failure to obtain authorization can result in non-payment.	**Consequences for failure to authorize**: • Failure to obtain authorization can result in non-payment for benefits for which it is required. • Failure to obtain notification does not result in a financial penalty.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FF M/S
5. How frequently or strictly is the NQTL applied?			
Frequency of review (and method of payment): • CR is conducted based on InterQual benchmark, on average every 3-11 days. (Providers are paid by per diem.) • Residential treatment (e.g. PRTS): CR is initially conducted after the first 30 days and then every 7 days thereafter. Providers are paid by per diem. • SUD treatment: CR is conducted base on InterQual benchmark, on average every 3-6 days. Providers are paid by PMPM capitation rates.	**Frequency of review (and method of payment) (OHA)**: • Gender reassignment surgery is authorized as a procedure. • The initial authorization for SCIP, SAIP, and subacute is 30 days. **Frequency of review (and method of payment) (Comagine Health)**: • Child residential services are paid by per diem. • Child residential services authorizations are conducted every 30-90 days. **Frequency of review (and method of payment) (Comagine Health)**: • Adult residential authorizations are conducted at least once per year. An independent and qualified agent (IQA) contacts MH provider quarterly for 1915i assessment accuracy. If member's status changes for more than 30 days, provider can contact IQA for a re-assessment.	**Frequency of review (and method of payment):** • SNF: CR is conducted base on InterQual criteria, initially every 7 days, (7/7/6). Providers are paid per diem. • IP admission is conducted base on InterQual benchmark, and criteria, on average every 3-7 days. Providers are paid by DRG.	**Frequency of review (and method of payment)**: • Most IP claims are paid DRG; as a result, CR is infrequently used. • CR is conducted monthly for LTAC and rehabilitation. • The State conducts CR for SNF at a frequency that is determined by the care manager, but not less than one time a year. • Authorization lengths are individualized by condition and are valid for up to a year. • Procedural authorizations are valid for three months.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FF M/S
RR conditions and timelines: • Medical Director can make exceptions to the process including determining if RR will be considered. • UR staff can retrospectively review within 90 days of discharge; exceptions additionally allowed.	**Retrospective Review:** • Retrospective authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why authorization could not have been obtained within the 90 days. **Reconsideration (OHA)**: • A provider may request review of an OHA denial decision for nonresidential MH/SUD services. The review occurs in weekly Medical Management Committee (MMC) meetings. • Exception requests for experimental and other non-covered benefits may be granted at the discretion of the MMC, which is led by the HSD medical director. • If a provider requests review of an OHA delegate level-of-care determination, KEPRO may conduct the second review. **Reconsideration (Comagine Health)**:	**RR conditions and timelines:** • Medical Director can make exceptions to the process including determining if RR will be considered. • UR staff can retrospectively review within 90 days of discharge; exceptions additionally allowed.	**Retrospective Review:** • Retrospective authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why authorization could not have been obtained within the 90 days. **Reconsideration**: • A provider may request review of a denial decision. The review occurs in weekly MMC meetings. • Exception requests for experimental and other non-covered benefits may be granted at the discretion of the MMC, which is led by the OHA's medical director.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FF M/S
	organizations such as the American Medical Association or the American Psychiatric Association, are used to establish PA frequency for non-residential MH/SUD services. • There are only two OHA designee reviewers for level-of-care review for SCIP, SAIP, and subacute and no specific criteria, so N/A. **Methods to promote consistent application of criteria (Comagine Health):** • Parallel chart reviews for the two reviewers. (No criteria.) **Methods to promote consistent application of criteria (Comagine Health)**: • Monthly clinical team meetings in which randomly audited charts are reviewed/discussed by peers using Comagine Health compliance department-approved audit tool. • Results of the audit are compared, shared and discussed by the team and submitted to Compliance		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	FF M/S
	Department monthly for review and documentation. • Individual feedback is provided to each clinician during supervision on their authorization as well as plan-of-care reviews.		
6. What standard supports the frequency or rigor with which the NQTL is applied?			
Evidence for UM frequency: • ASAM, HERC, OAR, per diem payment. The CCO also uses InterQual length of stay benchmark information.	**Evidence for UM frequency (OHA (and designee for level-of-care review), Comagine and KEPRO)**: • PA length and CR frequency are tied to HERC PL and guidelines, OAR, CFRs, InterQual, reviewer expertise and timelines for expectations of improvement.	**Evidence for UM frequency:** • HERC, OAR, InterQual, DRG.	**Evidence for UM frequency**: • PA length and CR frequency are tied to HERC PL and guidelines, DRGs, OAR, CFRs, InterQual, reviewer expertise and timelines for expectations of improvement.
Data reviewed to determine UM application: • Number of PA/CR requests and denials. • IRR results.	**Data reviewed to determine UM application**: • Denial/appeal overturn rates; number of PA requests; stabilization of cost trends; and number of hearings requested. These data are reviewed in subcontractor reports, on a quarterly basis by the State. (Applicable to non-residential MH/SUD services.)	**Data reviewed to determine UM application:** • Number of PA/CR requests and denials. • IRR results.	**Data reviewed to determine UM application**: • A physician led group of clinical professionals conducts an annual review to determine which services receive or retain PA. Items reviewed include: – Utilization. – Approval/denial rates. – Documentation/ justification of services.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FF M/S
	Data reviewed to determine UM application (Comagine): • N/A **Data reviewed to determine UM application (Comagine Health):** • N/A		– Cost data.
IRR standard: • Inter-rater reliability testing is performed biannually with an 80% testing standard.	**IRR standard (OHA):** • KEPRO has a formal policy including an 80% standard using InterQual criteria, conducting reviews at least annually. **IRR standard (Comagine Health):** • Spot-checks performed through supervision. Formal policy to be developed. **IRR standard (Comagine Health):** • Spot-checks performed through supervision.	**IRR standard:** • Inter-rater reliability testing is performed biannually with an 80% testing standard.	**IRR standard (OHA):** • KEPRO has a formal policy including an 80% standard using InterQual criteria, conducting reviews at least annually.
Analysis			
UHA was responsible for delivering IP MH/SUD and M/S Medicaid benefits to members in all four benefit packages (CCOA, CCOB, CCOE, and CCOG), whereas OHP FFS was fully managing IP M/S benefits for CCOE and CCOG benefit packages. Emergency MH/SUD and M/S IP hospital admissions required notification, with most ongoing IP services requiring subsequent CR. Regarding nonemergent CCO MH/SUD and M/S IP admissions, PA or level-of-care approval was required. PA was also required for extra-contractual coverage requests (including experimental services); planned surgical procedures (including transplants); and associated imaging, rehabilitation, and professional surgical services delivered in an IP setting and listed in OAR 410-130-0200, Table 130-0200-1. For psychiatric residential treatment services (PRTS) benefits (e.g., Secure			

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

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

HSAG's analysis of UHA's PA data for IP and OP benefits did not reveal any concerns related to MHP. Of the total 14,220 IP and OP PA requests reported, 11.55 percent were denied, with only 75 appeals. Of the 75 MH/SUD PA requests denied, representing 4.57 percent of the 1,642 MH/SUD PA requests, seven denials resulted in an appeal. Approximately 40 percent of MH/SUD PA denials were requests for IP services.

Comparability

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

Emergency MH/SUD and M/S IP hospital admissions required notification within 48 hours, with child emergency residential admissions separately requiring notification within 14 days. Most CCO documentation requirements for MH/SUD included an admission note and records submitted via telephone, fax, or electronically. OARs required authorization decisions within 24 hours for emergencies, 72 hours for urgent requests, and 14 days for standard requests. Both UHA and OHP FFS adhered to these requirements across all benefit packages. Most ongoing IP services required subsequent CR. Documentation requirements for child residential PA/level-of-care review included a psychiatric evaluation or a psychiatrist-to-psychiatrist telephonic review. Comagine Health, OHP FFS's subcontractor, accepted information for child residential CR via mail, email, fax, and Web portal. Adult and youth residential required an assessment (i.e., completion of a relevant level-of-care tool [e.g., ASAM, LSI, or LOCUS]) and plan-of-care consistent with State plan requirements. Comagine Health documentation submission could be done using mail, email, fax, or Web portal. Consistent with OARs, federal CON procedures, and due to the potential absence of a psychiatric referral, the PRTS documentation requirements included a cover sheet, a behavioral health assessment, and service plan meeting the requirements described in OAR 309-019-0135 through 0140. HSAG determined the MH/SUD authorization time frames and documentation requirements were comparable to those applied to M/S authorization requests.

Stringency

Qualified individuals conducted UM applying OARs, HERC, InterQual, national guidelines, and ASAM for CCO SUD. The CCO and OHP FFS subcontractors required all MH/SUD and M/S denials to be made by physicians; however, nurses could deny benefits managed by OHP FFS.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FF M/S
HSAG determined this difference to be an issue of quality rather than parity. OHP FFS's subcontractor, Comagine Health (a licensed MH professional), made denial determinations for level-of-care review for certain child residential services. Both the CCO and OHA allowed 90-day RR for MH/SUD and M/S when providers failed to obtain authorization. Exceptions to these time frames were allowed by both the CCO and OHP FFS. For adult and youth residential services, Comagine Health allowed reconsideration of denials with the submission of additional documentation within 10 days of the denial. For OHP FFS and Comagine Health, the review of denial decisions occurred during MMC meetings. MH/SUD and M/S denial decisions could be appealed through appeals and/or State fair hearing processes. Failure to obtain authorization could result in noncoverage, although SCIP, SAIP, and subacute services could be covered by general fund dollars. Regarding IRR, both the CCO and OHP FFS subcontractor conducted reviews at least annually—biannually for the CCO—using a 90 percent testing standard for both benefit types.			
Outcome			
HSAG determined the processes, strategies, and evidentiary standards for UM of IP MH/SUD benefits to be comparable and no more stringently applied, in writing and in operation, to M/S prescription drugs.			

Category II—Utilization Management Limits Applied to Outpatient Services

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

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

Classification: OP

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

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

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FF M/S
1. To which benefit is the NQTL assigned?				
• (2) Applied Behavior Analysis (ABA). • (2) OT, PT, ST for MH conditions are	• The following services are managed by DHS:	• (2, 4) PA: Psychological testing. • (2, 4) OT/PT/ST (after initial 8 visits).	• PA is required for: • (2, 3, 4) MRI. • (2, 3, 4) DME.	The following services are managed by OHA: • (2, 3) Out of hospital births.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FF M/S
managed through RR; PA is not required.	• (1) 1915(c) Comprehensive DD waiver. • (1) 1915(c) Support Services DD waiver. • (1) 1915(c) Behavioral DD Model waiver. • (1) 1915(c) Aged & Physically Disabled waiver. • (1) 1915(c) Hospital Model waiver. • (1) 1915(c) Medically Involved Children's NF waiver. • (1) 1915(k) Community First Choice State Plan option. • (1) 1915(j): Self-directed personal assistance.	• (2, 4) PA and CR: ABA (OON only). • (4, 5) Experimental. • (2, 3, 4, 5) OOS/OON.	• (2, 3, 4) Prosthetics/medical supplies. • (2, 3, 4) Chiropractic services. • (2, 3,4) OT/PT/ST (after initial 8 visits). • (2, 3, 4) Dermatology. • (2, 5) Experimental. • (2, 3, 4, 5) OOS/OON.	• (2) Home health services. • (2) OT, PT, ST for MH conditions are managed through RR; PA is not required. • (2, 3) Imaging. • (2) DME.
2. Why is the NQTL assigned to these benefits?				
• (2) HERC PL. • (2) OAR 410-172-0650 for ABA services. • (2) PA requests with insufficient documentation to demonstrate MNC or	• (1) The State requires PA of HCBS in order to meet federal requirements regarding PCSPs and ensure services are provided in accordance with a	• (2) To ensure coverage, medical necessity and prevent unnecessary overutilization. • (3) Ensure appropriate treatment in the least	• (2) To ensure coverage, medical necessity and prevent unnecessary overutilization. • (3) Ensure appropriate treatment in the least	• (2) To prevent services being delivered in violation of relevant OARs, associated HERC PL and

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FF M/S
HERC PL guidelines are not being followed.	participant's PCSP and in the last restrictive setting.	restrictive environment that maintains the safety of the individual. • (4) Limited capacity/high demand service • (5) Compliance with OARs and applicable federal requirements.	restrictive environment that maintains the safety of the individual. • (4) Limited capacity/high demand service • (5) Compliance with OARs and applicable federal requirements.	guidelines and federal regulations. • (3) Services are associated with increased health or safety risks.
3. What evidence supports the rationale for the assignment?				
• (2) HERC PL • (2) OAR 410-172-0650 for ABA services. • (2) PA requests with insufficient documentation to demonstrate medical necessity is not being met or HERC PL guidelines are not being followed.	• (1) Federal requirements regarding PCSPs for 1915(c), 1915(k), and 1915(j) services (e.g., 42 CFR 441.301, 441.468, and 441.540) and the applicable approved 1915(c) waiver application/State plan amendment. • (1) Federal requirements regarding 1915(c) and 1915(i) services require that HCBS are provided in the least restrictive setting possible.	• (2) InterQual, OARs, HERC PL and guidelines, and federal guidelines. • (2, 4) UM and claims reports are reviewed for trends in overutilization on a quarterly basis. • (2, 4) Annual cost and utilization reports. • (3) Oregon Performance Plan (OPP) requires that BH services be provided in least restrictive setting possible. The OPP is a DOJ-negotiated Olmsted settlement.	• (2) InterQual, OARs, HERC PL and guidelines, and federal guidelines. • (2, 4) UM and claims reports are reviewed for trends in overutilization on a quarterly basis. • (2) Annual cost and utilization reports. • (3) HERC guidelines re safety concerns and InterQual. • (4) Difficulty finding available appointments. • (5) Applicable federal guidelines and OARs.	• (2) HERC PL and guidelines and clinical practice guidelines. • (2) PA requests with insufficient documentation to demonstrate medical necessity are not being met or HERC PL guidelines are not being followed. • (3) HERC Guidelines - Recommended limits on services for member safety.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FF M/S
		• (3) HERC guidelines re safety concerns, InterQual, and ASAM. • (4) Difficulty finding available appointments. • (5) Applicable federal guidelines and OARs.		
4. What are the NQTL procedures?				
Timelines for authorizations: • Urgent requests are processed in three business days and immediate requests in one business day. Routine requests are processed in 14 days. • OT, PT, ST for MH conditions are managed through RR; PA is not required.	**Timelines for authorizations**: • A PCSP must be approved within 90 days from the date a completed application is submitted.	**Timelines for authorizations:** • PA form should be submitted prior to service delivery. Non urgent requests are processed within 14 days.	**Timelines for authorizations:** • PA form should be submitted prior to service delivery (or after designated number of PT/ST/OT visits) and provider should wait for authorization before delivering the service. Non urgent requests are processed within 14 days. • A new PA is required when the initial number of units/dates is exhausted.	**Timelines for authorizations**: • Urgent requests are processed in three business days and immediate requests in one business day. Routine requests are processed in 14 days. • OT, PT, ST for MH conditions are managed through RR; PA is not required.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FF M/S
Documentation requirements: • Form is one cover page. • Require diagnostic and CPT code and rationale for medical necessity plus any additional supporting documentation. • In addition, as part of the supporting documentation ABA must have an evaluation and referral for treatment from a licensed practitioner described in OAR 410-172-0760 (1)(a-d) and a treatment plan from a licensed health care professional described in 410-172-0650(B). • Documentation supporting medical necessity is required at the time of billing for OT, PT, ST services.	**Documentation 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:** • Psych Testing PA requires a 1 page form. Diagnosis, CPT code and MNC rationale are required. • CR for psychiatric day treatment and skills training is done in joint face-to-face meetings. There is no other formal PA.	**Documentation requirements:** • PA form is 1 page which can be faxed or submitted online. Diagnosis, CPT code and MNC rationale are required. • PCP evaluation and referral required for chiropractic and dermatology services.	**Documentation requirements**: • A cover page form is required. In addition, diagnostic information, a CPT code(s), a rationale for medical necessity plus any additional supporting documentation are required. • Documentation supporting medical necessity is required at the time of billing for OT, PT, ST services.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FF M/S
Method of document submission: • Paper (fax) or online PA/POC submitted prior to the delivery of services.	**Method of document submission**: • All 1915(c), 1915(k), and 1915(j) services must be included in a participant's PCSP and approved by a qualified case manager at the local case management entity (CME) prior to service delivery. • Information is obtained during a face-to-face meeting, often at the individual's location.	**Method of document submission:** • Fax or online.	**Method of document submission:** • Fax or online.	**Method of document submission**: • Paper (fax) or online PA/POC submitted prior to the delivery of services.
Qualifications of reviewers: • For ABA services, physicians review services. • For OT, PT, ST services, nurses may authorize and deny services. • Professional peers deny for other OP services.	**Qualifications of reviewers:** • A case manager must have at least: – A bachelor's degree (BA) in behavioral science, social science, or a closely related field; or – A BA in any field AND one year of human services related experience; or	**Qualifications of reviewers:** • PA and CR is completed by an individual who has clinical expertise in addressing the member's medical, behavioral, or oral health needs or in consultation with a health care professional with clinical expertise in treating the member's condition or disease	**Qualifications of reviewers:** • PA and CR is completed by an individual who has clinical expertise in addressing the member's medical, behavioral, or oral health needs or in consultation with a health care professional with clinical expertise in treating the member's condition or disease	**Qualifications of reviewers:** • Nurses may authorize and deny services.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FF M/S
	– An associate's degree (AA) in a behavioral science, social science, or a closely related field AND two years human services related experience; orThree years of human services related experience.	staff make a CR authorization decision. Only physicians can deny a request.	staff make a CR authorization decision. Only physicians can deny a request.	
Criteria: • Authorizations are based on applicable HERC guidelines, Oregon Statute, Oregon Administrative rules, federal regulations, and evidence-based guidelines from private and professional associations such as the American Psychiatric Association, where no State or federal guidelines exist.	**Criteria**: • Qualified case managers approve or deny services in the PCSP consistent with waiver/state plan and OAR requirements. • Once a PCSP is approved, itis entered into the payment management system as authorization by the CME staff.	**Criteria:** • Authorization decisions are made using ASAM, HERC guidelines, OARs, and InterQual.	**Criteria:** • PA includes eligibility and benefit coverage confirmation and MNC review • Authorization decisions are made using InterQual, UpToDate, HERC guidelines, and OARs. • ACR Appropriateness Criteria and CAP approved Guidelines.	**Criteria:** • Authorizations are based on applicable HERC PL and guidelines, Oregon Revised Statute, OAR, federal regulations, and evidence-based guidelines from private and professional associations such as the Society of American Gastrointestinal and Endoscopic Surgeons where no State or federal guidelines exist.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FF M/S
Reconsideration/RR: • A provider may request review of a denial decision, which occurs in weekly MMC meetings or Comagine's own comparable MMC meeting. • RR authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why authorization could not have been obtained within the 90 days. • OT, PT, ST are reviewed after the initial service prior to payment. Additionally, denial decisions can be requested and reviewed at weekly MMC meetings.	**Reconsideration/RR:** • (c) NA	**Reconsideration/RR:** • There is an opportunity for a peer-to-peer discussion between the provider and the Medical Director or psychiatrist after a notice of action has been issued. • UR staff can retrospectively review within 90 days of completion; exceptions may be allowed.	**Reconsideration/RR:** • There is an opportunity for a peer to peer discussion between the provider and the Medical Director after a notice of action has been issued. • UR staff can retrospectively review within 90 days of completion; exceptions may be allowed.	**Reconsideration/RR:** • A review of a denial decision can be requested and is reviewed in weekly MMC meetings. • RR authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why authorization could not have been obtained within the 90 days. • OT, PT, ST are reviewed after the initial service prior to payment. Additionally, denial decisions can be requested and reviewed at weekly MCM meetings.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FF M/S
Consequences for failure to authorize: • Failure to obtain authorization may result in non-payment.	**Consequences for failure to authorize:** • Failure to obtain authorization may result in non-payment.	**Consequences for failure to authorize:** • Failure to obtain authorization can result in non-payment.	**Consequences for failure to authorize:** • Failure to obtain authorization can result in non-payment.	**Consequences for failure to authorize:** • Failure to obtain authorization may result in non-payment.
Appeals: • Notice and fair hearing rights apply.	**Appeals**: • Notice and fair hearing rights apply.	**Appeals:** • Standard appeal rights apply.	**Appeals:** • Standard appeal rights apply.	**Appeals**: • Notice and fair hearing rights apply.
5. How frequently or strictly is the NQTL applied?				
Frequency of review: • PA is granted for different LOS depending on the service and can be adjusted. PAs for extensive services usually range from 6 months to 1 year. • ABA is usually multiple service codes approved for 6 months. • Exceptions may be made at the discretion of the MMC, which is led by the HSD medical director.	**Frequency of review:** • PCSPs are reviewed and revised as needed, but at least every 12 months.	**Frequency of review:** • CR is completed every 30 days during staff/team meeting for TLC day treatment and skills training. The Medical Director attends every 90 days. The average LOS for TLC Day Treatment is 192. The ALOS for skills training is 154 days. There is no PA requirement for these services. • Psych testing is authorized for the code and number of units requested by the provider.	**Frequency of review:** • Length of authorization ranges from 3 months to 1 year depending on the service. • Medical director can make exceptions to the process.	**Frequency of review**: • PA is granted for different authorization periods depending on the service and can be adjusted. PAs for extensive services usually range from 6 months to 1 year. • Exceptions may be made at the discretion of the MMC, which is led by the HSD medical director.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FF M/S
		• PT/ST/OT is authorized consistent with HERC requirements. • For Psych Testing, Medical Director can make exceptions to the UM process. Case can be reviewed more frequently if deemed necessary by the Contracted vendor or board certified psychiatrist.		
Reconsideration/RR: • A provider may request review of a denial decision, which occurs in weekly MMC meetings or Comagine's own comparable MMC meeting. • RR authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why authorization	**Reconsideration/RR:** • N/A	**RR conditions and timelines:** • UR staff can retrospectively review within 90 days of discharge; exceptions may be allowed.	**RR conditions and timelines:** • UR staff can retrospectively review within 90 days of discharge; exceptions may be allowed.	**Reconsideration/RR:** • A review of a denial decision can be requested and is reviewed in weekly MMC meetings. • RR authorization requests can be made within 90 days of the date of service or after the 90 days based on provider demonstration of a specific reason why authorization could not have been

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FF M/S
could not have been obtained within the 90 days. • OT, PT, ST are reviewed after the initial service prior to payment. Additionally, denial decisions can be requested and reviewed at weekly MMC meetings.				obtained within the 90 days. • OT, PT, ST are reviewed after the initial service prior to payment. Additionally, denial decisions can be requested and reviewed at weekly MCM meetings.
Methods to promote consistent application of criteria: • For ABA, a sample of cases are reviewed for ability to address assessed member needs and whether OARs were met.	**Methods to promote consistent application of criteria:** • DHS Quality Assurance Review teams review a representative sample of PCSPs as part of quality assurance and case review activities to assure that PCSPs meet program standards. • Additionally, OHA staff review a percentage of files to assure quality and compliance.	**Method to promote consistent application of criteria:** • Consistency of application of MNC is measured through chart review.	**Method to promote consistent application of criteria:** • Consistency of application of MNC is measured through chart review.	**Methods to promote consistent application of criteria**: • Nurses are trained on the application of the HERC guidelines, which is spot checked through ongoing supervision.

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FF M/S
6. What standard supports the frequency or rigor with which the NQTL is applied?				
Evidence for UM frequency: • HERC guidelines (for ABA and OT, PT, ST) of which there are more M/S than MH/SUD because 1) there are more technological procedures (e.g., surgery, devices, procedures and diagnostic tests); 2) the literature is more robust. • The amount of time a PA covers for services is limited by OAR 410-120-1320(7) which states that PAs can be approved and renewed up to one year at a time. • Whenever possible, practice guidelines from clinical professional organizations such as the American Medical Association or the	**Evidence for UM frequency**: • Federal requirements regarding PCSPs and 1915(c), 1915(k), and 1915(j) services (e.g., 42 CFR 441.301, 441.468, and 441.540) and the applicable approved 1915(c) waiver application/State plan amendment.	**Evidence for UM frequency:** • ASAM, InterQual benchmark information, HERC guidelines, OARs • Per OAR 309-022-0140(3)(h) "The interdisciplinary team shall conduct a review of progress and transfer criteria at least every 30 days from the date of entry and shall document the member's present, progress, and changes made. • For Psychiatric Day Treatment Services, the review is conducted every 30 days, and the licensed provider shall participate in the review at least every 90 days."	**Evidence for UM frequency:** • UpToDate, InterQual, HERC guidelines, OARs.	**Evidence for UM frequency**: • HERC guidelines of which there are more M/S than MH/SUD because 1) there are more technological procedures (e.g., surgery, devices, procedures and diagnostic tests); and 2) the literature is more robust. • The amount of time a PA covers for services is limited by OAR 410-120-1320(7) which states that PAs can be approved and renewed up to one year at a time. • Whenever possible, practice guidelines from clinical professional organizations such as the American Medical Association or the American Psychiatric

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FF M/S
American Psychiatric Association, are used to establish PA frequency.				Association, are used to establish PA frequency.
Data reviewed to determine UM application: • A physician-led group of clinical professionals conduct an annual review to determine which services receive or retain a PA; items reviewed include: – Utilization – Approval/denial rates – Documentation/justification of services – Cost data	**Data reviewed to determine UM application:** • N/A	**Data reviewed to determine UM application:** • Number of PA requests and denials.	**Data reviewed to determine UM application:** • Number of PA requests • Denial and appeal overturn rates.	**Data reviewed to determine UM application:** • A physician-led group of clinical professionals conduct an annual review to determine which services receive or retain a PA; items reviewed include: – Utilization – Approval/denial rates – Documentation/justification of services – Cost data
IRR standard (OHA): • KEPRO has a formal policy including an 80% standard using InterQual criteria. **IRR standard (Comagine):** • Spot-checks performed through supervision. Formal	**IRR standard:** • Spot-checks performed through supervision.	**IRR standard:** • Inter-rater reliability testing is performed biannually with a 80% testing standard.	**IRR standard:** • Inter-rater reliability testing is performed biannually with a 80% testing standard.	**IRR standard (OHA):** • KEPRO has a formal policy including an 80% standard using InterQual criteria.

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

Analysis

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

HSAG's analysis of UHA's PA data for IP and OP benefits did not reveal any concerns related to MHP. Of the total 14,220 IP and OP PA requests reported, 11.55 percent were denied, with only 75 appeals. Of the 75 MH/SUD PA requests denied, representing 4.57 percent of the 1,642 MH/SUD PA requests, seven denials resulted in an appeal. Approximately 60 percent of MH/SUD PA denials were requests for IP services.

Comparability

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

OARs require authorization decisions within 24 hours for emergencies, 72 hours for urgent requests, and 14 days for standard requests. Most CCO documentation requirements for MH/SUD included an admission note and records submitted via telephone, fax, or electronically. CCO M/S was electronically notified of an admission, and care was reviewed via electronic health record (EHR). Alternatively, documentation could be submitted via fax. PCSPs for both M/S and MH/SUD must be developed within 90 days. The PCSP for both MH/SUD and M/S was based on an assessment and other relevant supporting documentation. It was developed by the member, the member's care team, and the member's case manager. Qualified individuals conducted UM applying OARs, HERC, InterQual, national guidelines, and ASAM for CCO SUD. MH/SUD and M/S DHS reviewers

FFS HCBS MH/SUD	FFS HCBS M/S	CCO MH/SUD	CCO M/S	FF M/S
were required to have a BA in a related field; a BA in any field plus one year of experience; an AA with two years' experience; or three years' experience. The CCO and Comagine required all MH/SUD and M/S denials to be made by physicians and professional peers; however, nurses could deny M/S benefits managed by OHP FFS. HSAG determined this difference to be an issue of quality rather than a parity concern. HSAG determined that the MH/SUD PA review time frames, documentation requirements, and qualification of reviewers were comparable to those applied to M/S benefits. **Stringency** Qualified individuals conducted UM applying OARs, HERC, MCG, national guidelines, and ASAM for CCO SUD. The CCO and OHA subcontractors required all MH/SUD and M/S denials to be made by professional peers; however, nurses could deny M/S benefits managed by OHP FFS. HSAG determined this difference to be an issue of quality rather than parity. Both the CCO and OHA allowed 90-day RR for MH/SUD and M/S when providers failed to obtain authorization. Exceptions to these time frames were allowed by both the CCO and OHP FFS. MH/SUD and M/S denial decisions could be appealed through appeals and/or State fair hearing processes. Failure to obtain authorization could result in noncoverage. Regarding IRR, both the CCO and OHP FFS subcontractor conducted reviews at least annually—biannually for the CCO—using a 90 percent testing standard for both benefit types.				
Outcome				
HSAG determined the processes, strategies, and evidentiary standards for UM of OP MH/SUD benefits to be comparable and no more stringently applied, in writing and in operation, to M/S prescription drugs.				

Category III—Prior Authorization for Prescription Drug Limits

NQTL: PA for Prescription Drugs

Benefit Package: CCOA and CCOB for adults and children

Classification: Prescription Drugs

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

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
practices, professional guidelines, the Prioritized List, and applicable OARs.	guidelines, and P&T Committee review and recommendations. • Federal and state regulations/OAR and the Prioritized List.	practices, professional guidelines, the Prioritized List, and applicable OARs.
4. What are the NQTL procedures?		
• Providers, patients or pharmacies can request PA by contacting the CCO by phone, fax or provider portal. • Providers are required to submit PA requests. Most PA criteria require documentation, such as chart notes, to support medical appropriateness and FDA approved use and dosing. • All PA requests are responded to within 24 hours. • The CCO's call center is available 24 hours per day, every day, to answer questions. CCO pharmacy staff are on call weekends and holidays to review any urgent requests that come in when the CCO is closed. • The PA criteria are developed by pharmacists and in consultation with the P&T Committee. • Failure to obtain PA with an absence of medical necessity results in no provider reimbursement.	• PA requests are typically faxed to the Pharmacy Call Center, but requests can also be submitted through the online portal, by phone, or by mail. • The standard PA form is one page long, except for nutritional supplement requests. Most PA criteria require clinical documentation such as chart notes. • All PA requests are responded to within 24 hours. • The PA criteria are developed by pharmacists in consultation with the P&T Committee. • Failure to obtain PA in combination with an absence of medical necessity results in no provider reimbursement. • Notice of Benefit Determination sent to both Recipient and Provider. - Denials letters include information on required criteria, denial reasons, and how the provider can appeal and member hearing rights.	• Providers, patients or pharmacies can request PA by contacting the CCO by phone, fax or provider portal. • Providers are required to submit PA requests. Most PA criteria require documentation, such as chart notes, to support medical appropriateness and FDA approved use and dosing. • All PA requests are responded to within 24 hours. • The CCO's call center is available 24 hours per day, every day, to answer questions. CCO pharmacy staff are on call weekends and holidays to review any urgent requests that come in when the CCO is closed. • The PA criteria are developed by pharmacists and in consultation with the P&T Committee. • Failure to obtain PA with an absence of medical necessity results in no provider reimbursement.

CCO MH/SUD	FFS MH Carve Out	CCO M/S
5. How frequently or strictly is the NQTL applied?		
• Typically, the frequency range is three months to a year, depending on medical appropriateness and safety, as recommended by the P&T Committee, Pain Committee, Clinical Advisory Panel, or Utilization Management Committee. • Approximately 36% of MH/SUD drugs are subject to PA criteria for clinical reasons. • Providers may provide additional information for a reconsideration of a denial. • Providers and patients may appeal any denial; patients may request a hearing. All appeals are reviewed by a Plan Medical Director for redetermination. • The CCO assesses stringency through review of the number of PA requests, PA denial/approval rates, and pricing reports. • PA criteria are reviewed for appropriateness on an ad hoc basis	• The State approves PAs for up to 12 months, depending on medical appropriateness and safety, as recommended by the P&T Committee. • Approximately 19% of MH/SUD drugs are subject to PA criteria for clinical reasons. • The State allows providers to submit additional information for reconsideration of a denial. • Providers can appeal denials on behalf of a member, and members have fair hearing rights. • There were 10 client fair hearing requests for denied MH/SUD medications. None were reversed after agency reconsideration or, and none were reversed by hearing. • The State assesses stringency through review of PA denial/approval and appeal rates; number of drugs requiring PA; number of PA requests; and pharmacy utilization data/reports. • PA criteria are reviewed as needed due to clinical developments, literature, studies, and FDA medication approvals.	• Typically, the frequency range is three months to a year, depending on medical appropriateness and safety, as recommended by the P&T Committee, Pain Committee, Clinical Advisory Panel, or Utilization Management Committee. • Approximately 46% of M/S drugs are subject to PA criteria for clinical reasons. • Providers may provide additional information for a reconsideration of a denial. • Providers and patients may appeal any denial; patients may request a hearing. All appeals are reviewed by a Plan Medical Director for redetermination. • The CCO assesses stringency through review of the number of PA requests, PA denial/approval rates, and pricing reports. • PA criteria are reviewed for appropriateness on an ad hoc basis

CCO MH/SUD	FFS MH Carve Out	CCO M/S
6. What standard supports the frequency or rigor with which the NQTL is applied?		
• PA requirements created by pharmacists and in consultation with the P&T Committee, UM Committee or Clinical Advisory Panel, and based on best practices, professional guidelines, the Prioritized List, and applicable OARs.	• 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 requirements created by pharmacists and in consultation with the P&T Committee, UM Committee or Clinical Advisory Panel, and based on best practices, professional guidelines, the Prioritized List, and applicable OARs.
Analysis		
UHA applied PA criteria to MH/SUD and M/S prescription drug benefits and applied PA to certain MH/SUD and M/S drugs to promote appropriate and safe treatment, and cost-effective use of prescription drugs. Since 2018, the CCO conducted an evaluation of its formulary and made changes that either added prescription drugs, added and removed PA criteria to prescription drugs, and adjusted criteria for prescription drugs in the formulary. PA was consistent across all benefit packages (CCOA, CCOB, CCOE, and CCOG). HSAG's analysis of UHA's counts for prescription drug PA requests did not reveal any concerns related to parity. Of the total 3,558 prescription drug PA requests reported, 47.44 percent were denied. Less than 2 percent (1.30 percent) of the 1,688 prescription drug PA request denials were appealed, with only four PA denials resulting in an overturned decision. The majority of denied prescription drug PA requests were denied for "not covered" and "not medically necessary" categorical reasons. **Comparability** The State applied PA to certain MH FFS carve-out drugs to promote appropriate and safe treatment. Evidence used by the CCO and OHP FFS to determine which MH/SUD and M/S drugs are subject to PA included Food and Drug Administration (FDA) prescribing guidelines, medical evidence, best practices, professional guidelines, and Pharmacy and Therapeutic (P&T) Committee review and recommendations. The PA criteria for both MH/SUD and M/S drugs were developed by pharmacists in consultation with the P&T Committee. PA requests for both MH/SUD and M/S drugs could be submitted by fax, phone, or online. **Stringency** For both MH/SUD and M/S drugs, most PA criteria required clinical documentation such as chart notes. Failure to obtain PA for MH/SUD and M/S drugs subject to PA in combination with an absence of medical necessity resulted in no reimbursement for the drug. Decisions were responded to within 24 hours, with decisions being made within 72 hours. For both MH/SUD and M/S drugs, the length of authorizations was dependent on medical appropriateness and safety, as recommended by the P&T Committee, based on clinical evidence such as FDA prescribing guidelines, best practices, and clinical practice guidelines. Both the CCO and OHA allowed exceptions to the formulary and preferred drug list based on medical		

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

Category IV—Provider Admission—Closed Network

NQTL: Provider Admission

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

Classification: IP and OP

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
1. To which benefit is the NQTL assigned?			
• CCO does not close its network for new 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.	• N/A • 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. Why is the NQTL assigned to these benefits?			
• When CCO closes its network to new MH/SUD providers, it is done to: – Balance member access needs with safety and quality concerns.	• N/A	• When CCO closes its network to new M/S providers, it is done to: – Balance member access needs with safety and quality concerns.	• N/A

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
– Balance member access needs with cost effectiveness/cost control.		– Balance member access needs with cost effectiveness/cost control.	
3. Why is the NQTL assigned to these benefits?			
• 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. What are the NQTL procedures?			
• New providers that are denied admission into the network due to network closure will not be able to participate in the CCO network and may not be	• 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. • The organization conducts a network adequacy study to determine if the panel is sufficient. Historically that decision has been led by the COO and presented to the Board for approval of a closed network. The CCO always considers new provider applications and considers their unique skill set when making decisions. • CCO considers the following criteria to evaluate the network: provider availability requirements, time and distance standards, members to PCP ratios, grievance analysis, special requests and • accommodations, utilization trends, requests for out of network services, community needs assessments, requests for second opinions, CAHPS, access to care and satisfaction survey results when making the determination to close the network.		reimbursed for services provided to CCO members. • The organization conducts a network adequacy study to determine if the panel is sufficient. Historically that decision has been led by the COO and presented to the Board for approval of a closed network. The CCO always considers new provider applications and considers their unique skill set when making decisions. • CCO considers the following criteria to evaluate the network: provider availability requirements, time and distance standards, members to PCP ratios, grievance analysis, special requests and • accommodations, utilization trends, requests for out of network services, community needs assessments, requests for second opinions, CAHPS, access to care and satisfaction survey results when making the determination to close the network.	

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Providers that are denied the opportunity to participate in CCO's network may not challenge CCO's decision. • Exceptions may not be made.		• Providers that are denied the opportunity to participate in CCO's network may not challenge CCO's decision. • Exceptions may not be made.	
5. How frequently or strictly is the NQTL applied?			
• When the CCO decides to close the network to particular specialties/ provider types, all new outpatient providers applying for those particular providers/provider types are subject to this NQTL. The NQTL is rarely applied, most recently Feb 2018. • One mental health provider was 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 outpatient providers applying for those particular providers/provider types are subject to this NQTL. The NQTL is rarely applied, most recently Feb 2018. • One mental health provider was impacted by CCO's decision to close all or part of its network to new providers in the last contract year.	• N/A
6. What standard supports the frequency or rigor with which the NQTL is applied?			
• The CCO reviews the following data/information to determine how strictly to apply the criteria/considerations to close the CCO network to new providers:	• 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:	• N/A

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
– Member access to care measures (e.g., timely access, distance) – Provider to member ratios – Provider availability • CCO considers the following criteria to evaluate the network: provider availability requirements, time and distance standards, member to PCP ratios, grievance analysis, special requests and accommodations, utilization trends, requests for out of network services, community needs assessments, requests for second opinions, CAHPS, access to care and satisfaction survey results when making the determination to close the network.		– Member access to care measures (e.g., timely access, distance) – Provider to member ratios – Provider availability • CCO considers the following criteria to evaluate the network: provider availability requirements, time and distance standards, member to PCP ratios, grievance analysis, special requests and accommodations, utilization trends, requests for out of network services, community needs assessments, requests for second opinions, CAHPS, access to care and satisfaction survey results when making the determination to close the network.	
Analysis			
UHA may close its network to OP providers of MH/SUD and M/S services when the CCO determines there is no community need for new providers to meet service capacity and access standards. Developing a network based on network adequacy and sufficiency standards is supported by federal regulation, including the ability of a managed care organization (CCO) to limit contracting beyond the needs of its members to maintain quality and control costs (42 CFR §438.12). OAR 410-141-0220 also requires the CCO to meet network sufficiency standards, which impacts the application of this NQTL. In addition, provider network admission limits do not apply to FFS benefits, and the application of provider network admission NQTLs for benefits delivered under managed care is supported by 42 CFR §438.206 and §438.12. Accordingly, parity was not analyzed.			

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Comparability The closing of the CCO's network to new MH/SUD and M/S providers is to balance the ready and timely access of members to services; maintain and assure the integrity, safety, and quality of the network providers and facilities; and maintain a network that is cost-effective and meets the triple aim. Although the CCO closed its network to chiropractic and physical therapy providers in some ZIP Codes, it ended up accepting applications for those provider types. The CCO also reported a network closure to some mail order durable medical equipment (DME) providers to support store front DMEs in the CCO's region. These closures did not result in impacts on provider availability or parity across MH/SUD and M/S benefits. Based on these findings, the CCO's strategy and evidence for closing the network to OP 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. **Stringency** All requests for network admission of providers of MH/SUD and M/S services were reviewed for need based on the network adequacy of the current provider network. UHA reported that when it determines particular provider types are not needed, provider requests to join the network are declined and the provider may not be reimbursed for provided services. For MH/SUD providers, monitoring included reviewing the provider capacity report/mapping quarterly to ensure adequate geographic coverage, provider capacity reports by county and/or ZIP Code, and provider specialty and the number of covered lives in each county. Access to care complaints, timeliness of accessing care from the date of referral to first appointment, and the number of behavioral health integration sites in the community were being reviewed to determine whether or not to close the network to providers. The CCO reported that it had not closed its network to any providers but was prioritizing behavioral health providers to maximize the use of certain providers (e.g., qualified mental health professionals, integrated primary care providers, and providers with integrated pharmacy prescribing capabilities).			
Outcome			
HSAG's analysis of UHA's reported information resulted in the determination that the CCO's network closure processes and decisions for MH/SUD providers were comparable to and no more stringently applied to M/S providers.			

Category V—Provider Admission—Network Credentialing

NQTL: Provider Admission

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

Classification: IP and OP

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FF M/S
– Ensure capabilities of provider to deliver high quality of care – Ensure provider meets minimum competency standards	provider fraud, waste, and abuse.	– Ensure capabilities of provider to deliver high quality of care – Ensure provider meets minimum competency standards	provider fraud, waste, and abuse.
3. What evidence supports the rationale for the assignment?			
• Credentialing/re-cred requirements are supported by the following evidence: – State law and Federal regulations, including 42 CFR 438.214 – State contract requirements – Accreditation guidelines (NCQA)	• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E-Provider Screening and Enrollment.	• Credentialing/re-cred requirements are supported by the following evidence: – State law and Federal regulations, including 42 CFR 438.214 – State contract requirements – Accreditation guidelines (NCQA)	• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E-Provider Screening and Enrollment.
4. What are the NQTL procedures?			
• All providers must meet credentialing and re-credentialing requirements. • Providers must complete and provide OPCA/OPRCA. • Providers may submit supporting documentation by fax, paper and email. • CCO's credentialing process involves the following: after receipt of the completed OPCA/OPRCA, and ensuring	• 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	• All providers must meet credentialing and re-credentialing requirements. • Providers must complete and provide OPCA/OPRCA. • Providers may submit supporting documentation by fax, paper and email. • CCO's credentialing process involves the following: after receipt of the completed OPCA/OPRCA, and ensuring	• 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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FF M/S
no adverse information was identified, (i.e., felony convictions) the CCO then performs primary source verification of the following: State license, clinical privilege, 24 hour coverage, malpractice insurance, malpractice history, board certification, education, DEA certificate as applicable, impairments as applicable, HHS-OIG • LEIE, SAM, NPDB work history. Upon completion of the review, information is submitted to the credentialing committee to approve or deny application. The provider is notified via letter of the credentialing committee's decision. • CCO's credentialing process averages 15-90 days. • CCO's Credentialing Committee is responsible for reviewing required information and making provider credentialing decisions.	requirements such as NPI, tax ID, disclosures, and licensure/certification. The provider enrollment forms vary from 1 to 19 pages, depending on the provider type. Supporting documentation includes the provider's IRS letter, licensure, SSN number, and/or Medicare enrollment as applicable to the provider type. The enrollment forms and documentation can be faxed in or completed and submitted electronically to the State's provider enrollment unit. The State's provider enrollment process includes checking the forms for completeness, running the provider name against exclusion databases, and verifying any licenses, certifications or equivalents. The State's enrollment process averages 7 to 14 days. State staff in the provider enrollment unit are responsible for reviewing information and making provider enrollment decisions.	no adverse information was identified, (i.e., felony convictions) the CCO then performs primary source verification of the following: State license, clinical privilege, 24 hour coverage, malpractice insurance, malpractice history, board certification, education, DEA certificate as applicable, impairments as applicable, HHS-OIG • LEIE, SAM, NPDB work history. Upon completion of the review, information is submitted to the credentialing committee to approve or deny application. The provider is notified via letter of the credentialing committee's decision. • CCO's credentialing process averages 15-90 days. • CCO's Credentialing Committee is responsible for reviewing required information and making provider credentialing decisions.	requirements such as NPI, tax ID, disclosures, and licensure/certification. The provider enrollment forms vary from 1 to 19 pages, depending on the provider type. Supporting documentation includes the provider's IRS letter, licensure, SSN number, and/or Medicare enrollment as applicable to the provider type. The enrollment forms and documentation can be faxed in or completed and submitted electronically to the State's provider enrollment unit. The State's provider enrollment process includes checking the forms for completeness, running the provider name against exclusion databases, and verifying any licenses, certifications or equivalents. The State's enrollment process averages 7 to 14 days. State staff in the provider enrollment unit are responsible for reviewing information and making provider enrollment decisions

CCO MH/SUD	FFS MH/SUD	CCO M/S	FF M/S
• CCO performs re-credentialing every three years after the providers initial credentialing. • Providers who do not meet credentialing/re-credentialing requirements may be denied payment for care and denied participation as an in-network provider. • Providers who are adversely affected by credentialing or re-credentialing decisions may challenge the decision by requesting appeal within 30 days of the adverse action to the credentialing committee. The provider will be advised of the process and their hearing rights. The provider is permitted to introduce additional information to the credentialing committee for consideration or reversal of previous decisions. The fair hearing process will be conducted an ad hoc committee composed of 5 providers appointed by the credentialing committee consisting of current CCO panel providers.		• CCO performs re-credentialing every three years after the providers initial credentialing. • Providers who do not meet credentialing/re-credentialing requirements may be denied payment for care and denied participation as an in-network provider. • Providers who are adversely affected by credentialing or re-credentialing decisions may challenge the decision by requesting appeal within 30 days of the adverse action to the credentialing committee. The provider will be advised of the process and their hearing rights. The provider is permitted to introduce additional information to the credentialing committee for consideration or reversal of previous decisions. The fair hearing process will be conducted an ad hoc committee composed of 5 providers appointed by the credentialing committee consisting of current CCO panel providers.	

CCO MH/SUD	FFS MH/SUD	CCO M/S	FF M/S
5. How frequently or strictly is the NQTL applied?			
• All providers/provider types must be credentialed. • There are no exceptions to meeting these requirements.	• All providers/provider types are subject to enrollment/re-enrollment requirements. • There are no exceptions to meeting provider enrollment/re-enrollment requirements.	• All providers/provider types must be credentialed. • There are exceptions to meeting these requirements.	• All providers/provider types are subject to enrollment/re-enrollment requirements. • There are no exceptions to meeting provider enrollment/re-enrollment requirements.
6. What standard supports the frequency or rigor with which the NQTL is applied?			
• Requirement to conduct credentialing for all new providers is established by State law and Federal regulations. • The frequency with which CCO performs re-credentialing is based upon: – State law and Federal regulations. – State contract requirements. CCO contract. – Monitoring of provider performance. – National accreditation standards (NCQA). • CCO does not monitor data/information to determine how strictly to apply credentialing/ re-credentialing	• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E - Provider Screening and Enrollment. The frequency with which the State re-enrolls providers is based on State law and Federal regulations.	• Requirement to conduct credentialing for all new providers is established by State law and Federal regulations. • The frequency with which CCO performs re-credentialing is based upon: – State law and Federal regulations. – State contract requirements – CCO contract. – Monitoring of provider performance. – National accreditation standards (NCQA). • CCO does not monitor data/information to determine how strictly to apply credentialing/ re-credentialing	• 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	FF M/S
criteria but notes that there is a relatively		criteria but notes that there is a relatively	

Analysis

All IP and OP providers of MH/SUD and M/S services were subject to CCO credentialing and recredentialing requirements. UHA conducted credentialing and recredentialing for both providers of MH/SUD and M/S services to meet State and federal requirements, ensure providers are capable of delivering high-quality care, and ensure providers meet minimum competency standards. The CCO's processes were the same across all benefit packages (CCOA, CCOB, CCOE, and CCOG).

HSAG's analysis of UHA's provider credentialing data did not reveal parity concerns due to overall low denial rates reported for providers seeking credentialing during the reporting period. The total denial rate for all provider types was 20.83 percent, with 13.33 percent of MH/SUD providers denied as compared to 24.24 percent of M/S providers denied.

Comparability

UHA requires providers of MH/SUD and M/S services to successfully meet credentialing and recredentialing requirements in order to be admitted to and continue to participate in the CCO's network. Providers were required to complete and submit a credentialing application and provide supporting documentation as part of the credentialing process. Both MH/SUD and M/S providers had several methods of submitting their application and supporting documentation, including by fax, by mail, or electronically. Nonlicensed MH care providers (e.g., qualified mental health providers/assistants and traditional health care works) were vetted similarly, with verifications typically completed during the hiring process, according to qualifications and certifications related to specific provider type.

The CCO's credentialing process for MH/SUD providers included the primary source verification of licensing, board certification, Medicare Excluded Providers (Office of Inspector General), Medicare sanction (Excluded Parties List System/System for Award Management), Medicare opt-out (if applicable), and a National Practitioner Database query match to look for unexplained gaps in work history greater than six months. The process for M/S providers involved a similar review of each application to determine whether standards are met. Letters documenting the credentialing decision would be sent to the provider.

Stringency

The credentialing process for both MH/SUD and M/S providers averaged 15 to 90 days depending on the completeness of the application and timeliness of primary source verification documents. The CCO's credentialing committee was responsible for reviewing required information and making provider credentialing decisions for both MH/SUD and M/S providers. Recredentialing for both MH/SUD and M/S providers was conducted every three years, or as needed based on self-disclosure of certain kinds of incidents or background checks. Failure for MH/SUD and M/S providers to meet credentialing and recredentialing requirements resulted in exclusion from the CCO's network. MH/SUD and M/S providers

CCO MH/SUD	FFS MH/SUD	CCO M/S	FF M/S
adversely affected by credentialing or recredentialing decisions could challenge the decision by requesting an appeal within 30 days of the adverse action to the credentialing committee.			
Outcome			
HSAG's analysis found UHA's credentialing and recredentialing processes to be comparable and no more stringently applied, in writing and in operation, to processes used for M/S provider admission across the applicable benefit packages (e.g., CCOA and CCOB).			

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

NQTL: OON and OOS limits

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

Classification: IP and OP

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

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

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

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availability of a qualified provider. • 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 declines to accept the Medicaid FFS (DMAP) rate. • The CCO's process for establishing a SCA includes contacting the provider and collecting pertinent information including claims address and tax ID and negotiating the terms of the SCA. • The average length of time to negotiate a SCA is 14 to 30 days. • Only providers enrolled in Oregon Medicaid can qualify as an OON/OOS provider.	• The timeframe for approving or denying a non-emergency OOS request is the same as for other PAs (14 days for standard and three business days for urgent). • OOS providers must enroll with Oregon Medicaid. • The State pays OOS providers the Medicaid FFS rate.	availability of a qualified provider. • 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 declines to accept the Medicaid FFS (DMAP) rate. • The CCO's process for establishing a SCA includes contacting the provider and collecting pertinent information including claims address and tax ID and negotiating the terms of the SCA. • The average length of time to negotiate a SCA is 14 to 30 days. • Only providers enrolled in Oregon Medicaid can qualify as an OON/OOS provider.	• The timeframe for approving or denying a non-emergency OOS request is the same as for other PAs (14 days for standard and three business days for urgent). • OOS providers must enroll with Oregon Medicaid. • The State pays OOS providers the Medicaid FFS rate.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FF M/S
• The CCO pays OON/OOS providers: – The Medicaid FFS rate; – A percentage of the Medicaid FFS rate; or – A negotiated rate.		• The CCO pays OON/OOS providers: – The Medicaid FFS rate; – A percentage of the Medicaid FFS rate; or – A negotiated rate.	
5. How frequently or strictly is the NQTL applied?			
• If a request for a non-emergency • OON/OOS benefit does not meet the CCO's OON/OOS criteria, it will not be prior authorized. • If a non-emergency OON/OOS benefit is not prior authorized, the service will not be covered, and payment for the service will be denied. • Members/providers may appeal the denial of an OON/OOS request. • The CCO measures the stringency of the application of OON/OOS requirements though claims data analysis. • The CCO evaluates the number of SCAs annually to determine whether the network should be expanded or a particular OON/OOS should	• If a request for a non-emergency OOS benefit does not meet the OAR criteria, it will not be authorized. • If a non-emergency OOS benefit is not authorized, the service will not be covered, and payment for the service will be denied. • Members/providers may appeal the denial of an OOS request. • The State measures the stringency of the application of OOS requirements by reviewing OOS denial/appeal rates.	• If a request for a non-emergency • OON/OOS benefit does not meet the CCO's OON/OOS criteria, it will not be prior authorized. • If a non-emergency OON/OOS benefit is not prior authorized, the service will not be covered, and payment for the service will be denied. • Members/providers may appeal the denial of an OON/OOS request. • The CCO measures the stringency of the application of OON/OOS requirements through claims data analysis. • The CCO evaluates the number of SCAs annually to determine whether the network should be expanded or a particular OON/OOS should	• If a request for a non-emergency OOS benefit does not meet the OAR criteria, it will not be authorized. • If a non-emergency OOS benefit is not authorized, the service will not be covered, and payment for the service will be denied. • Members/providers may appeal the denial of an OOS request. • The State measures the stringency of the application of OOS requirements by reviewing OOS denial/appeal rates.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FF M/S
Outcome			
HSAG determined the processes, strategies, and evidentiary standards for OON/OOS limits applied to MH/SUD to be comparable and no more stringently applied, in writing and in operation, to M/S OON/OOS limits across all benefit packages.			

Appendix C. Improvement Plan Template

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