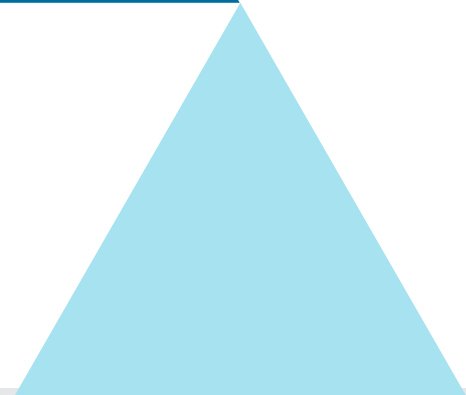
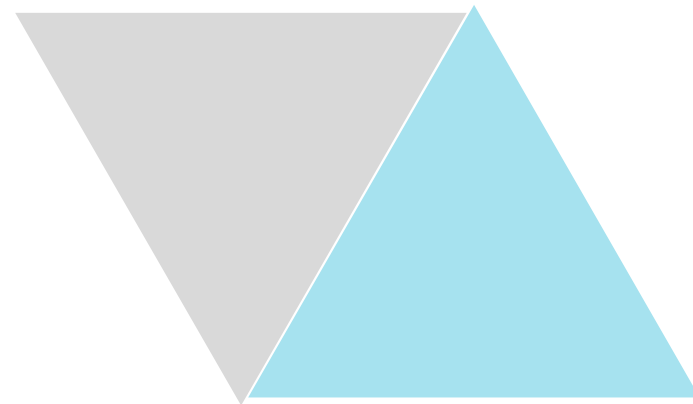
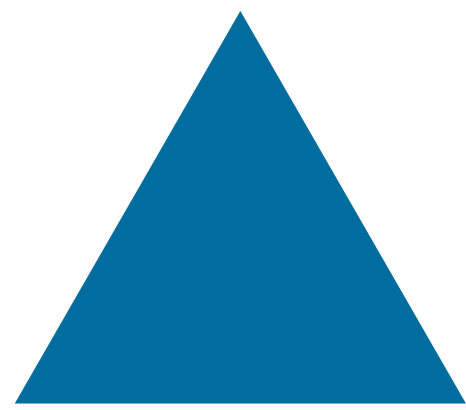


HEALTH WEALTH CAREER

**EASTERN OREGON  
COMMUNITY CARE  
ORGANIZATION (EOCCO)**

**NQTL ANALYSIS**



**MAKE TOMORROW, TODAY**



# CONTENTS

Introduction .....	3
Inpatient Utilization Management .....	5
Outpatient Utilization Management .....	26
Prior Authorization for Prescription Drugs NQTL Analysis .....	40
Provider Admission — Closed Network .....	45
Provider Admission — Network Credentialing and Requirements in Addition to State Licensing .....	52
Provider Admission — Provider Exclusions .....	61
Out of Network (OON)/Out of State (OOS) .....	63

## INTRODUCTION

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

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

OHA analyzed the following four NQTLs for each CCO:

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

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

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

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

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

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

**INPATIENT UTILIZATION MANAGEMENT**

**NQTL:** Utilization Management (PA, CR, RR)

**Benefit Package:** A and B for Adults and Children

**Classification:** Inpatient (IP)

**CCO:** Eastern Oregon Community Care Organization (EOCCO)

MH/SUD benefits in columns 1 (CCO MH/SUD) and 2 (FFS MH/SUD) compared using strategies 1-3 to M/S benefits in column 3 (CCO M/S). These benefit packages include MH/SUD IP benefits managed by the CCO (GOBHI administers MH/SUD benefits), OHA, HIA and KEPRO, compared to M/S IP benefits managed by the CCO (Moda administers M/S benefits).

**1. To which benefits is the NQTL assigned?**

CCO MH/SUD	FFS MH/SUD	CCO M/S <sup>1</sup>
<ul style="list-style-type: none"> <li>(1, 2, 3) PA and CR are required for planned non-emergency admissions to acute IP (in and out-of-network (OON)), PRTS and subacute.</li> <li>(1, 2, 3) Emergency admissions require notification within 1-3 days of admission and subsequent CR.</li> <li>(1, 3) Extra-contractual and experimental/investigational/ unproven benefit requests (i.e., exceptions) are submitted through a PA-like process.</li> </ul>	<ul style="list-style-type: none"> <li>(1, 3) PA (only) for MH/SUD procedures performed in a medical facility (e.g., gender reassignment surgery authorizations for benefit packages E and G), experimental/investigational, and extra-contractual benefits are conducted by OHA consistent with the information in column 4 for benefit packages E and G.</li> <li>(2, 3, 4) A level-of-care review is required for SCIP, SAIP and subacute care that is conducted by an OHA designee. (CCO notification is required for emergency admissions to subacute.)</li> <li>(1, 3, 4) PA for SCIP, SAIP and subacute admission is obtained through a peer-to-</li> </ul>	<ul style="list-style-type: none"> <li>(1, 2, 3) PA and CR are required for planned non-emergency admissions to acute IP (in and out-of-network (OON).</li> <li>(1, 2, 3) Emergency admissions require notification within 1-3 days of admission and subsequent CR.</li> <li>(1, 2, 3) Skilled nursing facility benefits (first 20 days) require PA.</li> <li>(1, 3) Extra-contractual and experimental/investigational/ unproven benefit requests (i.e., exceptions) are submitted through a PA-like process.</li> </ul>

<sup>1</sup> Multiple State agencies also administer a M/S benefit, Behavior Rehabilitation Services (BRS). BRS' unique processes are not reflected in the analysis below; however, OHA determined that including BRS processes would not impact the parity findings.

CCO MH/SUD	FFS MH/SUD	CCO M/S <sup>1</sup>
	<p>peer review between an HIA psychiatrist and the referring psychiatrist.</p> <ul style="list-style-type: none"> <li>• (1, 2, 3, 4) CR and RR for SCIP and SAIP are performed by HIA.</li> <li>• (1, 2, 3) CR and RR for subacute care are conducted by the CCO. (See column 1.)</li> <li>• (1, 2, 3) PA, inclusive of a Certificate of Need (CONS) process, is conducted by HIA for PRTS. PRTS CR is conducted by the CCO. (See column 1.)</li> <li>• (1, 2, 3, 4) PA and CR for AFH, SRTF, SRTH, YAP, RTF, and RTH are performed by KEPRO.</li> </ul>	

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>• (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<sup>2</sup>).</li> <li>• (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual.</li> </ul>	<ul style="list-style-type: none"> <li>• (1) UM is assigned to ensure medical necessity of services/prevent overutilization of these high cost services.</li> <li>• (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).</li> </ul>	<ul style="list-style-type: none"> <li>• (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).</li> <li>• (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual.</li> </ul>

<sup>2</sup> Reference to HERC PL and/or guidelines includes the Prioritized List of Health Services, guideline notes, and the body of literature behind the guideline notes.

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>(3) To comply with federal and State requirements</li> </ul>	<ul style="list-style-type: none"> <li>(3) To comply with federal and State requirements.</li> <li>(4) Most MH residential services were excluded from the capitated arrangements with the CCOs due to the high cost and unpredictability of services and associated risk.</li> </ul>	<ul style="list-style-type: none"> <li>(3) To comply with federal and State requirements</li> </ul>

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>(1, 2 and 3) HERC PL and guidelines.</li> <li>(1) UM and claims reports are reviewed for trends in overutilization on a quarterly basis. Reviews are conducted relative to average cost per episode, comparisons of similar providers and procedure codes.</li> <li>(1) Annual cost and utilization reports that confirm IP as a cost driver based on percentage of spend.</li> <li>(1) Medical literature demonstrates high cost of unnecessary medical care (i.e. 30% of medical costs). (Institute of Medicine Report, (2012). Also see Fisher, Elliott S., MD, MPH, Wennberg, David E., MD, MPH, Stukel, Therese A., PhD et al., The Implications of Regional Variations in Medicare Spending: Part 2. Health Outcomes and Satisfaction with Care, Center for the Evaluative Clinical Sciences, Dartmouth Medical School, VA</li> </ul>	<ul style="list-style-type: none"> <li>(1, 2 and 3) HERC PL and guidelines. (HERC provides outcome evidence and clinical indications for certain diagnoses that may be translated into UM requirements.)</li> <li>(1) Medical literature demonstrates high cost of unnecessary medical care (i.e., 30% of medical costs). (Institute of Medicine Report, (2012). Also see Fisher, Elliott S., MD, MPH, Wennberg, David E., MD, MPH, Stukel, Therese A., PhD et al., The Implications of Regional Variations in Medicare Spending: Part 2. Health Outcomes and Satisfaction with Care, Center for the Evaluative Clinical Sciences, Dartmouth Medical School, VA Outcomes Group, White River Junction</li> </ul>	<ul style="list-style-type: none"> <li>(1, 2 and 3) HERC PL and guidelines.</li> <li>(1) UM and claims reports are reviewed for trends in overutilization on a quarterly basis.</li> <li>(1) Annual cost and utilization reports that confirm IP as a cost driver based on percentage of spend.</li> <li>(1) Medical literature demonstrates high cost of unnecessary medical care (i.e. 30% of medical costs). (Institute of Medicine Report, (2012)). Also see Fisher, Elliott S., MD, MPH, Wennberg, David E., MD, MPH, Stukel, Therese A., PhD et al., The Implications of Regional Variations in Medicare Spending: Part 2. Health Outcomes and Satisfaction with Care, Center for the Evaluative Clinical Sciences, Dartmouth Medical School, VA Outcomes Group, White River Junction VT, Center for Outcomes Research and</li> </ul>

CCO MH/SUD	FFS MH/SUD	CCO M/S
<p>Outcomes Group, White River Junction VT, Center for Outcomes Research and Evaluation, Maine Medical Center, &amp; Institute for the Evaluative Clinical Sciences, Toronto, Canada, Financial support was provided by grants from the Robert, Wood Johnson Foundation, the National Institutes of Health (Grant Number CA52192) and the National Institute of Aging (Grant Number 1PO1AG19783-01), 2002, pp 1-32.</p> <ul style="list-style-type: none"> <li>• (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 &amp; Nelson, K., A Review of Economic Evaluations of Community Mental Health Care, Sage Journals, Oct. 1, 2005, 1-13. Accessed May 25, 2018. <a href="http://journals.sagepub.com/doi/10.1177/1077558705279307">http://journals.sagepub.com/doi/10.1177/1077558705279307</a>.</li> </ul>	<p>VT, Center for Outcomes Research and Evaluation, Maine Medical Center, &amp; Institute for the Evaluative Clinical Sciences, Toronto, Canada, Financial support was provided by grants from the Robert, Wood Johnson Foundation, the National Institutes of Health (Grant Number CA52192) and the National Institute of Aging (Grant Number 1PO1AG19783-01), 2002, pp 1-32.</p> <ul style="list-style-type: none"> <li>• (2) The Oregon Performance Plan (OPP) requires that BH services be provided in the least restrictive setting possible. The OPP is a DOJ-negotiated Olmsted settlement.</li> </ul>	<p>Evaluation, Maine Medical Center, &amp; Institute for the Evaluative Clinical Sciences, Toronto, Canada, Financial support was provided by grants from the Robert, Wood Johnson Foundation, the National Institutes of Health (Grant Number CA52192) and the National Institute of Aging (Grant Number 1PO1AG19783-01), 2002, pp 1-32.</p> <ul style="list-style-type: none"> <li>• (2) Medical errors in the hospital is the third leading cause of death in the US. Makary, M. &amp; Daniel, M. Medical Error - The Third Leading Cause of Death in the US, BMJ, 2016;353:i2139.</li> </ul>

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>(2) Inherent restrictiveness of residential settings and dangers associated with seclusion and restraint. Also see Cusack, K.J., Frueh, C., Hiers, T., et. al., <i>Trauma within the Psychiatric Setting: A Preliminary Empirical Report</i>, Human Services Press, Inc., 2003. 453-460.</li> <li>(3) Applicable State and federal requirements.</li> </ul>	<ul style="list-style-type: none"> <li>(3) PRTS CONS: OAR 410-172-0690 and 42 CFR 441.156.</li> <li>(3) OARs and other applicable federal and State requirements.</li> <li>(4) Cost and utilization reports.</li> </ul>	<ul style="list-style-type: none"> <li>(3) Applicable State and federal requirements.</li> </ul>

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
<p><b>Timelines for authorizations:</b></p> <ul style="list-style-type: none"> <li>PA must be obtained prior to IP admission, preferably 14 days prior to admission, except in the case of emergencies, when notification is required 1–3 days following the admission.</li> <li>Authorization requests for sub-acute admissions must be made within 1 calendar day of admission.</li> <li>For youth residential (PRTS and subacute), most referrals originate with CCO and require a Certificate of Need (CON) be completed by HIA (usually takes 1 week to complete).</li> <li>Authorization decisions for acute hospitalization, acute non-hospitalization,</li> </ul>	<p><b>Timelines for gender reassignment surgery authorizations (for benefit packages E and G):</b>  <b>(OHA)</b></p> <ul style="list-style-type: none"> <li>Standard requests are to be processed within 14 days.</li> </ul> <p><b>Timelines for child residential authorizations:</b>  <b>(OHA)</b></p> <ul style="list-style-type: none"> <li>OHA provides the initial authorization (level-of-care review) within 3 days of requests for SCIP, SAIP or subacute.</li> </ul> <p><b>(HIA)</b></p> <ul style="list-style-type: none"> <li>Authorization requests for PRTS are submitted prior to admission or within 14 days of an emergency admission. An</li> </ul>	<p><b>Timelines for authorizations:</b></p> <ul style="list-style-type: none"> <li>PA must be obtained prior to IP admission, preferably 14 days prior to admission, except in the case of emergencies, when notification is required 1–3 days following the admission.</li> <li>The full 20 day SNF benefit is authorized during PA.</li> <li>Authorization decisions for acute hospitalization and OON requests are</li> </ul>

CCO MH/SUD	FFS MH/SUD	CCO M/S
<p>PRTS, residential and OON requests are made within the following timelines:</p> <ul style="list-style-type: none"> <li>– Concurrent (within 1 calendar day)</li> <li>– Urgent pre-service (2 calendar days)</li> <li>– Non urgent pre-service (14 calendar days)</li> <li>– Post-service (within 30 days)</li> </ul> <p><b>Documentation requirements:</b></p> <ul style="list-style-type: none"> <li>• PA form is 1 page long and requires supporting documentation to be submitted.</li> </ul>	<p>emergency admission is acceptable only under unusual and extreme circumstances, subject to RR by HIA.</p> <p><b>Timelines for adult residential and YAP authorizations: (KEPRO)</b></p> <ul style="list-style-type: none"> <li>• OARs require emergency requests be processed within 24 hours, urgent within 72 hours, and standard requests within 14 days.</li> </ul> <p><b>Documentation requirements (OHA):</b></p> <ul style="list-style-type: none"> <li>• PA documentation requirements for non-residential MH/SUD benefits in benefit packages E and G include a form that consists of a cover page. Diagnostic and CPT code information and a rationale for medical necessity must be provided, plus any additional supporting documentation.</li> <li>• The documentation requirement for level-of-care assessment for SCIP, SAIP and subacute is a psychiatric evaluation. Other information may be reviewed when available.</li> </ul> <p><b>Documentation requirements for PRTS CONS and CR for SCIP and SAIP (HIA):</b></p> <ul style="list-style-type: none"> <li>• PRTS CONS requires documentation that supports the justification for child residential services including:</li> </ul>	<p>made within the following timeline submissions:</p> <ul style="list-style-type: none"> <li>– Concurrent (within 1 calendar day)</li> <li>– Urgent pre-service (2 calendar days)</li> <li>– Non urgent pre-service (14 calendar days)</li> <li>– Post-service (within 30 days)</li> </ul> <p><b>Documentation requirements:</b></p> <ul style="list-style-type: none"> <li>• PA form is 1 page long and requires supporting documentation to be submitted. Some requests may require additional forms or treatment plans.</li> </ul>

CCO MH/SUD	FFS MH/SUD	CCO M/S
	<p>(a) A cover sheet detailing relevant provider and recipient Medicaid numbers;</p> <p>(b) Requested dates of service;</p> <p>(c) HCPCS or CPT Procedure code requested; and</p> <p>(d) Amount of service or units requested;</p> <p>(e) A behavioral health assessment and service plan meeting the requirements described in OAR 309-019-0135 through 0140; or</p> <p>(f) Any additional supporting clinical information supporting medical justification for the services requested;</p> <p>(g) 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.</p> <ul style="list-style-type: none"> <li>• There were no reported specific documentation requirements for CR of SCIP or SAIP.</li> </ul> <p><b>Documentation requirements (KEPRO):</b></p> <ul style="list-style-type: none"> <li>• Documentation may include assessment, service plan, plan-of-care, Level-of-care Utilization System (LOCUS), Level of Service Inventory (LSI) or other relevant documentation.</li> </ul>	

CCO MH/SUD	FFS MH/SUD	CCO M/S
<p><b>Method of document submission:</b></p> <ul style="list-style-type: none"> <li>• Authorization requests can be made by phone, fax, email or US mail</li> </ul>	<p><b>Method of document submission (OHA):</b></p> <ul style="list-style-type: none"> <li>• For non-residential MH/SUD services in benefit packages E and G, paper (fax) or online PA requests are submitted prior to the delivery of services for which PA is required.</li> <li>• For SCIP, SAIP and subacute level-of-care review, the OHA designee may accept information via fax, mail or email and has also picked up information. Supplemental information may be obtained by phone.</li> </ul> <p><b>Method of document submission (HIA):</b></p> <ul style="list-style-type: none"> <li>• Packets are submitted to HIA by mail, fax, email or web portal for review for child residential services. Telephonic clarification may be obtained.</li> <li>• Psychiatrist to psychiatrist review is telephonic.</li> </ul> <p><b>Method of document submission (KEPRO):</b></p> <ul style="list-style-type: none"> <li>• Providers submit authorization requests for adult MH residential to KEPRO by mail, fax, e-mail or via portal, but documentation must still be faxed if the request is through the portal. Telephonic clarification may be obtained.</li> </ul>	<p><b>Method of document submission:</b></p> <ul style="list-style-type: none"> <li>• Notification for urgent/emergent admissions can be by faxed admission form or by phone</li> </ul>

CCO MH/SUD	FFS MH/SUD	CCO M/S
<p><b>Qualifications of reviewers:</b></p> <ul style="list-style-type: none"> <li>• PA decisions are made by licensed healthcare professionals with appropriate credentials.</li> <li>• Medical director or licensed physician reviewers determine denials.</li> </ul>	<p><b>Qualifications of reviewers (OHA):</b></p> <ul style="list-style-type: none"> <li>• OHA M/S staff conduct PA and CR (if applicable) for gender reassignment surgery (for benefit packages E and G). (See processes, strategies and evidentiary standards in column 4.)</li> <li>• The OHA designee is a licensed, masters'-prepared therapist that reviews psychiatric evaluations to approve or deny the level-of-care requested. Psychiatric consultation is available if needed.</li> </ul> <p><b>Qualifications of reviewers (HIA):</b></p> <ul style="list-style-type: none"> <li>• Two LCSWs with QMHP designation make residential authorization decisions.</li> <li>• Two psychiatrists make CONS determinations.</li> </ul> <p><b>Qualifications of reviewers (KEPRO):</b></p> <ul style="list-style-type: none"> <li>• KEPRO QMHPs must meet minimum qualifications (see below) and demonstrate the ability to conduct and review an assessment, including identifying precipitating events, gathering histories of mental and physical health, substance use, past mental health services and criminal justice contacts, assessing family, cultural, social and work</li> </ul>	<p><b>Qualifications of reviewers:</b></p> <ul style="list-style-type: none"> <li>• PA decisions are made by a nurse.</li> <li>• Medical director determines denials.</li> </ul>

CCO MH/SUD	FFS MH/SUD	CCO M/S
<p><b>Criteria:</b></p> <ul style="list-style-type: none"> <li>• Authorization decisions are made using MCG, ASAM, HERC PL and guidelines, OAR, internal UM guidelines or other MNC relevant to the situation.</li> </ul>	<p>relationships, and conducting/reviewing a mental status examination, complete a DSM diagnosis, and write and supervise the implementation of a PCSP.</p> <ul style="list-style-type: none"> <li>• A QMHP must meet one of the follow conditions:           <ul style="list-style-type: none"> <li>– Bachelor’s degree in nursing and licensed by the State or Oregon;</li> <li>– Bachelor’s degree in occupational therapy and licensed by the State of Oregon;</li> <li>– Graduate degree in psychology;</li> <li>– Graduate degree in social work;</li> <li>– Graduate degree in recreational, art, or music therapy;</li> <li>– Graduate degree in a behavioral science field; or</li> <li>– A qualified Mental Health Intern, as defined in 309-019-0105(61).</li> </ul> </li> </ul> <p><b>Criteria (OHA):</b></p> <ul style="list-style-type: none"> <li>• Authorizations for non-residential MH/SUD services in benefit packages E and G are based on the HERC PL and guidelines, Oregon Statute, OAR, federal regulations, and evidence-based guidelines from private and professional associations.</li> </ul>	<p><b>Criteria:</b></p> <ul style="list-style-type: none"> <li>• Authorizations decisions are made using MCG, InterQual, HERC PL and guidelines, OAR.</li> </ul>

CCO MH/SUD	FFS MH/SUD	CCO M/S
	<ul style="list-style-type: none"> <li>• The OHA designee reviews requests relative to the least restrictive environment requirement.</li> </ul> <p><b>Criteria (HIA):</b></p> <ul style="list-style-type: none"> <li>• HERC PL and HIA policy are used for residential CR.</li> </ul> <p><b>Criteria (KEPRO):</b></p> <ul style="list-style-type: none"> <li>• QMHPs review information submitted by providers relative to State plan and OAR requirements and develop a PCSP.</li> <li>• The PCSP components are entered into MMIS as an authorization.</li> </ul>	
<p><b>Reconsideration/RR:</b></p> <ul style="list-style-type: none"> <li>• RR is offered for providers who fail to PA medically necessary care.</li> </ul>	<p><b>Reconsideration/RR (OHA):</b></p> <ul style="list-style-type: none"> <li>• A provider may request review of an OHA denial decision. The review occurs in weekly Medical Management Committee (MMC) meetings. (Applies to non-residential MH/SUD services in benefit packages E and G.)</li> <li>• Exception requests for experimental and other non-covered benefits (for benefit packages E and G) may be granted at the discretion of the MMC, which is led by the HSD medical director.</li> <li>• If a provider requests review of an OHA designee level-of-care determination, HIA may conduct the second review.</li> </ul>	<p><b>Reconsideration/RR:</b></p> <ul style="list-style-type: none"> <li>• RR is offered for providers who fail to PA medically necessary care.</li> </ul>

CCO MH/SUD	FFS MH/SUD	CCO M/S
<p><b>Appeals:</b></p> <ul style="list-style-type: none"> <li>• Providers/members have appeal rights</li> <li>• The only procedural difference for children (relative to adults) is the parental guardian procedures.</li> </ul>	<p><b>Reconsideration/RR (HIA):</b></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• No policy for CR denials.</li> </ul> <p><b>Reconsideration/RR (KEPRO):</b></p> <ul style="list-style-type: none"> <li>• Within 10 days of a denial, the provider may send additional documentation to KEPRO for reconsideration.</li> </ul> <p>A provider may request review of a denial decision, which occurs in weekly MMC meetings or KEPRO's comparable MM meeting.</p> <p><b>Appeals (OHA):</b></p> <ul style="list-style-type: none"> <li>• Members may request a hearing on any denial decision.</li> </ul> <p><b>Appeals (HIA):</b></p> <ul style="list-style-type: none"> <li>• Documentation has not included the fair hearing process.</li> </ul> <p><b>Appeals (KEPRO):</b></p> <ul style="list-style-type: none"> <li>• Members may request a hearing on any denial decision.</li> </ul>	<p><b>Appeals:</b></p> <ul style="list-style-type: none"> <li>• Providers/members have appeal rights</li> </ul>

CCO MH/SUD	FFS MH/SUD	CCO M/S
<p><b>Consequences for failure to authorize:</b></p> <ul style="list-style-type: none"> <li>Failure to obtain authorization can result in no payment</li> </ul>	<p><b>Consequences for failure to authorize (OHA):</b></p> <ul style="list-style-type: none"> <li>Failure to obtain authorization for non-residential MH/SUD services in benefit packages E and G can result in non-payment for benefits for which it is required.</li> <li>Failure to obtain notification for non-residential MH/SUD services in benefit packages E and G does not result in a financial penalty.</li> <li>For SCIP, SAIP and subacute, if coverage is retroactively denied, general funds may be used to cover the cost of care.</li> </ul> <p><b>Consequences for failure to authorize (HIA):</b></p> <ul style="list-style-type: none"> <li>Non-coverage.</li> </ul> <p><b>Consequences for failure to authorize (KEPRO):</b></p> <p>Failure to obtain authorization can result in non-payment for benefits for which it is required.</p>	<p><b>Consequences for failure to authorize:</b></p> <ul style="list-style-type: none"> <li>Failure to notify of urgent or emergent admission can result in delay or no payment</li> </ul>

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
<p><b>Frequency of review (and method of payment):</b></p> <ul style="list-style-type: none"> <li>• Authorizations for acute care are a maximum of 3 days per medical director</li> <li>• Subacute is reviewed every 5 days</li> <li>• PRTS is reviewed every 30 days.</li> <li>• SUD residential is every 30-90 days (i.e., check documentation for progress every 30 days and make authorization determination every 90 days).</li> </ul> <p><b>RR conditions and timelines:</b></p> <ul style="list-style-type: none"> <li>• RR is offered for providers who fail to PA medically necessary care. RR is offered consistent with OARs requirements.</li> </ul>	<p><b>Frequency of review (and method of payment) (OHA):</b></p> <ul style="list-style-type: none"> <li>• Gender reassignment surgery (for benefit packages E and G) is authorized as a procedure.</li> <li>• The initial authorization for SCIP, SAIP and subacute is 30 days.</li> </ul> <p><b>Frequency of review (and method of payment) (HIA):</b></p> <ul style="list-style-type: none"> <li>• Child residential services are paid by per diem.</li> <li>• Child residential services authorizations are conducted every 30-90 days.</li> </ul> <p><b>Frequency of review (and method of payment) (KEPRO):</b></p> <ul style="list-style-type: none"> <li>• Adult residential and YAP authorizations are conducted at least once per year. In practice reviews average every 6 months.</li> </ul> <p><b>RR conditions and timelines (OHA):</b></p> <ul style="list-style-type: none"> <li>• RR for non-residential MH/SUD services in benefit packages E and G is only available for retro eligibility situations (e.g., the person became eligible during the stay).</li> </ul>	<p><b>Frequency of review (and method of payment):</b></p> <ul style="list-style-type: none"> <li>• Notifications are given a 2 day authorization and chart notes are required for continued stay</li> <li>• Concurrent review timeframes are case dependent and average 3 days.</li> <li>• SNF /swing bed post-hospital extended care services are approved for a maximum of 20 days per the benefit allowance</li> <li>• Standard authorizations are valid for a date span of 90 days. If a provider is unable to perform the services within the time span, the provider can call and request an extension.</li> </ul> <p><b>RR conditions and timelines:</b></p> <ul style="list-style-type: none"> <li>• RR is offered for providers who fail to PA medically necessary care. RR is offered consistent with OARs requirements.</li> </ul>

CCO MH/SUD	FFS MH/SUD	CCO M/S
<p><b>Methods to promote consistent application of criteria:</b></p> <ul style="list-style-type: none"> <li>IRR testing is conducted semiannually.</li> </ul>	<p><b>RR conditions and timelines (HIA):</b></p> <ul style="list-style-type: none"> <li>No policy.</li> </ul> <p><b>RR conditions and timelines (KEPRO):</b></p> <ul style="list-style-type: none"> <li>The request for authorization is received within 30 days of the date of service.</li> <li>Any requests for authorization after 30 days from date of service require documentation from the provider that authorization could not have been obtained within 30 days of the date of service.</li> </ul> <p><b>Methods to promote consistent application of criteria (OHA):</b></p> <ul style="list-style-type: none"> <li>Nurses are trained on the application of the HERC PL and guidelines, which is spot-checked through ongoing supervision. Whenever possible, practice guidelines from clinical professional organizations such as the American Medical Association or the American Psychiatric Association, are used to establish PA frequency for services in the FFS system. (Applicable to non-residential MH/SUD services in benefit packages E and G.)</li> <li>There is only one OHA designee reviewer for level-of-care review for SCIP, SAIP,</li> </ul>	<p><b>Methods to promote consistent application of criteria:</b></p> <ul style="list-style-type: none"> <li>IRR testing is conducted semiannually.</li> </ul>

CCO MH/SUD	FFS MH/SUD	CCO M/S
	<p>and subacute and no specific criteria, so N/A.</p> <p><b>Methods to promote consistent application of criteria (HIA):</b></p> <ul style="list-style-type: none"> <li>• Parallel chart reviews for the two reviewers. (No criteria.)</li> </ul> <p><b>Methods to promote consistent application of criteria (KEPRO):</b></p> <ul style="list-style-type: none"> <li>• Monthly clinical team meetings in which randomly audited charts are reviewed/discussed by peers using the KEPRO compliance department-approved audit tool.</li> <li>• Results of the audit are compared, shared and discussed by the team and submitted to the Compliance Department monthly for review and documentation.</li> <li>• Individual feedback is provided to each clinician during supervision on their authorization as well as plan-of-care reviews.</li> </ul>	

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
<p><b>Evidence for UM frequency:</b></p> <ul style="list-style-type: none"> <li>• Concurrent review for acute IP and IP rehabilitation are guided by MCG and are case dependent.</li> <li>• MCG is set up for daily IP review. MCG provides the evidence-based goal for each day by diagnosis. If goal is met, MCG moves to the next phase of treatment. If treatment is not progressing consistent with daily MCG goals, then identify variance and address why (which extends expected length of stay).</li> <li>• ASAM criteria are integrated into MCG.</li> </ul>	<p><b>Evidence for UM frequency (OHA (and designee for level-of-care review), HIA and KEPRO):</b></p> <ul style="list-style-type: none"> <li>• PA length and CR frequency are tied to HERC PL and guidelines, OAR, CFRs, reviewer expertise and timelines for expectations of improvement.</li> <li>• The Commission that develops HERC consists of 13 appointed members, which include five physicians, a dentist, a public health nurse, a pharmacist and an insurance industry representative, a provider of complementary and alternative medicine, a behavioral health representative and two consumer representatives. The Commission is charged with maintaining a priority list of services, developing or identifying evidence-based health care guidelines and conducting comparative effectiveness research.</li> <li>• HERC guidelines of which there are fewer for MH/SUD than M/S. This is because 1) there are fewer technological procedures for MH/SUD (e.g., cognitive behavioral therapy and psychodynamic therapy are billed using the same codes, no surgeries, few devices); 2) the MH/SUD literature is not as robust (e.g., fewer randomized</li> </ul>	<p><b>Evidence for UM frequency:</b></p> <ul style="list-style-type: none"> <li>• Concurrent review for acute IP and IP rehabilitation and are guided by MCG and are case dependent.</li> </ul>

CCO MH/SUD	FFS MH/SUD	CCO M/S
<p><b>Data reviewed to determine UM application:</b></p> <ul style="list-style-type: none"> <li>EOCCO/GOBHI tracks all service authorization requests and evaluates the types of authorizations and denials, tracks number of denials, grievances and appeals and the outcomes.</li> </ul> <p><b>IRR standard:</b></p> <ul style="list-style-type: none"> <li>IRR testing is conducted to a standard of 80%.</li> </ul> <p><b>Results of criteria application:</b></p> <ul style="list-style-type: none"> <li>2017 IP appeal overturn rate was 58% (no hearings).</li> </ul>	<p>trials, more subjective diagnoses (or the ICD-10-CM diagnoses represent a spectrum) and less standardization in interventions).</p> <p><b>Data reviewed to determine UM application (OHA):</b></p> <ul style="list-style-type: none"> <li>Denial/appeal overturn rates; number of PA requests; stabilization of cost trends; and number of hearings requested. These data are reviewed in contractor reports, on a quarterly basis by the State. (Applicable to non-residential MH/SUD services in benefit packages E and G.)</li> </ul> <p><b>Data reviewed to determine UM application (HIA):</b> N/A</p> <p><b>Data reviewed to determine UM application (KEPRO):</b> N/A</p> <p><b>IRR standard:</b></p> <ul style="list-style-type: none"> <li>OHA: N/A</li> <li>HIA: N/A</li> <li>KEPRO: N/A</li> </ul> <p><b>Results of criteria application:</b></p> <ul style="list-style-type: none"> <li>OHA: 0 appeal overturns</li> <li>HIA: 0 appeal overturns</li> <li>KEPRO: 0 appeal overturns</li> </ul>	<p><b>Data reviewed to determine UM application:</b></p> <ul style="list-style-type: none"> <li>EOCCO/Moda tracks all service authorization requests for authorizations and denials, tracks number of denials, grievances and appeals and outcomes.</li> </ul> <p><b>IRR standard:</b></p> <ul style="list-style-type: none"> <li>IRR testing is conducted to a standard of 80%.</li> </ul> <p><b>Results of criteria application:</b></p> <ul style="list-style-type: none"> <li>In 2017, IP appeal overturn rate was 68%.</li> </ul>

## 7. Compliance Determination for CCO Benefit Packages A and B

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

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

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

Qualified individuals conduct UM applying OARs, HERC, and ASAM and MCG for CCO MH/SUD and M/S. The OHA designee reviews authorization requests to determine if the level-of-care is the least restrictive environment. HIA reviews care relative to policy. KEPRO develops PCSPs based on State plan and OAR requirements. *OHA plans to enhance the evidence base for child residential authorization decisions through additional research, resulting in admission and CR criteria development.* The medical director or a licensed physician determines CCO MH/SUD and M/S denials. The OHA designee, who is a licensed MH professional, makes denial determinations for level-of-care review for

certain child residential services. HIA denials are made by psychiatrists. KEPRO QMHPs develop PCSPs. *OHA plans to ensure that all denial decisions are made by professional peers.* The CCO may make RR available for MH/SUD and M/S. Upon provider request, the OHA designee obtains RR by HIA. HIA allows reconsideration of CONS determinations, but reported they do not have an RR policy for HIA's CR denials for child residential services. For adult residential and YAP services, KEPRO allows reconsideration of denials with the submission of additional documentation within 10 days of the denial. For OHA and KEPRO, the review of a denial decision occurs in a weekly MMC meeting. *OHA intends to standardize RR processes when feasible.* Providers may appeal a MH/SUD and M/S denial decision by the CCO. OHA FFS reviews denials through the fair hearing process, but HIA and the OHA designee have not encouraged use of this process. *OHA plans to confirm all notices of action, appeal and fair hearing processes are consistent with federal requirements.* Failure to obtain authorization may result in non-coverage, although SCIP, SAIP and subacute services may be covered by general fund dollars. Inclusive of OHA's action plans, the MH/SUD and M/S processes are comparable and no more stringently applied to MH/SUD benefits.

**Stringency of Strategy and Evidence:** Concurrent review is case dependent but, on average, is conducted every 3 days for MH/SUD and M/S IP hospital. CCO MH/SUD residential (e.g., SUD, subacute and PRTS) frequency of review ranges from every 5 days to 3 months. FFS child residential is reviewed every 30-90 days while FFS adult residential and YAP are reviewed no less than annually, but in practice averages 6 months. The CCO authorizes the full 20 day benefit for SNF. Evidence for the frequency of CCO review includes ASAM and MCG. *OHA plans to task FFS subcontractors with review of CR residential frequencies relative to the most recent research to confirm MH/SUD review frequency is directly tied to evidence rather than historical standard practice.* The CCO offers RR within 30 days of admission for MH/SUD and 90 days to 1 year of admission for M/S. KEPRO makes RR available for 30 days post-admission. The OHA designee and HIA do not have standard policies describing when RR is available. In addition, it was discovered that there are conflicting State rules regarding RR timelines. *OHA plans to standardize the availability of RR, including the conditions under which it is permissible and the timeframes. OHA will align OAR requirements and RR offerings by contractors.* The CCO and State review utilization data to determine if PA or CR should be added or adjusted for MH/SUD and M/S IP benefits. For both MH/SUD and M/S the CCO conducts IRR testing to a standard of 80%. HIA conducts parallel chart reviews for its two reviewers and KEPRO team meetings include random chart audits using a compliance tool followed by team discussion. There is no formal oversight of criteria application for the OHA designee level-of-care review process for certain child residential services. *OHA plans to institute a more formalized measurement of criteria application when feasible.* The CCO reported a 68% appeal overturn rate for M/S and a 58% appeal overturn rate for MH/SUD. FFS MH/SUD appeal overturn rates were 0 in 2017. Inclusive of OHA action plans, the strategy and evidence are no more stringently applied to MH/SUD than to M/S in writing or in operation.

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

*Below are the OHA action plans:*

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

**OUTPATIENT UTILIZATION MANAGEMENT**

**NQTL:** Utilization Management (PA, CR, RR)

**Benefit Package:** A and B for Adults and Children

**Classification:** Outpatient (OP)

**CCO:** EOCCO

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

**1. To which benefits is the NQTL assigned?**

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>• (1) 1915(c) Comprehensive DD waiver (operated/managed by DHS)</li> <li>• (1) 1915(c) Support Services DD waiver (operated/managed by DHS)</li> <li>• (1) 1915(c) Behavioral DD Model waiver (operated/managed by DHS)</li> <li>• (1) 1915(i)(HK) services for adults (home-based habilitation, behavioral habilitation and psychosocial rehab for persons with CMI) (managed by KEPRO under contract with OHA)</li> </ul>	<p>The following services are managed by DHS:</p> <ul style="list-style-type: none"> <li>• (1) 1915(c) Comprehensive DD waiver</li> <li>• (1) 1915(c) Support Services DD waiver</li> <li>• (1) 1915(c) Behavioral DD Model waiver</li> <li>• (1) 1915(c) Aged &amp; Physically Disabled waiver</li> <li>• (1) 1915(c) Hospital Model waiver</li> <li>• (1) 1915(c) Medically Involved Children’s NF waiver</li> <li>• (1) 1915(k) Community First Choice State Plan option</li> <li>• (1) 1915(j): Self-directed personal assistance</li> </ul>	<ul style="list-style-type: none"> <li>• (2) ABA (including PT/ST/OT)</li> <li>• (3) ECT</li> <li>• (3) SUD MAT</li> <li>• (2, 3) OON OP - requires notification followed by a medical necessity review and qualifications check.</li> </ul>	<ul style="list-style-type: none"> <li>• (2) PT/OT/ST</li> <li>• (3) Bariatric evaluation</li> <li>• (2) Acupuncture</li> <li>• (2) Chiropractic services</li> <li>• (2) OMT and CMT, habilitative or rehabilitative</li> <li>• (2) DME</li> <li>• (2, 3) Imaging</li> <li>• (2) Elective surgical procedures</li> <li>• (3) Pain management related to back pain (only if practitioner is not qualified in CBT or pain management, requiring a SCA)</li> <li>• (2) OP transplants</li> </ul>

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
			<ul style="list-style-type: none"> <li>(2) Potentially cosmetic services</li> </ul>

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>(1) The State requires PA of HCBS in order to meet federal requirements regarding PCSPs and ensure services are provided in accordance with a participant's PCSP and in the least restrictive setting.</li> </ul>	<ul style="list-style-type: none"> <li>(1) The State requires PA of HCBS in order to meet federal requirements regarding PCSPs and ensure services are provided in accordance with a participant's PCSP and in the least restrictive setting.</li> </ul>	<ul style="list-style-type: none"> <li>(2) To ensure coverage, medical necessity and prevent unnecessary overutilization.</li> <li>(3) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual.</li> </ul>	<ul style="list-style-type: none"> <li>(2) To ensure coverage, medical necessity and prevent unnecessary overutilization.</li> <li>(3) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual.</li> </ul>

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>(1) Federal requirements regarding PCSPs for 1915(c) and 1915(i) services (e.g., 42 CFR 441.301 and 441.725) and the applicable approved 1915(c) waiver application/1915(i) State plan amendment.</li> <li>(1) Oregon Performance Plan (OPP) requires that all BH services are provided in the least restrictive setting possible as do federal</li> </ul>	<ul style="list-style-type: none"> <li>(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.</li> <li>(1) Federal requirements regarding 1915(c) and 1915(i) services require that HCBS</li> </ul>	<ul style="list-style-type: none"> <li>(2) OARs, HERC PL and guidelines, and federal guidelines.</li> <li>(2) UM and encounter reports are reviewed for trends in overutilization on a quarterly basis. Reviews compare cost per episode, provider to provider utilization and procedure code utilization.</li> <li>(2) Annual cost and utilization reports.</li> </ul>	<ul style="list-style-type: none"> <li>(2) OARs, HERC PL and guidelines, and federal guidelines.</li> <li>(2) UM and claims reports are reviewed for trends in overutilization on a quarterly basis.</li> <li>(2) Annual cost and utilization reports.</li> <li>(2) Medical literature demonstrates high cost of unnecessary medical care (i.e. 30% of medical costs).</li> </ul>

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
<p>requirements regarding 1915(c) and 1915(i) services.</p>	<p>are provided in the least restrictive setting possible.</p>	<ul style="list-style-type: none"> <li>• (2) Medical literature demonstrates high cost of unnecessary medical care (i.e. 30% of medical costs). (Institute of Medicine Report, (2012).</li> <li>• (3) State and federal requirements.</li> <li>• (3) Oregon Performance Plan (OPP) requires that BH services be provided in least restrictive setting possible. The OPP is a DOJ-negotiated Olmsted settlement.</li> <li>• (3) HERC guidelines re safety concerns. MCG and ASAM.</li> </ul>	<p>(Institute of Medicine Report, (2012).</p> <ul style="list-style-type: none"> <li>• (3) HERC guidelines re safety concerns. MCG and InterQual.</li> </ul>

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
<p><b>Timelines for authorizations:</b></p> <ul style="list-style-type: none"> <li>• A PCSP must be approved within 90 days from the date a completed application is submitted.</li> </ul>	<p><b>Timelines for authorizations:</b></p> <ul style="list-style-type: none"> <li>• A PCSP must be approved within 90 days from the date a completed application is submitted.</li> </ul>	<p><b>Timelines for authorizations:</b></p> <ul style="list-style-type: none"> <li>• Authorizations for SUD MAT and OP OON requests occur within the following timelines:               <ul style="list-style-type: none"> <li>– Urgent pre-service (2 calendar days)</li> <li>– Non urgent pre-service (14 calendar days)</li> </ul> </li> </ul>	<p><b>Timelines for authorizations:</b></p> <ul style="list-style-type: none"> <li>• Authorizations for OON requests are made within the following timelines:               <ul style="list-style-type: none"> <li>– Urgent pre-service (2 calendar days)</li> <li>– Non urgent pre-service (14 calendar days)</li> <li>– Post-service (within 30</li> </ul> </li> </ul>

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
<p><b>Documentation requirements:</b></p> <ul style="list-style-type: none"> <li>• (c)The PCSP is based on a functional needs assessment and other supporting documentation. It is developed by the individual, the individual’s team and the individual’s case manager.</li> <li>• (i)The PCSP is based on an assessment, service plan, plan-of-care, or Level-of-care Utilization System (LOCUS), Level of Service Inventory (LSI) or other relevant documentation. The PCSP is developed by the member’s treatment team in consultation with the member.</li> </ul> <p><b>Method of document submission:</b></p> <ul style="list-style-type: none"> <li>• All 1915(c) services must be included in a participant’s PCSP and approved by a qualified case manager at the local case management entity</li> </ul>	<p><b>Documentation requirements:</b></p> <ul style="list-style-type: none"> <li>• 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.</li> </ul> <p><b>Method of document submission:</b></p> <ul style="list-style-type: none"> <li>• 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</li> </ul>	<p>– Post-service (within 30 days)</p> <p><b>Documentation requirements:</b></p> <ul style="list-style-type: none"> <li>• PA form is 1 page long and requires supporting documentation to be submitted.</li> </ul> <p><b>Method of document submission:</b></p> <ul style="list-style-type: none"> <li>• Requests can be submitted by phone, fax, email or US mail prior to service delivery.</li> </ul>	<p>– days)</p> <p><b>Documentation requirements:</b></p> <ul style="list-style-type: none"> <li>• Most services use a PA form which is 1 page long and requires supporting documentation to be submitted. Some requests may require additional forms or treatment plans</li> </ul> <p><b>Method of document submission:</b></p> <ul style="list-style-type: none"> <li>• Imaging requests are submitted via portal, phone or fax with supporting documentation prior to service delivery.</li> </ul>

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
<p>(CME) prior to service delivery.</p> <ul style="list-style-type: none"> <li>Information is obtained during a face-to-face meeting, often at the individual's location.</li> <li>(i) Providers submit authorization requests to KEPRO by mail, fax email or via portal, but documentation must still be faxed if the request is submitted via portal.</li> </ul> <p><b>Qualifications of reviewers:</b></p> <ul style="list-style-type: none"> <li>(c) A case manager must have at least:           <ul style="list-style-type: none"> <li>A bachelor's degree (BA) in behavioral science, social science, or a closely related field; or</li> <li>A BA in any field AND one year of human services related experience; or</li> <li>An associate's degree (AA) in a behavioral science, social science, or a closely related field AND two years human</li> </ul> </li> </ul>	<p>(CME) prior to service delivery.</p> <ul style="list-style-type: none"> <li>Information is obtained during a face-to-face meeting, often at the individual's location.</li> </ul> <p><b>Qualifications of reviewers:</b></p> <ul style="list-style-type: none"> <li>A case manager must have at least:           <ul style="list-style-type: none"> <li>A BA in behavioral science, social science, or a closely related field; or</li> <li>A BA in any field AND one year of human services related experience; or</li> <li>An associate's degree (AA) in a behavioral science, social science, or a closely related field AND two years human</li> </ul> </li> </ul>	<p><b>Qualifications of reviewers:</b></p> <ul style="list-style-type: none"> <li>Approvals are made by licensed clinical staff.</li> <li>Denials are made by licensed physician reviewers.</li> </ul>	<p><b>Qualifications of reviewers:</b></p> <ul style="list-style-type: none"> <li>Authorizations decisions are made by a nurse</li> <li>Medical director determines denials.</li> </ul>

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
<p>services related experience; or</p> <ul style="list-style-type: none"> <li>– Three years of human services- related experience.</li> </ul> <p><b>(i) Qualifications of reviewers:</b></p> <ul style="list-style-type: none"> <li>• KEPRO QMHPs must meet minimum qualifications (see below) and demonstrate the ability to conduct and review an assessment, including identifying precipitating events, gathering histories of mental and physical health, substance use, past mental health services and criminal justice contacts, assessing family, cultural, social and work relationships, and conducting/reviewing a mental status examination, complete a DSM diagnosis, write and supervise the implementation of a PCSP.</li> <li>• A QMHP must meet one of the following conditions:           <ul style="list-style-type: none"> <li>– Bachelor’s degree in nursing and licensed by the State or Oregon;</li> </ul> </li> </ul>	<p>services related experience; or</p> <ul style="list-style-type: none"> <li>– Three years of human services- related experience.</li> </ul>		

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>– Bachelor’s degree in occupational therapy and licensed by the State of Oregon;</li> <li>– Graduate degree in psychology;</li> <li>– Graduate degree in social work;</li> <li>– Graduate degree in recreational, art, or music therapy;</li> <li>– Graduate degree in a behavioral science field; or</li> <li>– A qualified Mental Health Intern, as defined in 309-019-0105(61).</li> </ul>			
<p><b>Criteria:</b></p> <ul style="list-style-type: none"> <li>• (c) Qualified case managers approve or deny services in the PCSP consistent with waiver and OAR requirements.</li> <li>• Once a PCSP is approved, services in the PCSP are entered into the payment</li> </ul>	<p><b>Criteria:</b></p> <ul style="list-style-type: none"> <li>• Qualified case managers approve or deny services in the PCSP consistent with waiver/state plan and OAR requirements.</li> <li>• Once a PCSP is approved, it is entered into the payment management system as</li> </ul>	<p><b>Criteria:</b></p> <ul style="list-style-type: none"> <li>• MCG, ASAM, HERC or OARs.</li> </ul>	<p><b>Criteria:</b></p> <ul style="list-style-type: none"> <li>• MCG, InterQual or other guidelines specified by OAR or HERC.</li> </ul>

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
<p>management system by the CME staff as authorizations.</p> <ul style="list-style-type: none"> <li>(i) QMHPs approve or deny services in the PCSP consistent with State plan and OAR requirements.</li> <li>QMHPs enter prior authorizations into the MMIS based on the member's PCSP.</li> </ul> <p><b>Reconsideration/RR:</b></p> <ul style="list-style-type: none"> <li>(c) N/A</li> <li>(i) Within 10 days of a denial, the provider may send additional documentation to KEPRO for reconsideration.</li> <li>(i) A provider may request review of a denial decision, which occurs in weekly MMC meetings or KEPRO's own comparable MMC meeting.</li> </ul>	<p>authorization by the CME staff.</p> <p><b>Reconsideration/RR:</b></p> <ul style="list-style-type: none"> <li>N/A</li> </ul>	<p><b>Reconsideration/RR:</b></p> <ul style="list-style-type: none"> <li>RR is offered for providers who fail to PA medically necessary care. (See below for conditions.)</li> </ul>	<p><b>Reconsideration/RR:</b></p> <ul style="list-style-type: none"> <li>RR is offered for providers who fail to PA medically necessary care. (See below for conditions.)</li> </ul>

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
<p><b>Consequences for failure to authorize:</b></p> <ul style="list-style-type: none"> <li>Failure to obtain authorization may result in non-payment.</li> </ul> <p><b>Appeals:</b></p> <ul style="list-style-type: none"> <li>Notice and fair hearing rights apply.</li> </ul>	<p><b>Consequences for failure to authorize:</b></p> <ul style="list-style-type: none"> <li>Failure to obtain authorization may result in non-payment.</li> </ul> <p><b>Appeals:</b></p> <ul style="list-style-type: none"> <li>Notice and fair hearing rights apply.</li> </ul>	<p><b>Consequences for failure to authorize:</b></p> <ul style="list-style-type: none"> <li>Failure to obtain prior or concurrent authorization can result in no payment</li> </ul> <p><b>Appeals:</b></p> <ul style="list-style-type: none"> <li>Providers and members have appeal rights</li> </ul>	<p><b>Consequences for failure to authorize:</b></p> <ul style="list-style-type: none"> <li>Failure to PA or notify of service can result in delay of or no payment</li> </ul> <p><b>Appeals:</b></p> <ul style="list-style-type: none"> <li>Providers/members have appeal rights</li> </ul>

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
<p><b>Frequency of review:</b></p> <ul style="list-style-type: none"> <li>PCSPs are reviewed and revised as needed, but at least every 12 months.</li> </ul>	<p><b>Frequency of review:</b></p> <ul style="list-style-type: none"> <li>PCSPs are reviewed and revised as needed, but at least every 12 months.</li> </ul>	<p><b>Frequency of review:</b></p> <ul style="list-style-type: none"> <li>ABA authorizations can be approved for up to 6 months and reauthorizations are per HERC guidelines.</li> <li>Continued authorization for ECT is based on medical appropriateness (usually authorize 10 sessions and then review).</li> <li>MAT is authorized consistent with applicability of associated documentation up to a year.</li> <li>OON OP is reviewed every 3 months.</li> </ul>	<p><b>Frequency of review:</b></p> <ul style="list-style-type: none"> <li>Standard authorizations are issued for a date span of 90 days. If a provider is unable to perform the services within the time span, the provider can call and request an extension.</li> <li>CBT for pain management related to back pain is authorized for up to 90 days and re-evaluation for effectiveness.</li> </ul>

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
<p><b>RR conditions and timelines:</b></p> <ul style="list-style-type: none"> <li>• (c) N/A</li> <li>• (i) Within 10 days of a denial, the provider may send additional documentation to KEPRO for reconsideration</li> <li>• (i) A provider may request review of a denial decision, which occurs in weekly Medical Management meetings or KEPRO’s own comparable MM meeting.</li> </ul> <p><b>Methods to promote consistent application of criteria:</b></p> <ul style="list-style-type: none"> <li>• For 1915(c), DHS Quality Assurance Review teams review a representative sample of PCSPs as part of quality assurance and case review activities to assure</li> </ul>	<p><b>RR conditions and timelines:</b></p> <ul style="list-style-type: none"> <li>• N/A</li> </ul> <p><b>Methods to promote consistent application of criteria:</b></p> <ul style="list-style-type: none"> <li>• DHS Quality Assurance Review teams review a representative sample of PCSPs as part of quality assurance and case review</li> </ul>	<ul style="list-style-type: none"> <li>• Majority of OP is sub-capitated. Other than the services listed above, the only other review for them is RR for fraud and abuse purposes.</li> </ul> <p><b>RR conditions and timelines:</b></p> <ul style="list-style-type: none"> <li>• RR is available consistent with OAR requirements.</li> <li>• For certain circumstances, RR may be submitted up to 12 months from the date of service.</li> </ul> <p><b>Method to promote consistent application of criteria:</b></p> <ul style="list-style-type: none"> <li>• IRR testing is conducted semi-annually.</li> </ul>	<p><b>RR conditions and timelines:</b></p> <ul style="list-style-type: none"> <li>• Post service review available except for advanced imaging which has no retro review period) consistent with OAR requirements.</li> <li>• For certain circumstances, RR may be submitted up to 12 months from the date of service.</li> </ul> <p><b>Method to promote consistent application of criteria:</b></p> <ul style="list-style-type: none"> <li>• IRR standard is conducted semi-annually</li> </ul>

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
<p>that PCSPs meet program standards.</p> <ul style="list-style-type: none"> <li>• Additionally, OHA staff review a percentage of 1915(c) participant files to assure quality and compliance.</li> <li>• For 1915(i), monthly clinical team meetings in which randomly audited charts are reviewed/discussed by peers using the KEPRO compliance department-approved audit tool.</li> <li>• Results of the audit are compared, shared and discussed by the team and submitted to Compliance Department monthly for review and documentation.</li> <li>• Individual feedback is provided to each clinician during supervision on their PA.</li> <li>• For 1915(i), on a quarterly basis a representative sample of cases are reviewed for ability to address assessed member needs, whether the PCSPs are updated annually, whether OARs are met, and</li> </ul>	<p>activities to assure that PCSPs meet program standards.</p> <ul style="list-style-type: none"> <li>• Additionally, OHA staff review a percentage of files to assure quality and compliance.</li> </ul>		

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
whether member’s choices regarding services and providers were documented.			

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
<p><b>Evidence for UM frequency:</b></p> <ul style="list-style-type: none"> <li>Federal requirements regarding PCSPs and 1915(c) and 1915(i) services (e.g., 42 CFR 441.301 and 441.725) and the applicable approved 1915(c) waiver application/1915(i) State plan amendment.</li> </ul> <p><b>Data reviewed to determine UM application:</b></p> <ul style="list-style-type: none"> <li>N/A</li> </ul> <p><b>IRR standard:</b></p> <ul style="list-style-type: none"> <li>N/A</li> </ul>	<p><b>Evidence for UM frequency:</b></p> <ul style="list-style-type: none"> <li>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.</li> </ul> <p><b>Data reviewed to determine UM application:</b></p> <ul style="list-style-type: none"> <li>N/A</li> </ul> <p><b>IRR standard:</b></p> <ul style="list-style-type: none"> <li>N/A</li> </ul>	<p><b>Evidence for UM frequency:</b></p> <ul style="list-style-type: none"> <li>MCG is evidence for authorization frequency. MCG provides average length of stay for lightly and loosely managed programs. OP management is tied to stages and treatment progress (rather than average length of treatment).</li> </ul> <p><b>Data reviewed to determine UM application:</b></p> <ul style="list-style-type: none"> <li>EOCCO/GOBHI track all service authorization requests and evaluates the types of authorizations and denials, tracks number of denials, grievances and appeals and the outcomes</li> </ul> <p><b>IRR standard:</b></p> <ul style="list-style-type: none"> <li>IRR standard is 80%.</li> </ul>	<p><b>Evidence for UM frequency:</b></p> <ul style="list-style-type: none"> <li>MCG is evidence for authorization frequency.</li> </ul> <p><b>Data reviewed to determine UM application:</b></p> <ul style="list-style-type: none"> <li>EOCCO/Moda tracks all service authorization requests for authorizations and denials, tracks number of denials, grievances and appeals and outcomes</li> </ul> <p><b>IRR standard:</b></p> <ul style="list-style-type: none"> <li>IRR standard is 80%.</li> </ul>

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
<p><b>Results of criteria application (appeal overturn rates):</b></p> <ul style="list-style-type: none"> <li>(c): 0 appeal overturns</li> <li>(i) (KEPRO) 11% appeal overturn rate (1 out of 9 hearings)</li> </ul>	<p><b>Results of criteria application (appeal overturn rates):</b></p> <ul style="list-style-type: none"> <li>(c) for I/DD: 0 appeal overturns</li> <li>(c) for APD plus (k) and (j): 0.8% appeal overturn rate</li> </ul>	<p><b>Results of criteria application (appeal overturn rates):</b></p> <ul style="list-style-type: none"> <li>2017 IP appeal overturn rates were 0.</li> </ul>	<p><b>Results of criteria application (appeal overturn rates):</b></p> <ul style="list-style-type: none"> <li>In 2017, overturned 84/212 IP and OP appeals, or 40%.</li> </ul>

### 7. Compliance Determination for Benefit Packages A and B

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

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

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

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

RR when services are not authorized. Failure to obtain authorization may result in non-payment for MH/SUD and M/S. Notice and fair hearing rights apply. Accordingly, UM processes are comparable and no more stringently applied to HCBS MH/SUD benefits than to M/S benefits.

Non-HCBS CCO MH/SUD and M/S OP benefit reviews are conducted by qualified clinicians who evaluate clinical information that is submitted by telephone, email, mail or via fax relative to MCG, ASAM, InterQual, HERC, or OARs. Timelines for authorization decisions are the same for MH/SUD and M/S and defined in OARs. Documentation requirements include a one page form and information supporting medical necessity. Failure to obtain authorization may result in non-payment for MH/SUD and M/S services; although an exception process allows RR for CCO benefits, and standard appeal processes apply. There are no differences in processes for children and adults that are not tied to practice guidelines. Accordingly, UM processes are comparable to, and no more stringently applied, to non-HCBS CCO MH/SUD benefits than to M/S benefits.

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

General non-HCBS CCO MH/SUD service authorizations range from 3-6 months. M/S reported authorization lengths average 3 months. Service authorization lengths for both MH/SUD and M/S are based on MCG® guidelines. CCO makes RR available consistent with OARs. CCO MH/SUD and M/S MNC application is evaluated during IRR testing to a standard of 80%. At a minimum, the CCO reviews utilization and other data to determine if UM requires adjustment. The CCO reported a 40% appeal overturn rate for M/S and 0 appeal overturns for MH/SUD. FFS MH/SUD appeal overturn rates were also 0 in 2017. UM strategy and evidence are no more stringently applied to MH/SUD than to M/S OP benefits in operation or in writing.

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

**PRIOR AUTHORIZATION FOR PRESCRIPTION DRUGS NQTL ANALYSIS**

**NQTL:** Prior Authorization for Prescription Drugs

**Benefit Package:** A and B for Adults and Children

**Classification:** Prescription Drugs

**CCO:** EOCCO

**1. To which benefits is the NQTL assigned?**

CCO MH/SUD	FFS MH Carve Out	CCO M/S
<ul style="list-style-type: none"> <li>A, F, P, S drug groups</li> </ul>	<ul style="list-style-type: none"> <li>A and F drug groups</li> </ul>	<ul style="list-style-type: none"> <li>A, F, P, S drug groups</li> </ul>

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
<ul style="list-style-type: none"> <li>To promote appropriate and safe treatment of funded conditions and to encourage use of preferred and cost-effective agents.</li> </ul>	<ul style="list-style-type: none"> <li>To promote appropriate and safe treatment of funded conditions.</li> </ul>	<ul style="list-style-type: none"> <li>To promote appropriate and safe treatment of funded conditions and to encourage use of preferred and cost-effective agents.</li> </ul>

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
<ul style="list-style-type: none"> <li>In consultation with the P&amp;T Committee, pharmacists review medications based on FDA approved indications, the most up-to-date medical evidence, best practices, clinical guidelines, and the Prioritized List.</li> </ul>	<ul style="list-style-type: none"> <li>FDA prescribing guidelines, medical evidence, best practices, professional guidelines, and P&amp;T Committee review and recommendations.</li> <li>Federal and state regulations/OAR and the Prioritized List.</li> </ul>	<ul style="list-style-type: none"> <li>In consultation with the P&amp;T Committee, pharmacists review medications based on FDA approved indications, the most up-to-date medical evidence, best practices, clinical guidelines, and the Prioritized List.</li> </ul>

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
<ul style="list-style-type: none"> <li>• Requests are typically initiated by fax, but can be initiated by phone to the EOCCO Customer Service department.</li> <li>• A medication request form can contain several pages, including all relevant member information, drug information, and a request for chart notes. Subsequent pages contain all pertinent PA criteria questions needed to make a decision on the request.</li> <li>• If additional information is needed, a fax is sent to the provider requesting the relevant questions and/or chart notes that are needed to make a determination.</li> <li>• All PA requests are responded to within 24 hours.</li> <li>• The PA criteria are developed by pharmacists in consultation with the P&amp;T Committee.</li> <li>• In the absence of medical necessity, and the failure to obtain PA means medication coverage will be denied and providers do not get reimbursed.</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• The standard PA form is one page long, except for nutritional supplement requests. Most PA criteria require clinical documentation such as chart notes.</li> <li>• All PA requests are responded to within 24 hours.</li> <li>• The PA criteria are developed by pharmacists in consultation with the P&amp;T Committee.</li> <li>• Failure to obtain PA in combination with an absence of medical necessity results in no provider reimbursement.</li> </ul>	<ul style="list-style-type: none"> <li>• Requests are typically initiated by fax, but can be initiated by phone to the EOCCO Customer Service department.</li> <li>• A medication request form can contain several pages, including all relevant member information, drug information, and a request for chart notes. Subsequent pages contain all pertinent PA criteria questions needed to make a decision on the request.</li> <li>• If additional information is needed, a fax is sent to the provider requesting the relevant questions and/or chart notes that are needed to make a determination.</li> <li>• All PA requests are responded to within 24 hours.</li> <li>• The PA criteria are developed by pharmacists in consultation with the P&amp;T Committee.</li> <li>• In the absence of medical necessity, and the failure to obtain PA means medication coverage will be denied and providers do not get reimbursed.</li> </ul>

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
<ul style="list-style-type: none"> <li>• PAs are authorized for six months to a year, depending on the disease state, and if the medication is medically appropriate and safe per the recommendations of the P&amp;T Committee.</li> <li>• Approximately 40% of MH/SUD drugs are subject to PA criteria for clinical reasons.</li> <li>• Providers can appeal denials on behalf of a member, and members have appeal and fair hearing rights.</li> <li>• The appeal overturn rate for CY 2017 was 12%.</li> <li>• The CCO assesses stringency through review of the number of PA requests and PA denial/approval rates.</li> <li>• In general, PA criteria are reviewed for appropriateness on a biannual basis; however, that depends on the recommendation from the P&amp;T Committee or when new medical evidence arises.</li> </ul>	<ul style="list-style-type: none"> <li>• The State approves PAs for up to 12 months, depending on medical appropriateness and safety, as recommended by the P&amp;T Committee.</li> <li>• Approximately 17% of MH drugs are subject to PA criteria for clinical reasons.</li> <li>• The State allows providers to submit additional information for reconsideration of a denial.</li> <li>• Providers can appeal denials on behalf of a member, and members have fair hearing rights.</li> <li>• The appeal overturn rates for MH carve out drugs was 8:2 (25%).</li> <li>• 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.</li> <li>• PA criteria are reviewed as needed due to clinical developments, literature, studies, and FDA medication approvals.</li> </ul>	<ul style="list-style-type: none"> <li>• PAs are authorized for six months to a year, depending on the disease state, and if the medication is medically appropriate and safe per the recommendations of the P&amp;T Committee.</li> <li>• Approximately 40% of M/S drugs are subject to PA criteria for clinical reasons.</li> <li>• Providers can appeal denials on behalf of a member, and members have appeal and fair hearing rights.</li> <li>• The appeal overturn rate for CY 2017 was 16%.</li> <li>• The CCO assesses stringency through review of the number of PA requests and PA denial/approval rates.</li> <li>• In general, PA criteria are reviewed for appropriateness on a biannual basis; however, that depends on the recommendation from the P&amp;T Committee or when new medical evidence arises.</li> </ul>

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
<ul style="list-style-type: none"> <li>In consultation with the P&amp;T Committee, the frequency or rigor is based on FDA approved indications, the most up-to-date medical evidence, best practices, clinical guidelines, and the Prioritized List.</li> </ul>	<ul style="list-style-type: none"> <li>FDA prescribing guidelines, medical evidence, best practices, professional guidelines, and P&amp;T Committee review and recommendations.</li> <li>Federal and state regulations/OAR and the Prioritized List.</li> </ul>	<ul style="list-style-type: none"> <li>In consultation with the P&amp;T Committee, the frequency or rigor is based on FDA approved indications, the most up-to-date medical evidence, best practices, clinical guidelines, and the Prioritized List.</li> </ul>

**7. Compliance Determination for Benefit Packages CCO A and B**

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

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

**Stringency of Strategy and Evidence:** PAs for both MH/SUD and M/S drugs are approved for up to 12 months, depending on medical appropriateness and safety, as recommended by the applicable P&T Committee based on evidence such as FDA prescribing guidelines, best practices, and professional guidelines. The CCO and the State assess the stringency of strategy through review of PA denial/approval rates. The percent of MH/SUD drugs subject to PA requirements is comparable to M/S drugs. In addition, the appeal overturn rates are comparable. As a result, the strategies and evidentiary standards for prior authorization of prescription drugs are applied no more stringently to MH/SUD drugs than to M/S drugs.

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

**PROVIDER ADMISSION — CLOSED NETWORK**

**NQTL:** Provider Admission — Closed Network (Restriction from admitting new providers [all or a subset thereof] into the CCO's network)

**Benefit Package:** A and B for Adults and Children

**Classification:** Inpatient and Outpatient

**CCO:** EOCCO

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>CCO has not closed its network for new MH/SUD providers of inpatient and outpatient services; however, has a policy in place to do so, if indicated.</li> </ul>	<ul style="list-style-type: none"> <li>The State does not restrict new providers of inpatient or outpatient MH/SUD services from enrollment.</li> </ul>	<ul style="list-style-type: none"> <li>CCO has not closed its network for new M/S providers of inpatient and outpatient services, however, has a policy in place to do so, if indicated.</li> </ul>

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>When CCO closes its network to new MH/SUD providers, it is done to:               <ul style="list-style-type: none"> <li>Balance member access needs with safety and quality concerns.</li> <li>Balance member access needs with cost effectiveness/cost control.</li> <li>Balance member access need with provider oversight.</li> <li>Balance member access need with enhanced efficiency and improved provider relations.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>N/A</li> </ul>	<ul style="list-style-type: none"> <li>When CCO closes its network to new M/S providers, it is done to:               <ul style="list-style-type: none"> <li>Balance member access needs with safety and quality concerns.</li> <li>Balance member access needs with cost effectiveness/cost control.</li> <li>Balance member access need with provider oversight.</li> <li>Balance member access need with enhanced efficiency and improved provider relations.</li> </ul> </li> </ul>

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>• Network sufficiency standards are required by 42 CFR 438.206.</li> <li>• Requirements related to the selection and retention of providers are specified in 42 CFR 438.214.</li> <li>• 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.</li> <li>• State rule related to network sufficiency standards, OAR 410-141-0220.</li> <li>• OHA CCO contract.</li> </ul>	<ul style="list-style-type: none"> <li>• N/A</li> </ul>	<ul style="list-style-type: none"> <li>• Network sufficiency standards are required by 42 CFR 438.206.</li> <li>• Requirements related to the selection and retention of providers are specified in 42 CFR 438.214.</li> <li>• 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.</li> <li>• State rule related to network sufficiency standards, OAR 410-141-0220.</li> <li>• OHA CCO contract.</li> </ul>

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>• 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 reimbursed for services provided to CCO members.</li> <li>• CCO evaluates provider requests for network inclusion and reviews to determine network need. Provider requests for network inclusion are also tracked and assessed annually. Provider</li> </ul>	<ul style="list-style-type: none"> <li>• N/A</li> </ul>	<ul style="list-style-type: none"> <li>• 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 reimbursed for services provided to CCO members.</li> <li>• CCO evaluates provider requests for network inclusion and reviews to determine network need. Provider requests for network inclusion are also tracked and assessed annually. Provider</li> </ul>

CCO MH/SUD	FFS MH/SUD	CCO M/S
<p>requests and an annual provider and inclusion assessment are reviewed by the credentialing committee, which is responsible for making recommendations to maintain the current network (limit the acceptance of new providers) or solicit new providers.</p> <ul style="list-style-type: none"> <li>• The CCO Credentialing Physician, Accreditation Manager, Director of Health Systems Integration, and Contracts Manager are responsible for the decision-making process to close the network.</li> <li>• CCO considers capacity reports, access complaints, time to appointments, inpatient rates, complaints and grievances, internal reports on unmet needs, number of requests for OON, membership profile (cultural, racial, ethnic, linguistic, demographic makeup), other data that indicate a need in making the determination to close the network.</li> <li>• Providers that are denied the opportunity to participate in CCO’s network may challenge the CCO’s decision.</li> <li>• Exceptions may be made when management identifies a potential special network development need.</li> <li>• The evaluation includes determining: the validity of the need; whether the need is Network-wide or limited to a particular</li> </ul>		<p>requests and an annual provider and inclusion assessment are reviewed by the credentialing committee, which is responsible for making recommendations to maintain the current network (limit the acceptance of new providers) or solicit new providers.</p> <ul style="list-style-type: none"> <li>• The CCO Credentialing Physician, Accreditation Manager, Director of Health Systems Integration, and Contracts Manager are responsible for the decision-making process to close the network.</li> <li>• CCO considers capacity reports, access complaints, time to appointments, inpatient rates, complaints and grievances, internal reports on unmet needs, number of requests for OON, membership profile (cultural, racial, ethnic, linguistic, demographic makeup), other data that indicate a need in making the determination to close the network.</li> <li>• Providers that are denied the opportunity to participate in CCO’s network may challenge the CCO’s decision.</li> <li>• Exceptions may be made when management identifies a potential special network development need.</li> <li>• The evaluation includes determining: the validity of the need; whether the need is Network-wide or limited to a particular</li> </ul>

CCO MH/SUD	FFS MH/SUD	CCO M/S
<p>area(s) or region(s); the timeline for addressing the need based on the urgency of the situation; and, whether an existing Network Provider can address the need.</p> <ul style="list-style-type: none"> <li>• If the evaluation finds that the potential need is valid, a plan is developed to address the need including: interim solutions to address immediate needs; and, a timetable for affecting a comprehensive solution.</li> <li>• After CCO and the Provider reach agreement on the services to be provided and the associated costs, the Provider will enter CCO's Network via the standard Practitioner credentialing or Facility assessment processes if the Provider is not in the Network.</li> <li>• Staff authorized to make exception determination is the CEO or designee and credentialing committee.</li> </ul>		<p>area(s) or region(s); the timeline for addressing the need based on the urgency of the situation; and, whether an existing Network Provider can address the need.</p> <ul style="list-style-type: none"> <li>• If the evaluation finds that the potential need is valid, a plan is developed to address the need including: interim solutions to address immediate needs; and, a timetable for affecting a comprehensive solution.</li> <li>• After the CCO and the Provider reach agreement on the services to be provided and the associated costs, the Provider will enter the CCO's Network via the standard Practitioner credentialing or Facility assessment processes if the Provider is not in the Network.</li> <li>• Staff authorized to make exception determination is the CEO or designee and credentialing committee.</li> </ul>

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>• When the CCO decides to close the network to particular provider/provider types, all new outpatient providers applying for those particular providers/provider types are subject to this NQTL.</li> <li>• No provider or provider types were impacted by CCO's decision to close all or part of its network to new providers in the last contract year.</li> </ul>	<ul style="list-style-type: none"> <li>• N/A</li> </ul>	<ul style="list-style-type: none"> <li>• When the CCO decides to close the network to particular provider/provider types, all new outpatient providers applying for those particular providers/provider types are subject to this NQTL.</li> <li>• No provider or provider types were impacted by CCO's decision to close all or part of its network to new providers in the last contract year.</li> </ul>

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>• The CCO reviews the following data/information to determine how strictly to apply the criteria/ considerations to close the CCO network to new providers:               <ul style="list-style-type: none"> <li>– Member access to care measures (e.g., timely access, distance)</li> <li>– Provider to member ratios</li> <li>– Provider availability</li> <li>– Inpatient rates</li> <li>– Number of requests for OON.</li> <li>– Membership profile (cultural, racial, ethnic, linguistic, demographic makeup)</li> <li>– Member needs based on knowledge of prior services used, physio, social</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• N/A</li> </ul>	<ul style="list-style-type: none"> <li>• The CCO reviews the following data/information to determine how strictly to apply the criteria/ considerations to close the CCO network to new providers:               <ul style="list-style-type: none"> <li>– Member access to care measures (e.g., timely access, distance)</li> <li>– Provider to member ratios</li> <li>– Provider availability</li> <li>– Inpatient rates</li> <li>– Number of requests for OON.</li> <li>– Membership profile (cultural, racial, ethnic, linguistic, demographic makeup)</li> <li>– Member needs based on knowledge of prior services used, physio, social</li> </ul> </li> </ul>

CCO MH/SUD	FFS MH/SUD	CCO M/S
factors and member and family suggestions.		factors and member and family suggestions.

### 7. Compliance Determination for Benefit Packages CCO A and B

**Comparability of Strategy and Evidence:** The CCO has established policies to permit the CCO to close its network to inpatient and outpatient providers of MH/SUD and M/S services although it has not done so in operation. The CCO’s policies for closing its network to MH/SUD and M/S providers are the same. Under the CCO’s policy, network closure is done to balance member access needs with safety and quality concerns, cost effectiveness/cost control, provider oversight and enhanced provider relations.

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

**Comparability and Stringency of Processes:** Under the CCO’s policies, when the CCO determines that particular provider types are not needed to meet network adequacy standards, requests to join the network for that provider type are declined. Monitoring for network adequacy includes reviewing provider requests for network inclusion and reviews to determine network need; provider requests for network inclusion are also tracked and assessed annually. Provider requests and annual provider and inclusion assessments are reviewed by the credentialing committee, which is responsible for approving the current network or soliciting new providers. The CCO Credentialing Physician, Accreditation Manager, Director of Health Systems Integration, and Contracts Manager are responsible for the decision-making process to close the network. The CCO considers capacity reports, access complaints, time to appointments, inpatient rates, complaints and grievances, internal reports on unmet needs, number of requests for OON, membership profile (cultural, racial, ethnic, linguistic, demographic makeup), and other data that indicate a need in making the determination to close the network. If the evaluation finds that the potential need is valid, a plan is developed to address the need including interim solutions to address immediate needs and a timetable for affecting a comprehensive solution. Providers denied the opportunity to participate in the CCO’s network may challenge the CCO’s decision. Network staff authorized to make exception determinations are the CEO or designee and credentialing committee.

Based upon these findings, the CCO’s processes described in policy for closing the network to MH/SUD are comparable, and no more stringently applied, to the CCO’s processes in policy for providers of M/S services.

**Stringency of Strategy and Evidence:** Under the CCO's policies for both MH/SUD and M/S providers, when the CCO decides to close the network to particular specialties/provider types, all new providers applying for those particular specialties/provider types are subject to the NQTL. In operation, no MH/SUD or M/S provider were denied admission on the basis of network closure. In determining how strictly to apply network closure, the CCO monitors and reviews information such as: member access to care measures; provider to member ratios; provider availability; inpatient rates; number of requests for OON; the membership profile (cultural, racial, ethnic, linguistic, demographic makeup); and, member needs based on knowledge of prior services used, physiological, social factors and member and family suggestions.

Based upon these findings, the CCO's strategy and evidence used for MH/SUD providers are comparable, and applied no more stringently than, the CCO's strategy and evidence used for providers of M/S services.

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

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

**NQTL:** Provider Admission — Network Credentialing and Requirements in Addition to State Licensing

**Benefit Package:** A and B for Adults and Children

**Classification:** Inpatient and Outpatient

**CCO:** EOCCO

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>• CCO requires all participating providers to meet facility and independent practitioner credentialing and re-credentialing requirements.</li> <li>• CCO does not apply provider requirements in addition to State licensing.</li> </ul>	<ul style="list-style-type: none"> <li>• All FFS providers must be enrolled as a provider with Oregon Medicaid.</li> <li>• The State does not apply provider requirements in addition to State licensing.</li> </ul>	<ul style="list-style-type: none"> <li>• CCO requires all participating providers to meet facility and independent practitioner credentialing and re-credentialing requirements.</li> <li>• N/A</li> </ul>

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>• CCO applies credentialing and re-credentialing requirements to:             <ul style="list-style-type: none"> <li>– Reduce and/or eliminate the potential for negligent/ inappropriate care, Medicare/Medicaid fraud or abuse and unnecessary liability to either the member or the CCO.</li> <li>– Ensure equity by not excluding practitioners based on specialization, services to high risk populations, or the cost of treatment.</li> <li>– Meet State and Federal requirements</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Provider enrollment is required by State law and Federal regulations.</li> <li>• The State also specifies requirements for provider enrollment in order to ensure beneficiary health and safety and to reduce Medicaid provider fraud, waste, and abuse.</li> </ul>	<ul style="list-style-type: none"> <li>• CCO applies credentialing and re-credentialing requirements to:             <ul style="list-style-type: none"> <li>– Reduce and/or eliminate the potential for negligent/ inappropriate care, Medicare/Medicaid fraud or abuse and unnecessary liability to either the member or the CCO.</li> <li>– Ensure equity by not excluding practitioners based on specialization, services to high risk populations, or the cost of treatment.</li> <li>– Meet State and Federal requirements</li> </ul> </li> </ul>

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>- Ensure capabilities of provider to deliver high quality of care</li> <li>- Ensure provider meets minimum competency standards</li> </ul>		<ul style="list-style-type: none"> <li>- Ensure capabilities of provider to deliver high quality of care</li> <li>- Ensure provider meets minimum competency standards</li> </ul>

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>• Credentialing/recred requirements are supported by the following evidence:               <ul style="list-style-type: none"> <li>- OAR 410-141-3120, CCO Contract Exhibit B - Part 8 (18), 42 CFR 438.214, and the National Committee on Quality Assurance (NCQA) guidelines.</li> <li>- OAR 309-008-0100 through 1600 (IP)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E - Provider Screening and Enrollment.</li> </ul>	<ul style="list-style-type: none"> <li>• Credentialing/recred requirements are supported by the following evidence:               <ul style="list-style-type: none"> <li>- Required under OAR 410-141-3120, CCO Contract Exhibit B - Part 8 (18), 42 CFR 438.214, and NCQA guidelines.</li> </ul> </li> </ul>

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>• All facility and independent practitioner providers must meet credentialing and re-credentialing requirements.</li> <li>• Independent practitioners must complete and provide proof of:               <ul style="list-style-type: none"> <li>- Oregon Practitioner Credentialing Application (20 pages)</li> <li>- Independent Practitioner liability insurance coverage</li> <li>- Professional license/certification</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Providers must complete forms and documentation required for their provider type. This includes information demonstrating the provider meets provider enrollment requirements such as</li> </ul>	<ul style="list-style-type: none"> <li>• All facility and independent practitioner providers must meet credentialing and re-credentialing requirements.</li> <li>• Independent practitioners must complete and provide proof of:               <ul style="list-style-type: none"> <li>- Oregon Practitioner Credentialing Application (20 pages)</li> <li>- Independent Practitioner liability insurance coverage</li> <li>- Professional license/certification</li> </ul> </li> </ul>

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>– DEA registration and CDS certification or validation of a formal arrangement with a DEA registered physician and a CDS certified physician who can write all prescriptions requiring this registration</li> <li>– Written explanations if any positive attestations contained within the application package</li> <li>– Appropriate and highest level of education and training for services to be provided</li> <li>– Verification of licensing or Board certification or successful completion of residency for physicians not Board certified</li> <li>– At least five years of relevant work history with explanation of gaps of either six months or one year</li> <li>– Absence of sanctions, restrictions, or limitation on professional license or certification as verified with the NPDB</li> <li>– Absence of Medicare or Medicaid restrictions as verified with the NPDB</li> <li>– Possession of appropriate admitting privileges or admit plan as required</li> <li>• Facility providers (MH/SUD inpatient; MH/SUD residential; and MH/SUD</li> </ul>	<p>NPI, tax ID, disclosures, and licensure/certification.</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• The enrollment forms and documentation can be faxed in or completed and submitted electronically to the State’s provider enrollment unit.</li> <li>• 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.</li> <li>• The State’s enrollment process averages 7 to 14 days.</li> <li>• State staff in the provider enrollment unit are responsible for reviewing information and making provider enrollment decisions.</li> <li>• The State reviews all provider enrollment every three years, as required by Federal regulations.</li> </ul>	<ul style="list-style-type: none"> <li>– DEA registration and CDS certification or validation of a formal arrangement with a DEA registered physician and a CDS certified physician who can write all prescriptions requiring this registration</li> <li>– Written explanations if any positive attestations contained within the application package</li> <li>– Appropriate and highest level of education and training for services to be provided</li> <li>– Verification of licensing or Board certification or successful completion of residency for physicians not Board certified</li> <li>– At least five years of relevant work history with explanation of gaps of either six months or one year</li> <li>– Absence of sanctions, restrictions, or limitation on professional license or certification as verified with the NPDB</li> <li>– Absence of Medicare or Medicaid restrictions as verified with the NPDB</li> <li>– Possession of appropriate admitting privileges or admit plan as required</li> <li>• Facility providers (MH/SUD inpatient; MH/SUD residential; and MH/SUD</li> </ul>

CCO MH/SUD	FFS MH/SUD	CCO M/S
<p>outpatient for adults, children, and youth) are required to possess</p> <ul style="list-style-type: none"> <li>– Current accreditation by</li> <li>– (CARF, JCAHO, or DNV GL) or evidence of site by Federal or State authority</li> <li>– Medicare certification if applicable</li> <li>– Confirmation that the facility is in good standing with Oregon State and Federal regulatory body</li> </ul> <ul style="list-style-type: none"> <li>• Non-accredited IP facilities go through a 4-day outside assessment by CCO unless a recent (within previous 36 months or prior to expiration of certification) Oregon State certificate of approval has been awarded or another Federal regulatory body has awarded a certification or neither the State of Oregon or CMS has conducted a site review but the provider is in a rural area). The facilities prepare a "non-accredited facility assessment form" at least 30 calendar days prior to the review which details all required documentation and interviews and they must be in compliance with CCOs' standards of participation for non-accredited facilities.</li> </ul>	<ul style="list-style-type: none"> <li>• Providers who are not enrolled/re-enrolled are not eligible for Medicaid reimbursement.</li> <li>• Providers who are denied enrollment or re-enrollment may appeal the decision to the State.</li> </ul>	<p>outpatient for adults, children, and youth) are required to possess</p> <ul style="list-style-type: none"> <li>– Current accreditation by</li> <li>– (CARF, JCAHO, or DNV GL) or evidence of site by Federal or State authority</li> <li>– Medicare certification if applicable</li> <li>– Confirmation that the facility is in good standing with Oregon State and Federal regulatory body</li> </ul> <ul style="list-style-type: none"> <li>• Non-accredited IP facilities go through a 4-day outside assessment by the CCO if the State or CMS has not conducted a site review</li> <li>• Facility and independent practitioner may submit supporting documentation by fax, email and mail.</li> <li>• The complete process from receipt of application to final admission into network depends on the contents of the application and findings during the credentialing process. The credentialing process generally takes between 60-90 days for Independent Practitioners. The contracting process is a separate timeline.</li> <li>• CCO's Credentialing committee meets every 30 days and only reviews applications that are found to not meet the minimum requirements.</li> </ul>

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>• Providers may submit supporting documentation by fax, email, USPS and/ or in person.</li> <li>• The complete process from receipt of application to final admission into network for OP providers depends on the contents of the application and findings during the credentialing process.</li> <li>• The complete process from receipt of application to final admission into network for IP providers is 60 days for the credentialing process; the contracting process has a separate timeline.</li> <li>• CCO's Credentialing committee meets every 30 days and only reviews applications that are found to not meet the minimum requirements.</li> <li>• CCO's Medical Director or Credentialing Committee (meets every 6 weeks) are responsible for reviewing required information and Credentialing Committee for making provider credentialing decisions.</li> <li>• CCO performs re-credentialing at least every three years.</li> <li>• Providers who do not meet credentialing/re-credentialing requirements will not be able to join the network.</li> </ul>		<ul style="list-style-type: none"> <li>• CCO's Medical Director or Credentialing Committee (meets every 6 weeks) responsible for reviewing required information and making provider credentialing decisions.</li> <li>• CCO performs re-credentialing at least every three years.</li> <li>• Providers who do not meet credentialing/re-credentialing requirements will not be able to join the network.</li> <li>• Providers who are denied at the initial credentialing cycle may re-apply after one year. Providers who are denied at the re-credentialing cycle may appeal the decision.</li> </ul>

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>Providers who are denied at the initial credentialing cycle may re-apply after one year. Providers who are denied at the re-credentialing cycle may appeal the decision.</li> </ul>		

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>All facility and independent practitioner providers must be credentialed.</li> <li>Exceptions can be authorized by CCO's Chief Medical Officer (CMO) and the Credentialing Committee. Exceptions are made on a case by case basis, but cannot include any licensing/certification sanction or sanction imposed by CMS (must pass). If provider has not completed residency and not board certified, can make an exception.</li> <li>No providers were denied admission or terminated from the network in the last contract year as a result of credentialing and re-credentialing.</li> </ul>	<ul style="list-style-type: none"> <li>All providers/provider types are subject to enrollment/re-enrollment requirements.</li> <li>There are no exceptions to meeting provider enrollment/re-enrollment requirements.</li> <li>Less than 1% of providers were denied admission, and .005% of providers were terminated last CY for failure to meet enrollment/re-enrollment requirements.</li> </ul>	<ul style="list-style-type: none"> <li>All facility and independent practitioner providers must be credentialed.</li> <li>Exceptions can be authorized by CCO's Chief Medical Officer (CMO) and the Credentialing Committee. Exceptions are made on a case by case basis, but cannot include any licensing/certification sanction or sanction imposed by CMS (must pass). If provider has not completed residency and not board certified, can make an exception.</li> <li>No providers were denied admission or terminated from the network in the last contract year as a result of credentialing and re-credentialing.</li> </ul>

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>The frequency with which CCO performs re-credentialing is based upon:             <ul style="list-style-type: none"> <li>State law and Federal regulations</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E — Provider Screening and Enrollment.</li> </ul>	<ul style="list-style-type: none"> <li>The frequency with which CCO performs re-credentialing is based upon:             <ul style="list-style-type: none"> <li>State law and Federal regulations</li> </ul> </li> </ul>

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>- State contract requirements 2018 CCO Contract, Exhibit B SOW, Part 4 Providers and Delivery System, #3(b) Provider Selection Part 8 Operations #18 Credentialing (a)</li> <li>- National accreditation standards, National Committee for Quality Assurance (NCQA.)</li> </ul>	<ul style="list-style-type: none"> <li>• The frequency with which the State re-enrolls providers is based on State law and Federal regulations.</li> </ul>	<ul style="list-style-type: none"> <li>- State contract requirements 2018 CCO Contract, Exhibit B SOW, Part 4 Providers and Delivery System, #3(b) Provider Selection Part 8 Operations #18 Credentialing (a)</li> <li>- National accreditation standards, National Committee for Quality Assurance (NCQA)</li> </ul>
<ul style="list-style-type: none"> <li>• CCO monitors the following data/information to determine how strictly to apply credentialing/ re-credentialing criteria:               <ul style="list-style-type: none"> <li>- Patient complaints are monitored quarterly,</li> <li>- License action and sanctions are monitored monthly.</li> <li>- Adverse events are monitored on an ongoing basis.</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>• CCO monitors the following data/information to determine how strictly to apply credentialing/ re-credentialing criteria:               <ul style="list-style-type: none"> <li>- Patient complaints are monitored quarterly,</li> <li>- License action and sanctions are monitored monthly.</li> <li>- Adverse events are monitored on an ongoing basis.</li> </ul> </li> </ul>

### 7. Compliance Determination for Benefit Packages CCO A and B

**Comparability of Strategy and Evidence:** All IP and OP providers of MH/SUD and M/S services are subject to CCO credentialing and re-credentialing requirements. Credentialing and re-credentialing is conducted for both providers of MH/SUD and M/S services to reduce and/or eliminate the potential for negligent/ inappropriate care, Medicare/Medicaid fraud or abuse and unnecessary liability to either the member or the CCO. In addition, it is necessary to ensure equity by not excluding practitioners based on specialization, services to high risk populations, or the cost of treatment. The CCO applies credentialing and re-credentialing requirements to meet State and Federal requirements, NCQA guidelines and ensure capabilities of provider to deliver high quality of care and ensure providers meet minimum competency standards. Credentialing and re-credentialing of providers is supported by State law and Federal regulations and the CCO's contract with the State. Based upon these findings, the CCO's strategy and evidence for conducting credentialing and re-credentialing are comparable for providers of MH/SUD and M/S services.

**Comparability and Stringency of Processes:** All providers of MH/SUD and M/S services must successfully meet credentialing and re-credentialing requirements in order to be admitted to and continue to participate in the CCO's network. New providers of MH/SUD and M/S services are required to complete and submit substantially the same information and documentation as part of the credentialing process. Both MH/SUD and M/S providers are given several methods of submitting their application and supporting documentation, including by fax, by mail or electronically (also in person for MH/SUD). For both MH/SUD and M/S provider credentialing, the CCO's Medical Director or Credentialing Committee meets every 6 weeks and is responsible for reviewing required information. The Credentialing Committee makes provider credentialing decisions.

The CCO's credentialing process for both MH/SUD and M/S independent providers includes completion of the application; proof of liability coverage, license/certification, DEA registration/CDS certification, licensing/Board certification/residency; five years' work history, the absence of sanctions and Medicare/Medicaid restrictions. The CCO uses a similar approach for both non-accredited IP facilities for MH/SUD and M/S services, conducting a 4-day outside assessment by the CCO if the State or CMS has not conducted a site review. The credentialing process for MH/SUD providers averages 60 days from the day a complete application is received by the CCO and up to 90 days for M/S providers. CCO's Credentialing committee meets every 30 days and only reviews applications that are found to not meet the minimum requirements. The CCO's Medical Director and Credentialing Committee are responsible for reviewing required information and making provider credentialing decisions for both MH/SUD and M/S providers. Re-credentialing for both MH/SUD and M/S providers is conducted every three years. Failure for MH/SUD and M/S providers to meet credentialing and re-credentialing requirements result in a denial of admission to the CCO's network. MH/SUD and M/S providers who are adversely affected by credentialing decisions may re-apply after one year, while adverse re-credentialing decisions may be challenged by filing an appeal.

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

**Stringency of Strategy and Evidence:** All MH/SUD and M/S providers are subject to meeting credentialing and re-credentialing requirements. Exceptions can be authorized by CCO's Chief Medical Officer (CMO) and the Credentialing Committee. Exceptions are made on a very limited, case-by-case basis, but cannot include any licensing/certification sanction or sanction imposed by CMS (must pass). One exception applied by the CCO is if a provider has not completed residency and is not yet board certified. The exception is applied to both MH/SUD and M/S providers in the same way. In operation, MH/SUD and M/S providers have been comparably impacted by the application of credentialing and re-credentialing requirements, with no MH/SUD or M/S providers terminated from the network in the last contract year and no providers denied admission to the network.

The CCO monitors similar metrics related to applying credentialing and re-credentialing requirements for MH/SUD and M/S providers, including reviewing patient complaints (quarterly), license action and sanctions (monthly), and adverse events (on an ongoing basis). As a result, the strategies and evidentiary standards for credentialing and re-credentialing are no more stringently applied to MH/SUD providers than to M/S providers.

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

**PROVIDER ADMISSION — PROVIDER EXCLUSIONS**

**NQTL:** Provider Admission — Provider Exclusions (Categorical exclusion of a particular provider type from the CCO's network of participating providers.)

**Benefit Package:** A and B for Adults and Children

**Classification:** Inpatient and Outpatient

**CCO:** EOCCO

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>CCO does not categorically exclude certain provider types from participating in their network.</li> </ul>	<ul style="list-style-type: none"> <li>The State does not categorically exclude certain provider types from enrolling as Medicaid providers.</li> </ul>	<ul style="list-style-type: none"> <li>N/A</li> </ul>

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>NA</li> </ul>	<ul style="list-style-type: none"> <li>N/A</li> </ul>	<ul style="list-style-type: none"> <li>NA</li> </ul>

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>NA</li> </ul>	<ul style="list-style-type: none"> <li>N/A</li> </ul>	<ul style="list-style-type: none"> <li>NA</li> </ul>

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>NA</li> </ul>	<ul style="list-style-type: none"> <li>N/A</li> </ul>	<ul style="list-style-type: none"> <li>NA</li> </ul>

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>NA</li> </ul>	<ul style="list-style-type: none"> <li>N/A</li> </ul>	<ul style="list-style-type: none"> <li>NA</li> </ul>

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

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

**7. Compliance Determination for Benefit Packages CCO A and B**

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

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

**NQTL:** Out of Network (OON)/Out of State (OOS) Standards

**Benefit Package:** A and B for Adults and Children

**Classification:** Inpatient and Outpatient

**CCO:** EOCCO

**1. To which benefits is the NQTL assigned?**

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>The purpose of having an open network is to ensure that members have access to appropriate quality care.</li> <li>The purpose of providing OOS coverage is to provide needed services when they are not available in-State.</li> </ul>	<ul style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>The purpose of prior authorizing non-emergency OOS services is to ensure the criteria in OAR 410-120-1180 are met.</li> </ul>	<ul style="list-style-type: none"> <li>The purpose of having an open network is to ensure that members have access to appropriate quality care.</li> <li>The purpose of providing OOS coverage is to provide needed services when they are not available in-State.</li> <li>The purpose of prior authorizing non-emergency OOS benefits is to determine the medical necessity of the requested benefit and the availability of an in-State provider.</li> <li>The CCO requires referrals for non-emergency OOS office visits and consultations to ensure that the PCP is central to all health care pertinent to the members they manage and to identify potential gaps in the network.</li> </ul>

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>The CCO covers OON/OOS benefits in accordance with Federal and State requirements, including OAR and the CCO contract.</li> </ul>	<ul style="list-style-type: none"> <li>The State covers OOS benefits in accordance with OAR.</li> </ul>	<ul style="list-style-type: none"> <li>The CCO covers OON/OOS benefits in accordance with Federal and State requirements, including OAR and the CCO contract.</li> </ul>

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>A member has the right to request care from an OON/OOS provider.</li> <li>CCO has an open network so any service delivered by OON/OOS providers is treated identically to network providers from a coverage standpoint. In other words, if the benefit is covered and properly delivered, billed and authorized, the provider will be paid for those services at the DMAP rate.</li> <li>No PA is required for a member to seek services from an OON/OOS provider. However, in order to pay the claims, the CCO will require (if this information is not already in CCO possession) verification that the OON/OOS provider does not have any sanctions against license, is not excluded from participation in Medicaid, has a current DMAP number, and is willing to accept Medicaid FFS rates.</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency OOS services are not covered unless the service meets the OAR criteria.</li> <li>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.</li> <li>Requests for non-emergency OOS services are made through the State prior authorization process.</li> <li>The timeframe for approving or denying a non-emergency OOS request is the same as for other prior authorizations (14 days for standard and 72 hours for urgent).</li> <li>OOS providers must enroll with Oregon Medicaid.</li> <li>The State pays OOS providers the Medicaid FFS rate.</li> </ul>	<ul style="list-style-type: none"> <li>A member has the right to request care from an OON/OOS provider.</li> <li>CCO has an open network so any service delivered by in-State OON Medicaid providers is treated identically to network providers from a coverage standpoint. In other words, if the benefit is covered and properly delivered, billed and authorized, the provider will be paid for those services at the DMAP rate.</li> <li>No PA is required for a member to seek services from an OON provider. However, in order to pay the claims, the CCO will require (if this information is not already in CCO possession) verification that the OON provider does not have any sanctions against license, is not excluded from participation in Medicaid, has a current DMAP number, and is willing to accept Medicaid FFS rates.</li> </ul>

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>• The CCO establishes a single case agreement (SCA) with OON/OOS providers if the provider will not accept the DMAP rate.</li> <li>• The CCO's process for establishing a SCA includes contacting the OON/OOS provider to collect information and negotiating the terms of the SCA.</li> <li>• SCAs can be established within 24 hours of request.</li> <li>• Only providers enrolled in Oregon Medicaid can qualify as an OON/OOS provider.</li> <li>• The CCO generally pays OON/OOS providers the Medicaid FFS rate but in special circumstances pays a negotiated rate.</li> </ul>		<ul style="list-style-type: none"> <li>• Non-emergency OOS services are not covered unless medically necessary services are not available in-State.</li> <li>• Requests for non-emergency OOS services are made through the prior authorization process.</li> <li>• The timeframe for approving or denying a non-emergency OOS request is the same as for other prior authorizations (14 days for standard requests).</li> <li>• The CCO establishes a single case agreement (SCA) with OON/OOS providers if the provider will not accept the DMAP rate.</li> <li>• The CCO's process for establishing a SCA includes contacting the OON/OOS provider to collect information and negotiating the terms of the SCA.</li> <li>• SCAs can be established within 24 hours of request.</li> <li>• Only providers enrolled in Oregon Medicaid can qualify as an OON/OOS provider.</li> <li>• The CCO generally pays OON/OOS providers the Medicaid FFS rate but in special circumstances pays a negotiated rate.</li> </ul>

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>If a non-emergency OON/OOS benefit is not medically necessary or is delivered by a provider not-qualified to provide Medicaid services in Oregon, the service will not be covered and payment for the service will be denied.</li> <li>Members/providers may appeal the denial of payment for an OON/OOS service.</li> <li>Since CCO changed to an open network in January of 2018, it has received 34 claims for OON/OOS, and none of those claims has been denied.</li> <li>The CCO tracks OON/OOS utilization through the CCO's utilization management software and reports trends and findings to the UM committee quarterly. Utilization trends and claims are analyzed annually.</li> </ul>	<ul style="list-style-type: none"> <li>If a request for a non-emergency OOS benefit does not meet the OAR criteria, it will not be prior authorized.</li> <li>If a non-emergency OOS benefit is not prior authorized, the service will not be covered, and payment for the service will be denied.</li> <li>Members/providers may appeal the denial of an OOS request.</li> <li>The State measures the stringency of the application of OOS requirements by reviewing OOS denial/appeal rates.</li> </ul>	<ul style="list-style-type: none"> <li>If an OON/OOS claim does not meet the criteria for payment, including referral for OON and prior authorization for OOS, payment for the claim may be denied.</li> <li>Members/providers may appeal the denial of an OOS request or any non-payment.</li> <li>The CCO reviews all OON claims quarterly and annually to identify gaps in network coverage and PCP referral patterns.</li> <li>In CY 2017, the CCO received 58,295 non-emergency OON/OOS claims/requests, and 27,458 (47%) were denied.</li> <li>The CCO tracks OON/OOS utilization through the CCO's utilization management software and reports trends and findings to the UM committee quarterly. Utilization trends and claims are analyzed annually.</li> </ul>

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
<ul style="list-style-type: none"> <li>Federal and State requirements, including OAR and the CCO contract.</li> </ul>	<ul style="list-style-type: none"> <li>OAR</li> </ul>	<ul style="list-style-type: none"> <li>Federal and State requirements, including OAR and the CCO contract.</li> </ul>

## 7. Compliance Determination for Benefit Packages CCO A and B

**Comparability of Strategy and Evidence:** The CCO has an open network for both MH/SUD and M/S. This means that any service delivered by an OON Medicaid provider is treated identically to network providers from a coverage standpoint. In other words, if the benefit is covered and properly delivered, billed and authorized, the provider will be paid for those services at the DMAP rate. The purpose of having an open network is to ensure that members have access to appropriate quality care. The CCO's purpose for providing OOS coverage is to provide needed MH/SUD and M/S benefits when they are not available in-State. Similarly, for MH/SUD FFS benefits, the State provides OOS coverage to provide needed benefits when they are not available in-State. While the CCO does not require prior authorization for non-emergency OOS MH/SUD benefits, it does require prior authorization for non-emergency OOS M/S benefits. For both non-emergency FFS MH/SUD and CCO M/S, the State/CCO requires prior authorization to determine medical necessity and to ensure no in-State providers are available to provide the benefit. OON/OOS coverage requirements are based on Federal and State requirements, including OAR (for both the State and the CCO) and the CCO contract (for the CCO). As a result, the strategy and evidence for OON/OOS coverage of non-emergency inpatient and outpatient benefits are comparable for MH/SUD and M/S benefits.

**Comparability and Stringency of Processes:** Requests for non-emergency OOS CCO M/S benefits are made through the CCO's prior authorization process and are reviewed for medical necessity and in-State coverage. The prior authorization timeframes (14 days for standard requests and 72 hours for urgent requests) apply. Similarly, the State reviews requests for non-emergency OOS MH/SUD services through its prior authorization process, and the prior authorization timeframes (14 days for standard requests and 72 hours for urgent requests) apply. OOS providers are reimbursed the Medicaid FFS rate. If the OOS MH/SUD provider is not enrolled in Oregon Medicaid, the provider must enroll in Oregon Medicaid. Similarly, the CCO requires both MH/SUD and M/S OON/OOS providers to be enrolled with Oregon Medicaid. If the OON/OOS MH/SUD or M/S provider does not agree to the DMAP rate, then the CCO will establish a single case agreement (SCA). The CCO's process for establishing a SCA is the same for MH/SUD and M/S providers and includes collecting information necessary to complete the SCA and negotiating the terms of the SCA. For both MH/SUD and M/S, SCAs can be established within 24 hours. The CCO pays MH/SUD and M/S the Medicaid FFS rate or, in special circumstances, a negotiated rate. Based on this, the processes for MH/SUD and M/S non-emergency OON/OOS benefits are comparable and applied no more stringently to MH/SUD non-emergency OON/OOS benefits.

**Stringency of Strategy and Evidence:** For both FFS MH/SUD and CCO M/S, if a request for a non-emergency OOS benefit does not meet applicable criteria, which are based on Federal and State requirements, it will not be authorized, and payment for the service will be denied by the CCO/State. Similarly, if a payment request to the CCO for a non-emergency MH/SUD OOS benefit or a MH/SUD or M/S non-emergency OON benefit does not meet applicable criteria, which are based on Federal and State requirements, payment for the service will be denied. Members and providers may appeal the denial of OON/OOS authorization/payment requests to the CCO/State as applicable. While the State does not have statistics regarding OOS requests, the CCO states that since it changed to an open network for MH/SUD in January 1, 2018, it has received 34 OON/OOS claims, and none has been denied. For M/S, the CCO denied approximately 47% of OON/OOS claims. This

indicates that OON/OOS standards are not applied more stringently to MH/SUD benefits. As a result, the strategies and evidentiary standards for OON/OOS are no more stringently applied to MH/SUD benefits than to M/S benefits.

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