HEALTH WEALTH CAREER

JACKSON CARE CONNECT (JACKSON OR JCC) NQTL ANALYSIS

CONTENTS

INTRODUCTION

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

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

OHA analyzed the following four NQTLs for each CCO:

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

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

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

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

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

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

INPATIENT UTILIZATION MANAGEMENT

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

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

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

1. To which benefits is the NQTL assigned?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• (1, 2, 3, 4) PA and CR are required for planned non-emergency admissions to acute IP (in and out-of-network (OON)), PRTS, subacute. All psychiatric admissions require concurrent review except services paid by case rate. • (1, 2, 3, 4) Emergency and urgent admissions require notification within 24-48 hours of admission Monday through Friday and prior to noon the first business day after a weekend.	• (1, 4) PA (only) for MH/SUD procedures performed in a medical facility (e.g., gender reassignment surgery authorizations for benefit packages E and G), experimental/investigational, and extra-contractual benefits are conducted by OHA consistent with the information in column 4 for benefit packages E and G. • (2, 4, 5) A level-of-care review is required for SCIP, SAIP and subacute care that is conducted by an OHA	• (1, 2, 3, 4) PA and CR are required for planned non-emergency admissions to IP hospital (except no CR for DRG hospitals), (in and OON) and IP hospice/palliative care. • (1, 2, 3, 4) Emergency admissions require notification within 48 hours of admission and subsequent CR unless paid by DRG. • (1, 2, 3, 4) Skilled nursing facility benefits (first 20 days) require PA.	• (1, 2, 4) PA and CR are required for in-state and OOS planned surgical procedures (including transplants) and associated imaging, rehabilitation and professional surgical services delivered in an IP setting and listed in OAR 410-130-0200, Table 130-0200-1; rehabilitation, and long term acute care (LTAC). (Notification is required for all IP admissions.) • (1, 2, 4) PA, CR and RR for Behavior Rehabilitation

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

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

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

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• (1-4) HERC PL and guidelines. • (1) UM and claims reports are reviewed for trends in overutilization on a quarterly basis. • (1) CR: Inherent high cost of IP services (which includes room and board and services 24/7). $100,000 per month. • (1) Benefits that are low cost, unlikely to be over-utilized, diagnostic, or not cost-effective to devote resources to review are included on the Care Oregon non-authorization list. This list is modified occasionally based on complaints, utilization reports, staff resources, quality concerns.	• (1, 2 and 4) HERC PL and guidelines. (HERC provides outcome evidence and clinical indications for certain diagnoses that may be translated into UM requirements.)	• (1-4) HERC PL and guidelines. • (1) UM and claims reports are reviewed for trends in overutilization on a quarterly basis. CR: Inherent high cost of IP services (which includes room and board and services 24/7). $300,000 per month. • (1) Benefits that are low cost, unlikely to be over-utilized, diagnostic, or not cost-effective to devote resources to review are included on the Care Oregon non-authorization list. This list is modified occasionally based on complaints, utilization reports, staff resources, quality concerns.	• (1, 2 and 4) The HERC PL and guidelines. • (1) PA staff reports. If the UM team identifies any services for which utilization appears to be increasing (e.g., number of requests) or it appears that the State is paying for medically unnecessary care, the UM team consults with the health analytics team to analyze and evaluate adjustments to PA or CR. • (1) Health analytics reports. The health analytics team and policy analysts refer services that have been identified to have increasing utilization to the UM team for evaluation.
• (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,	• (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,	• (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,	

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
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 Evaluation, Maine Medical Center, & Institute for the Evaluative Clinical Sciences, Toronto, Canada, Financial support was provided by grants from the Robert, Wood Johnson Foundation, the National Institutes of Health (Grant Number CA52192) and the National Institute of Aging (Grant Number 1PO1AG19783-01), 2002, pp 1-32. • (2) Oregon Performance Plan (OPP) requires that BH services be provided in least restrictive setting possible. The OPP is a DOJ-negotiated Olmsted settlement. Also see	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 Evaluation, Maine Medical Center, & Institute for the Evaluative Clinical Sciences, Toronto, Canada, Financial support was provided by grants from the Robert, Wood Johnson Foundation, the National Institutes of Health (Grant Number CA52192) and the National Institute of Aging (Grant Number 1PO1AG19783-01), 2002, pp 1-32. • (2) The Oregon Performance Plan (OPP) requires that BH services be provided in the least restrictive setting possible. The OPP is a DOJ-	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 Evaluation, Maine Medical Center, & Institute for the Evaluative Clinical Sciences, Toronto, Canada, Financial support was provided by grants from the Robert, Wood Johnson Foundation, the National Institutes of Health (Grant Number CA52192) and the National Institute of Aging (Grant Number 1PO1AG19783-01), 2002, pp 1-32.	

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Roberts, E., Cumming, J & Nelson, K., A Review of Economic Evaluations of Community Mental Health Care, Sage Journals, Oct. 1, 2005, 1-13. Accessed May 25, 2018. http://journals.sagepub.com/doi/10.1177/1077558705279307 • (2, 3) Ka Ho Robin Kwok, Sze Ngar Vanessa Yuan & Dennis Ougrin, "Review: Alternatives to inpatient care for children and adolescents with mental health disorders", Child and Adolescent Mental Health 21, No. 1, 2016, pp. 3–10. See also, Inherent restrictiveness of residential settings and dangers associated with seclusion and restraint. Also see Cusack, K.J., Frueh, C., Hiers, T., et. al., Trauma within the Psychiatric Setting: A Preliminary Empirical Report, Human Services Press, Inc., 2003. 453-460. • (3) Medical errors in the hospital is the third leading cause of death in the US.	negotiated Olmsted settlement.	• (3) Medical errors in the hospital is the third leading cause of death in the US. Makary, M. & Daniel, M.	

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Makary, M. & Daniel, M. Medical Error - The Third Leading Cause of Death in the US, BMJ, 2016;353:i2139. • (4) Applicable federal and State requirements.	• (4) PRTS CONS: OAR 410-172-0690 and 42 CFR 441.156. • (4) OARs and other applicable federal and State requirements. • (5) Cost and utilization reports.	Medical Error - The Third Leading Cause of Death in the US, BMJ, 2016;353:i2139. • (4) OARs and other applicable federal and State requirements.	• (4) Applicable federal and State requirements.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Timelines for authorizations: • It is preferred that PA is requested two weeks prior to admission (consistent with mandated 14 day authorization turnaround time) but there is no limit. Urgent requests are expedited and generally completed in the same business day. • Due to nature of emergent inpatient stays, reviews are	**Timelines for gender reassignment surgery authorizations (for benefit packages E and G):** **(OHA)** • Standard requests are to be processed within 14 days. **Timelines for child residential authorizations**: **(OHA)** • OHA provides the initial authorization (level-of-care	**Timelines for authorizations:** • It is preferred that PA is requested two weeks prior to admission (consistent with mandated 14 day authorization turnaround time) but there is no limit. Urgent requests are expedited and generally completed in the same business day. • PA: Completion within regulatory timelines.	**Timelines for authorizations**: • All in-state and out-of-state (OOS) emergency admissions, LTAC, and IP rehabilitation require notification. Notification is preferred within 24 hours of admission, but there is no timeline requirement. Notification allows the State to conduct case management and discharge planning, but

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
necessarily retrospective, usually within 24-48 hours of admission. • Standard requests are completed within regulatory timeframes.	review) within 3 days of requests for SCIP, SAIP or subacute. **(HIA)** • Authorization requests for PRTS are submitted prior to admission or within 14 days of an emergency admission. An emergency admission is acceptable only under unusual and extreme circumstances, subject to RR by HIA. **Timelines for adult residential and YAP authorizations**: **(KEPRO)** • OARs require emergency requests be processed within 24 hours, urgent within 72 hours, and standard requests within 14 days.	• Due to nature of emergent inpatient stays, reviews are necessarily retrospective, usually within 24-48 hours of admission.	does not limit the scope or duration of the benefit. • PA is required before admission. • OARs require emergency requests be processed within 24 hours, urgent requests within 72 hours and standard requests within 14 days; although a backlog may develop.
Documentation requirements: • PA documentation: One page treatment notification form faxed with clinical summary and treating provider recommendation for requested service.	**Documentation requirements (OHA):** • PA documentation requirements for non-residential MH/SUD benefits in benefit packages E and G include a form that consists of	**Documentation requirements:** • PA documentation: Standard forms used for all services, typically one page with any applicable supporting medical documentation to support the	**Documentation requirements**: • PA documentation requirements include a form that consists of a cover page. Diagnostic and CPT code information and a rationale for medical necessity must be

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Clinical documentation is requested from the provider unless UM staff have access to their EMR • Submission of required documentation listed in practice guideline for SUD residential • Submission of updated treatment plan and progress toward goal, clinical and LMP notes as requested (PRTS, Subacute)	a cover page. Diagnostic and CPT code information and a rationale for medical necessity must be provided, plus any additional supporting documentation. • The documentation requirement for level-of-care assessment for SCIP, SAIP and subacute is a psychiatric evaluation. Other information may be reviewed when available. **Documentation requirements for PRTS CONS and CR for SCIP and SAIP (HIA)**: • PRTS CONS requires documentation that supports the justification for child residential services including: (a) A cover sheet detailing relevant provider and recipient Medicaid numbers; (b) Requested dates of service; (c) HCPCS or CPT Procedure code requested; and (d) Amount of service or units requested;	medical necessity of the request.	provided, plus any additional supporting documentation.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	(e) A behavioral health assessment and service plan meeting the requirements described in OAR 309-019-0135 through 0140; or (f) Any additional supporting clinical information supporting medical justification for the services requested; (g) For substance use disorder services (SUD), the Division uses the American Society of Addiction Medicine (ASAM) Patient Placement Criteria second edition-revised (PPC-2R) to determine the appropriate level of SUD treatment of care. • There were no reported specific documentation requirements for CR of SCIP or SAIP. **Documentation requirements (KEPRO)**: • Documentation may include assessment, service plan, plan-of-care, Level-of-Care Utilization System (LOCUS), Level of Service Inventory		

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Method of document submission: • Submitted via provider portal or fax. • CR: Providers use statewide electronic census tool (PreManage), which automatically submits notification to CareOregon about inpatient request. • CR: In most cases, QMHP staff have access to hospital EMR to conduct authorization review, and issue determination of approval or denial. CR is based on review of the medical record, requested clinical notes or phone conversations with UM staff as indicated.	(LSI) or other relevant documentation. **Method of document submission (OHA):** • For non-residential MH/SUD services in benefit packages E and G, paper (fax) or online PA requests are submitted prior to the delivery of services for which PA is required. • For SCIP, SAIP and subacute level-of-care review, the OHA designee may accept information via fax, mail or email and has also picked up information. Supplemental information may be obtained by phone. **Method of document submission (HIA):** • Packets are submitted to HIA by mail, fax, email or web portal for review for child residential services. Telephonic clarification may be obtained.	**Method of document submission:** • Currently faxed to plan. • CR: Providers use statewide electronic census tool (PreManage) which automatically submits notification to CareOregon about inpatient request. • CR: In most cases, RN staff have access to hospital EMR to conduct authorization review, and issue determination of approval or denial.	**Method of document submission**: • Paper (fax) or online PA requests are submitted prior to the delivery of services for which PA is required.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Qualifications of reviewers: • PA: RNs or licensed MH/SUD professionals authorize coverage relative to InterQual and HERC. • Denials must be reviewed and determined by an MD/DO.	• Psychiatrist to psychiatrist review is telephonic. **Method of document submission (KEPRO):** • Providers submit authorization requests for adult MH residential to KEPRO by mail, fax, e-mail or via portal, but documentation must still be faxed if the request is through the portal. Telephonic clarification may be obtained. **Qualifications of reviewers (OHA)**: • OHA M/S staff conduct PA and CR (if applicable) for gender reassignment surgery (for benefit packages E and G). (See processes, strategies and evidentiary standards in column 4.) • The OHA designee is a licensed, masters'-prepared therapist that reviews psychiatric evaluations to approve or deny the level-of-care requested. Psychiatric	**Qualifications of reviewers:** • RNs authorize coverage relative to InterQual and HERC. • Denials must be reviewed and determined by an MD/DO.	**Qualifications of reviewers**: • Nurses may authorize and deny authorization requests relative to OAR, HERC PL guidelines and associated notes, and other industry guidelines (e.g., AIM for radiology).

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	consultation is available if needed. **Qualifications of reviewers (HIA)**: • Two LCSWs with QMHP designation make residential authorization decisions. • Two psychiatrists make CONS determinations. **Qualifications of reviewers (KEPRO)**: • KEPRO QMHPs must meet minimum qualifications (see below) and demonstrate the ability to conduct and review an assessment, including identifying precipitating events, gathering histories of mental and physical health, substance use, past mental health services and criminal justice contacts, assessing family, cultural, social and work relationships, and conducting/reviewing a mental status examination, complete a DSM diagnosis, and write and supervise the implementation of a PCSP.		

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Criteria: • HERC, ASAM, InterQual and OARs.	• A QMHP must meet one of the follow conditions: – Bachelor's degree in nursing and licensed by the State or Oregon; – Bachelor's degree in occupational therapy and licensed by the State of Oregon; – Graduate degree in psychology; – Graduate degree in social work; – Graduate degree in recreational, art, or music therapy; – Graduate degree in a behavioral science field; or – A qualified Mental Health Intern, as defined in 309-019-0105(61). **Criteria (OHA)**: • Authorizations for non-residential MH/SUD services in benefit packages E and G are based on the HERC PL and guidelines, Oregon	**Criteria:** • HERC, InterQual, and OARs	**Criteria**: • Authorizations are based on the HERC PL and applicable guidelines, Oregon Statute, OAR, federal regulations, evidence-based guidelines

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	Statute, OAR, federal regulations, and evidence-based guidelines from private and professional associations. • The OHA designee reviews requests relative to the least restrictive environment requirement. **Criteria (HIA)**: • HERC PL and HIA policy are used for residential CR. **Criteria (KEPRO)**: • QMHPs review information submitted by providers relative to State plan and OAR requirements and develop a PCSP. • The PCSP components are entered into MMIS as an authorization.		from private and professional associations such as the Society of American Gastrointestinal and Endoscopic Surgeons and InterQual, where no State or federal guidelines exist.
Reconsideration/RR: • Exceptional circumstances can allow (e.g. member coverage could not have been known), a facility to submit a post-service claim review request.	**Reconsideration/RR (OHA)**: • A provider may request review of an OHA denial decision. The review occurs in weekly Medical Management Committee (MMC) meetings. (Applies to non-residential MH/SUD	**Reconsideration/RR:** • Exceptional circumstances can allow (e.g. member coverage could not have been known) a facility to submit a post-service claim review request.	**Reconsideration/RR**: • A provider may request review of a denial decision. The review occurs in weekly MMC meetings. • Exception requests for experimental and other non-covered benefits may be

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	services in benefit packages E and G.) • Exception requests for experimental and other non-covered benefits (for benefit packages E and G) may be granted at the discretion of the MMC, which is led by the HSD medical director. • If a provider requests review of an OHA designee level-of-care determination, HIA may conduct the second review. **Reconsideration/RR (HIA)**: • If the facility requests a reconsideration of a CONS denial, a second psychiatrist (who did not make the initial decision) will review the documentation and discuss with the facility in a formal meeting. • No policy for CR denials. **Reconsideration/RR (KEPRO)**: • Within 10 days of a denial, the provider may send additional documentation to KEPRO for reconsideration.		granted at the discretion of the MMC, which is led by the HSD medical director.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Consequences for failure to authorize: • PA: No payment to provider and/or facility for procedures performed outside of emergent situations without authorization. • If no authorization, all facility charges for that inpatient stay are denied. Professional charges (other than facility) are paid to providers who are not penalized for facility failure to secure authorization.	• A provider may request review of a denial decision, which occurs in weekly MMC meetings or KEPRO's comparable MM meeting. **Consequences for failure to authorize (OHA)**: • Failure to obtain authorization for non-residential MH/SUD services in benefit packages E and G can result in non-payment for benefits for which it is required. • Failure to obtain notification for non-residential MH/SUD services in benefit packages E and G does not result in a financial penalty. • For SCIP, SAIP and subacute, if coverage is retroactively denied, general funds may be used to cover the cost of care. **Consequences for failure to authorize (HIA)**: • Non-coverage. **Consequences for failure to authorize (KEPRO)**:	**Consequences for failure to authorize:** • PA: No payment to provider and/or facility for procedures performed outside of emergent situations without authorization. • If no authorization, all facility charges for that inpatient stay are denied. Professional charges (other than facility) are paid to providers who are not penalized for facility failure to secure authorization.	**Consequences for failure to authorize**: • Failure to obtain authorization can result in non-payment for benefits for which it is required. • Failure to obtain notification does not result in a financial penalty.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Appeals: • Standard appeal processes apply.	Failure to obtain authorization can result in non-payment for benefits for which it is required. **Appeals (OHA)**: • Members may request a hearing on any denial decision. **Appeals (HIA)**: • Documentation has not included the fair hearing process. **Appeals (KEPRO)**: • Members may request a hearing on any denial decision.	**Appeals:** • Standard appeal processes apply.	**Appeals**: • Members may request a hearing on any denial decision.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Frequency of review (and method of payment): • CR: Most IP is paid on a per diem basis. Concurrent review is based on InterQual and as clinically indicated based on estimated LOS. • IP hospital ranges from 1 day to 1 week; average of 3 days.	**Frequency of review (and method of payment) (OHA)**: • Gender reassignment surgery (for benefit packages E and G) is authorized as a procedure. • The initial authorization for SCIP, SAIP and subacute is 30 days.	**Frequency of review (and method of payment):** • PA: Services are authorized based on InterQual expected length of stay. Additional review is required if LOS exceeds this initial estimate. • Most IP stays are paid by DRG (no concurrent).	**Frequency of review (and method of payment)**: • Most IP claims are paid DRG; as a result, CR is infrequently used. • CR is conducted monthly for LTAC and rehabilitation. • The State conducts CR for SNF after the first 20 days (which are managed by the

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Subacute: 7 days • SUD residential: Don't do CR; review post-discharge and only if LOS was beyond 75 days • PRTS: 30 days CR (on average) **RR conditions and timelines:** • RR is offered (with some limitations) for providers who fail to PA medically necessary care.	**Frequency of review (and method of payment) (HIA)**: • Child residential services are paid by per diem. • Child residential services authorizations are conducted every 30-90 days. **Frequency of review (and method of payment) (KEPRO)**: • Adult residential and YAP authorizations are conducted at least once per year. In practice reviews average every 6 months. **RR conditions and timelines (OHA)**: • RR for non-residential MH/SUD services in benefit packages E and G is only available for retro eligibility situations (e.g., the person became eligible during the stay). **RR conditions and timelines (HIA):** • No policy **RR conditions and timelines (KEPRO)**:	• For A/B hospitals, CR is conducted daily. • Per diem ranges from 1-3 days. • SNF: Initial authorization for 20 days is granted when medically necessary. • Subsequent reviews are performed on a schedule based on clinical judgment of reviewing clinicians (RN/MD/DO). **RR conditions and timelines:** • RR is offered (with some limitations) for providers who fail to PA medically necessary care.	CCO) at a frequency that is determined by the care manager, but not less than one time a year. • Authorization lengths are individualized by condition and are valid for up to a year. • Procedural authorizations are valid for 3 months. **RR conditions and timelines**: • RR is only available for retro eligibility situations (e.g., the person became eligible during the stay).

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Methods to promote consistent application of criteria: • Annual IRR testing is conducted.	• The request for authorization is received within 30 days of the date of service. • Any requests for authorization after 30 days from date of service require documentation from the provider that authorization could not have been obtained within 30 days of the date of service. **Methods to promote consistent application of criteria (OHA)**: • Nurses are trained on the application of the HERC PL and guidelines, which is spot-checked through ongoing supervision. Whenever possible, practice guidelines from clinical professional organizations such as the American Medical Association or the American Psychiatric Association, are used to establish PA frequency for services in the FFS system. (Applicable to non-residential MH/SUD services in benefit packages E and G.)	**Methods to promote consistent application of criteria:** • Annual IRR testing is conducted.	**Methods to promote consistent application of criteria**: • Nurses are trained on the application of the HERC PL and guidelines, which is spot-checked through ongoing supervision. Whenever possible, practice guidelines from clinical professional organizations such as the American Medical Association or the American Psychiatric Association, are used to establish PA frequency for services in the FFS system.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	• There is only one OHA designee reviewer for level-of-care review for SCIP, SAIP, and subacute and no specific criteria, so N/A. **Methods to promote consistent application of criteria (HIA):** • Parallel chart reviews for the two reviewers. (No criteria.) **Methods to promote consistent application of criteria (KEPRO)**: • Monthly clinical team meetings in which randomly audited charts are reviewed/discussed by peers using the KEPRO compliance department-approved audit tool. • Results of the audit are compared, shared and discussed by the team and submitted to the Compliance Department monthly for review and documentation. • Individual feedback is provided to each clinician during supervision on their authorization as well as plan-of-care reviews.		

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Evidence for UM frequency: • PA: Practice guidelines are adapted from InterQual. • Most MH/SUD IP is paid on a per diem basis, increasing the potential for overutilization.	**Evidence for UM frequency (OHA (and designee for level of care review), HIA and KEPRO)**: • PA length and CR frequency are tied to HERC PL and guidelines, OAR, CFRs, reviewer expertise and timelines for expectations of improvement. • The Commission that develops HERC consists of 13 appointed members, which include five physicians, a dentist, a public health nurse, a pharmacist and an insurance industry representative, a provider of complementary and alternative medicine, a behavioral health representative and two consumer representatives. The Commission is charged with maintaining a priority list of services, developing or identifying evidence-based health care guidelines and conducting comparative effectiveness research.	**Evidence for UM frequency:** • PA: InterQual • CR: For DRG hospitals, following the expiration of the DRG associated time (focus on underutilization). For non-DRG services, practice guidelines adapted from InterQual. Expectations for improvement. • SNF: Historical analysis (determined the vast majority of members use the entire benefit (and many SNF's refuse to take a member if the maximum benefit isn't authorized up front) when approved for SNF admission so 20 days are granted). This is an attempt to reduce administrative burden. SNFs are expected to ensure members meet medical necessity for continued stay.	**Evidence for UM frequency**: • PA length and CR frequency are tied to HERC PL and guidelines, DRGs, OAR, CFRs, reviewer expertise and timelines for expectations of improvement. • The Commission that develops HERC consists of 13 appointed members, which include five physicians, a dentist, a public health nurse, a pharmacist and an insurance industry representative, a provider of complementary and alternative medicine, a behavioral health representative and two consumer representatives. The Commission is charged with maintaining a priority list of services, developing or identifying evidence-based health care guidelines and conducting comparative effectiveness research. • HERC guidelines of which there are more M/S than

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	• 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 trials, more subjective diagnoses (or the ICD-10-CM diagnoses represent a spectrum) and less standardization in interventions).		MH/SUD because 1) there are more technological procedures (e.g., surgery, devices, procedures and diagnostic tests); and 2) the literature is more robust.
Data reviewed to determine UM application: • PA: Inter-rater reliability measures, denial rates, appeal monitoring and rates, and results of hearings, which can alert plan to need to review denials later overturned by judge. • CR & RR: Denial rates, inter-rater reliability, Medical Director review of all denials,	**Data reviewed to determine UM application (OHA)**: • Denial/appeal overturn rates; number of PA requests; stabilization of cost trends; and number of hearings requested. These data are reviewed in contractor reports, on a quarterly basis by the State. (Applicable to non-residential MH/SUD	**Data reviewed to determine UM application:** • PA: Inter-rater reliability measures, denial rates, appeal monitoring and rates, and results of hearings, which can alert plan to need to review denials later overturned by judge. • CR: Denial rates, inter-rater reliability. Medical Director reviews all denials.	**Data reviewed to determine UM application**: • A physician led group of clinical professionals conducts an annual review to determine which services receive or retain PA. Items reviewed include: – Utilization – Approval/denial rates

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
psych rounds occur weekly with multiple clinical staff in attendance, as well as care coordinators who will work with members post-discharge. • Investigational: Coverage decisions made by Medical Director, discussed in Psych Rounds for BH cases, with all review staff present for input/consultation. **IRR standard:** • 80% standard **Results of criteria application: (Appeal overturn rates)** • 0 appeal overturns.	services in benefit packages E and G.) **Data reviewed to determine UM application (HIA)**: N/A **Data reviewed to determine UM application (KEPRO):** N/A **IRR standard:** • OHA: N/A • HIA: N/A • KEPRO: N/A **Results of criteria application**: • OHA: 0 appeal overturns. • HIA: 0 appeal overturns. • KEPRO: 0 appeal overturns.	• RR: Appeal/Grievance process; use of nationally recognized medical necessity criteria; cost trends • Investigational: Decisions made by Medical Director. Exceptions are discussed in Psych Rounds for BH cases, with all review staff present for input/consultation. Exceptions are marked in system to allow for analysis patterns. **IRR standard:** • 80% standard **Results of criteria application: (Appeal overturn rates)** • Appeal overturn rate of 42% for IP and OP combined.	– Documentation/ justification of services – Cost data **IRR Standard**: • N/A **Results of criteria application**: • 0 appeal overturns.

7. Compliance Determination for Benefit Packages CCO A and B

IP Benefits: All non-emergent CCO MH/SUD and M/S IP admissions require PA or level-of-care approval. Emergency CCO MH/SUD and M/S IP admissions require notification within 24-48 hours (or one business day following the weekend for MH/SUD) and most (i.e., non-DRG) ongoing IP services require subsequent CR. Emergency child residential admissions require notification within 14 days. The CCO conducts PA and CR for MH/SUD and M/S IP hospital benefits. An OHA designee conducts level-of-care review for SCIP, SAIP and subacute. CR for SCIP and SAIP child residential benefits is conducted by HIA. HIA conducts the CONS procedure and PA for PRTS. KEPRO conducts PA and CR for adult residential and YAP. The CCO conducts CR for subacute and PRTS. SNF CR is conducted by the CCO for the first 20 days (after which the State conducts CR).

Comparability of Strategy and Evidence: UM is assigned to MH/SUD and M/S IP benefits primarily using four strategies: 1) To ensure coverage, medical necessity and prevent unnecessary overutilization (e.g., in violation of relevant OARs, the HERC PL and guidelines) of high cost services. (The cost threshold for MH/SUD is lower than for M/S because the threshold is set to identify a similar percentage of MH/SUD and M/S costs and overall MH/SUD costs are lower.) Evidence of MH/SUD overutilization includes HERC, research demonstrating 30% of IP costs are unnecessary; and for MH/SUD and M/S benefits administered by the CCO, utilization reports. 2) To ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. Although strategy (2) primarily applies to MH/SUD benefits, it is permissible because it is a requirement resulting from a DOJ-negotiated Olmstead settlement agreement. Safety issues for M/S are supported by HERC. 3) To maximize use of INN providers to promote cost-effectiveness. Maximizing network utilization only applies to MH/SUD and M/S benefits administered by the CCO.[2] Evidence for the cost-effectiveness of network utilization for both MH/SUD and M/S includes the contracted fees and credentials verification process associated with network participation. 4) To comply with federal and State requirements. As a result, the strategies and evidence are comparable.

Comparability and Stringency of Processes: PreManage notifies the CCO that there has been an IP admission. OARs require authorization decisions within 24 hours for emergencies, 72 hours for urgent requests and 14 days for standard requests. Providers are encouraged to submit requests for authorization sufficiently in advance to be consistent with OAR time frames. Most documentation requirements for MH/SUD and M/S IP admissions include a form and information that supports medical necessity such as an updated treatment plan and progress notes. The CCO has access to some facilities' MH/SUD and M/S information via the EHR. Alternatively, documentation may be submitted by fax or web portal. Documentation requirements for child residential PA/level-of-care review include a psychiatric evaluation or a psychiatrist-to-psychiatrist telephonic review. HIA accepts information for child residential CR via mail, email, fax and web portal. Adult residential and YAP require an assessment (i.e., completion of a relevant level-of-care tool (e.g., ASAM, LSI, LOCUS)) and plan-of-care consistent with State plan

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

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, ASAM (for CCO SUD) and InterQual 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.* CCO MH/SUD and M/S denials must be reviewed and determined by a physician. The OHA designee, who is a licensed MH professional, makes denial determinations for level-of-care review for certain child residential services. HIA denials are made by psychiatrists. KEPRO QMHPs develop PCSPs. *OHA plans to ensure that all denial decisions are made by professional peers*. The CCO makes RR available for MH/SUD and M/S in exceptional circumstances (e.g., member coverage could not have been known). 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 action plans, the MH/SUD and M/S processes are comparable and no more stringently applied to MH/SUD benefits.

Stringency of Strategy and Evidence: Concurrent review is conducted as clinically indicated based on estimated LOS, but averages every 3 days for MH/SUD IP hospital not paid by DRG, while M/S acute IP hospital services paid by per diem are reviewed every 1-3 days. CCO MH/SUD subacute is reviewed weekly and PRTS every 30 days. SUD residential is retrospectively reviewed if the length of stay exceeds 75 days. FFS child residential is reviewed every 30-90 days while FFS adult residential and YAP are reviewed no less than annually, but in practice averages 6 months. After an analysis that showed providers consistently use all of the 20 day SNF benefit, the CCO stopped CR and authorizes the full benefit during PA. Evidence for the frequency of CCO review includes ASAM, InterQual, federal regulations (PRTS), and expected ALOS. *OHA plans to task the FFS residential subcontractors with review of CR frequencies relative to the most recent research to confirm MH/SUD review frequency is directly tied to evidence rather than historical standard practice.* In exception circumstances, such as when coverage is not able to be determined at the time of admission, MH/SUD and M/S facilities may submit a post service claim review request to the CCO. 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 and other 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 annual 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 42% appeal overturn rate for M/S while MH/SUD (FFS and CCO) had 0 appeal overturns 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 the 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.*

8. Compliance Determination for Benefit Packages CCO E and G

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

Comparability of Strategy and Evidence: UM is assigned to MH/SUD and M/S IP benefits primarily using three strategies: 1) To ensure coverage, medical necessity and prevent unnecessary overutilization (e.g., in violation of relevant OARs, HERC PL or guidelines). Evidence of

MH/SUD overutilization includes HERC, research demonstrating 30% of IP costs are unnecessary; and for MH/SUD benefits administered by the CCO, utilization reports. 2) To ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. Although strategy (2) primarily applies to MH/SUD benefits, it is permissible because it is a requirement resulting from a DOJ-negotiated Olmstead settlement agreement. M/S safety issues are supported by HERC. 3) To comply with federal and State requirements. As a result, the strategy and evidence are comparable.

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

Qualified individuals conduct MH/SUD CCO UM applying OARs, HERC, ASAM and InterQual. OHA reviews authorization requests relative to HERC PL and guidelines and applicable practice guidelines from national organizations. The OHA designee reviews authorization requests to determine if the proposed level-of-care is the least restrictive environment. HIA reviews care relative to policy. KEPRO develops PCSPs relative to State plan and OAR requirements. *OHA plans to enhance the evidence base for child residential authorization decisions through additional research, resulting in admission and CR criteria development.* All denial determinations are made by a physician for CCO MH/SUD. FFS MH/SUD and M/S allow MA licensed therapists and nurses to make a denial determination. *Although not a parity concern in these benefit packages, OHA plans to ensure that all denial decisions are made by professional peers.* In exceptional circumstances the CCO makes RR available when providers of MH/SUD fail to obtain authorization. Upon provider request, the OHA designee obtains RR by HIA. HIA allows reconsideration of CONS determinations, but reported they do not have an RR policy for HIA's CR denials for child residential services. For adult residential and YAP services, KEPRO allows reconsideration of denials with the submission of additional documentation within 10 days of the denial. For OHA and KEPRO, the review of a denial decision occurs in a weekly MMC meeting. FFS M/S limits RR to retro eligibility circumstances. *Although not a parity issue in these benefit packages, OHA intends to standardize RR processes when feasible.* Providers may

appeal a MH/SUD denial decision by the CCO to the CCO. OHA FFS reviews denials through the fair hearing process, but HIA and the OHA designee have not encouraged use of this process. *OHA plans to confirm all notices of action, appeal and fair hearing processes are consistent with federal requirements*. Failure to obtain authorization may result in non-coverage. Inclusive of OHA action plans, the MH/SUD and M/S processes are comparable and no more stringently applied to MH/SUD benefits.

Stringency of Strategy and Evidence: Concurrent review is conducted, on average, every 3 days for MH/SUD IP hospital (which is paid by per diem), while FFS M/S rarely conducts CR unless services extend beyond the DRG expected length of stay. CCO MH/SUD subacute is reviewed weekly and PRTS every 30 days. SUD residential is retrospectively reviewed if the length of stay exceeds 75 days. FFS child residential is reviewed every 1-3 months while FFS adult residential and YAP are reviewed no less than annually but in practice average 6 month reviews. SNF is also reviewed no less than annually after the first 20 days. LTAC and rehab hospital (M/S IP) are reviewed monthly. Evidence for the frequency of review for CCO MH/SUD is ASAM and InterQual. *OHA plans to task FFS residential subcontractors with review of CR frequencies relative to the most recent research to confirm MH/SUD review frequency is directly tied to evidence rather than historical standard practice*. CCO MH/SUD offers RR in exceptional circumstances. KEPRO makes RR available for 30 days post-admission. FFS MH/SUD only allows RR for retro-eligibility circumstances. The OHA designee and HIA do not have standard policies describing when RR is available. In addition, it was discovered that there are conflicting State rules regarding RR timelines. *OHA plans to standardize the availability of RR, including the conditions under which it is permissible and the timeframes. OHA will align OAR requirements and RR offerings by contractors*. The CCO and State review utilization data to determine if PA or CR should be added or adjusted for MH/SUD and M/S IP benefits. For MH/SUD, the CCO conducts chart review to promote consistency of MNC application. HIA conducts IRR and parallel chart reviews for its two reviewers and KEPRO team meetings include random chart audits using a compliance tool followed by team discussion. HIA and the OHA designee do not have specific criteria against which decisions are made. FFS M/S conducts spot-checks through supervision to assess criteria application. *OHA plans to institute a more formalized measurement of criteria application when feasible even though this is not a parity issue in these benefit packages.* MH/SUD reported 0 appeal overturns in 2017. FFS M/S's appeal overturn rate was also 0. 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 for IP benefit packages A and B above, the UM processes, strategies and evidentiary standards are comparable and no more stringently applied to MH/SUD IP benefits than to M/S IP benefits, in writing or in operation, in the child or adult benefit packages.

OUTPATIENT UTILIZATION MANAGEMENT

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

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

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

1. To which benefits is the NQTL assigned?

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
• (1) 1915(c) Comprehensive DD waiver (operated/managed by DHS) • (1) 1915(c) Support Services DD waiver (operated/managed by DHS) • (1) 1915(c) Behavioral DD Model waiver (operated/managed by DHS)	The following services are managed by DHS: • (1) 1915(c) Comprehensive DD waiver • (1) 1915(c) Support Services DD waiver • (1) 1915(c) Behavioral DD Model waiver • (1) 1915(c) Aged & Physically Disabled waiver • (1) 1915(c) Hospital Model waiver	• PA only: – (2, 4) Intensive, treatment services including PDTS, Neuropsych testing, – (2, 3, 4) OOS services – (2, 3, 4) PT/ST/OT • CR: – (2) Investigational procedures • (2, 3, 4) PA and CR: ABA and OT/PT/ST	• PA: • (2, 4) Specialist visits • (2, 3, 4) Elective procedures performed in OP hospital setting and/or ASC • (2, 4) Selected procedures performed in PCP offices • (2, 3, 4) Rehab services (PT/OT/ST) • (3, 4) Selected imaging and lab studies	The following services are managed by OHA: • (2, 3) Out of hospital births • (2) Home health services • (2) OT, PT, ST, and audiology for M/S conditions (and autistic disorder, which is also managed according to the processes, strategies and

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
• (1)1915(i)(HK) services for adults (home-based habilitation, behavioral habilitation and psychosocial rehab for persons with CMI) (managed by KEPRO under contract with OHA)	• (1) 1915(c) Medically Involved Children's NF waiver • (1) 1915(k) Community First Choice State Plan option • (1) 1915(j): Self-directed personal assistance		• (2, 4) Durable medical equipment (DME) • (2, 4) Vision services • (2, 4) Chiropractic care • (2, 4) Circumcision • Any service not on the "No Auth Required List" unless it is delivered out of state • (2) Investigational procedures	evidentiary standards described for FFS M/S OP) • (2) Imaging • (2) DME

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
• (1) The State requires PA of HCBS in order to meet federal requirements regarding PCSPs and ensure services are provided in accordance with a participant's PCSP and in the least restrictive setting.	• (1) The State requires PA of HCBS in order to meet federal requirements regarding PCSPs and ensure services are provided in accordance with a participant's PCSP and in the least restrictive setting.	• (2) Ensure services adhere to State criteria defined in Prioritized List of Health Services to prevent overutilization. • (3) Ensure members receive safe and indicated procedures. • (4) Ensure clinical appropriateness, medical necessity and	• (2) Ensure services adhere to State criteria defined in Prioritized List of Health Services to prevent overutilization. • (3) Ensure members receive safe and indicated procedures. • (4) Ensure clinical appropriateness, medical necessity,	• (2) To prevent services being delivered in violation of relevant OARs, associated HERC PL and guidelines and federal regulations. • (3) Services are associated with increased health or safety risks.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
		least restrictive environment.	least restrictive environment.	

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
• (1) Federal requirements regarding PCSPs for 1915(c) and 1915(i) services (e.g., 42 CFR 441.301 and 441.725) and the applicable approved 1915(c) waiver application/1915(i) State plan amendment. • (1) Oregon Performance Plan (OPP) requires that all BH services are provided in the least restrictive setting possible as do federal requirements regarding 1915(c) and 1915(i) services.	• (1) Federal requirements regarding PCSPs for 1915(c), 1915(k), and 1915(j) services (e.g., 42 CFR 441.301, 441.468, and 441.540) and the applicable approved 1915(c) waiver application/State plan amendment. • (1) Federal requirements regarding 1915(c) and 1915(i) services require that HCBS are provided in the least restrictive setting possible.	• (2-4) HERC and InterQual • (2) Utilization review reports. Evaluate costs per episode of care and compare to network average to identify outliers (by diagnosis). • (2) At a high level, approximately 30% of medical care in the US is estimated to be "unnecessary"; reviewing for medical appropriateness is the main process to ensure appropriate utilization. http://www.healthcarefinancenews.com/news/unnecessary-medical-tests-treatments-cost-	• (2-4) HERC and InterQual • (2) Utilization review reports • (2) At a high level, approximately 30% of medical care in the US is estimated to be "unnecessary"; reviewing for medical appropriateness is the main process to ensure appropriate utilization. http://www.healthcarefinancenews.com/news/unnecessary-medical-tests-treatments-cost-200-billion-annually-cause-harm (2) OP Program contracts	• (2) HERC PL • (2) PA requests with insufficient documentation demonstrate MNC are not being met or HERC PL guidelines are not being followed. • (3) HERC Guidelines - Recommended limits on services for member safety.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
		200-billion-annually-cause-harm • (2) OP Program contracts • (4) Oregon Performance Plan (OPP) requires that all BH services be provided in least restrictive setting possible as do federal requirements regarding 1915(c) and 1915(i) services.		

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Timelines for authorizations: • A PCSP must be approved within 90 days from the date a completed application is submitted.	**Timelines for authorizations**: • A PCSP must be approved within 90 days from the date a completed application is submitted.	**Timelines for authorizations:** • Only conduct reviews of OP when care exceeds one year. • Complies with regulatory timeframes.	**Timelines for authorizations:** • Complies with regulatory timeframes.	**Timelines for authorizations**: • Urgent requests are processed in 72 hours and immediate requests in 24 hours. Routine requests are processed in 14 days.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Documentation requirements: • (c)The PCSP is based on a functional needs assessment and other supporting documentation. It is developed by the individual, the individual's team and the individual's case manager. • (i)The PCSP is based on an assessment, service plan, plan-of-care, Level-of-Care Utilization System (LOCUS), Level of Service Inventory (LSI) or other relevant documentation. The PCSP is developed by the member's treatment team in consultation with the member.	**Documentation requirements**: • The PCSP is based on a functional needs assessment and other supporting documentation. It is developed by the individual, the individual's team and the individual's case manager.	**Documentation requirements:** • Submission of required documentation listed in practice guideline (SUD outpatient detox) • Submission of updated treatment plan and progress toward goals, clinical and LMP notes as requested. (PDTS)	**Documentation requirements:** • Provider to submit requested codes with chart documentation to support requested payment for service, as required by OAR.	**Documentation requirements**: • A cover page form is required. In addition, diagnostic information, a CPT code(s), a rationale for medical necessity plus any additional supporting documentation are required.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Method of document submission: • All 1915(c) services must be included in a participant's PCSP and approved by a qualified case manager at the local case management entity (CME) prior to service delivery. • Information is obtained during a face-to-face meeting, often at the individual's location. • (i) Providers submit authorization requests to KEPRO by mail, fax email or via portal, but documentation must still be faxed if the request is submitted via portal.	**Method of document submission**: • All 1915(c), 1915(k), and 1915(j) services must be included in a participant's PCSP and approved by a qualified case manager at the local case management entity (CME) prior to service delivery. • Information is obtained during a face-to-face meeting, often at the individual's location.	**Method of document submission:** • Documentation is submitted via fax, although training is in process for use of a provider web portal.	**Method of document submission:** • Web portal.	**Method of document submission**: • Paper (fax) or online PA/POC submitted prior to the delivery of services.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Qualifications of reviewers: • (c) A case manager must have at least: – A bachelor's degree (BA) in behavioral science, social science, or a closely related field; or – A BA in any field AND one year of human services related experience; or – An associate's degree (AA) in a behavioral science, social science, or a closely related field AND two years human services related experience; or – Three years of human services-	**Qualifications of reviewers**: • A case manager must have at least: – A BA in behavioral science, social science, or a closely related field; or – A BA in any field AND one year of human services related experience; or – An associate's degree (AA) in a behavioral science, social science, or a closely related field AND two years human services related experience; or – Three years of human services-related experience.	**Qualifications of reviewers:** • Licensed clinical or unlicensed supervised clinicians authorize coverage relative to InterQual criteria and ASAM. • All denials are reviewed by the Medical Director. • Investigational: Physician reviews/denies. • Denials receive review by second Psychiatrist during any appeal process initiated by member.	**Qualifications of reviewers:** • RNs authorize coverage and can deny some requests relative to InterQual criteria. • Investigational: Medical Director approves and denies.	**Qualifications of reviewers:** • Nurses may authorize and deny services.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
related experience. (i) **Qualifications of reviewers**: • KEPRO QMHPs must meet minimum qualifications (see below) and demonstrate the ability to conduct and review an assessment, including identifying precipitating events, gathering histories of mental and physical health, substance use, past mental health services and criminal justice contacts, assessing family, cultural, social and work relationships, and conducting/reviewing a mental status examination, complete a DSM diagnosis, write and supervise				

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
the implementation of a PCSP. • A QMHP must meet one of the following conditions: – Bachelor's degree in nursing and licensed by the State or Oregon; – Bachelor's degree in occupational therapy and licensed by the State of Oregon; – Graduate degree in psychology; – Graduate degree in social work; – Graduate degree in recreational, art, or music therapy; – Graduate degree in a behavioral science field; or – A qualified Mental Health Intern, as				

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Reconsideration/RR: • (c) N/A • (i) Within 10 days of a denial, the provider may send additional documentation to KEPRO for reconsideration. • (i) A provider may request review of a denial decision, which occurs in weekly MMC meetings or KEPRO's own comparable MMC meeting. **Consequences for failure to authorize**: • Failure to obtain authorization may result in non-payment. **Appeals**: Notice and fair hearing rights apply.	**Reconsideration/RR**: • N/A **Consequences for failure to authorize**: • Failure to obtain authorization may result in non-payment. **Appeals**: Notice and fair hearing rights apply.	**Reconsideration/RR:** • Providers may request a reconsideration of a denied service, whether or not a member appeals a denial. **Consequences for failure to authorize:** • PA & CR: Failure to obtain authorization results in non-coverage. **Appeals:** • Notice and fair hearing rights apply.	**Reconsideration/RR:** • Providers may request a reconsideration of a denied service, whether or not a member appeals a denial. **Consequences for failure to authorize:** • PA & CR: No payment to provider and/or facility for procedures performed outside of emergent situations **Appeals**: • Notice and fair hearing rights apply.	**Reconsideration/RR**: • A review of a denial decision can be requested and is reviewed in weekly MMC meetings. **Consequences for failure to authorize**: • Failure to obtain authorization may result in non-payment. **Appeals**: • Members may request a hearing on any denial decision.

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Frequency of review: • (c)PCSPs are reviewed and revised as needed, but at least every 12 months. • (i) KEPRO PCSPs are reviewed and revised as needed, but at least every 12 months. • A PA may be extended and/or adjusted when the initial number of units is exhausted and additional service is desired for up to a year per OAR 410-120-1320(7).	**Frequency of review:** • PCSPs are reviewed and revised as needed, but at least every 12 months.	**Frequency of review and method of payment:** • CR is conducted for ABA. The frequency is every 3-6 months. • Day treatment is reviewed every 30 days and OP detox if lasts longer than 6 days.	**Frequency of review and method of payment:** • PA is authorized based on the length of time/number of services for which treatment should be completed. • Minimal CR is conducted. • DME average is every 3 months.	**Frequency of review**: • PA is granted for different LOS depending on the service and can be adjusted. Auths for extensive services usually range from 6 months to 1 year. • PT, ST, OT is usually for one year (i.e., 30 visits) • PA renewals may be an extension of an older PA if within a year or a new PA. • Exceptions may be made at the discretion of the Medical Management Committee (MMC) which is led by the HSD medical director.

FFS/HCBS 1915(c)(i) MH/SUD	FFS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
RR conditions and timelines: • **KEPRO:** Within 10 days of a denial, the provider may send additional documentation to KEPRO for reconsideration.	**RR conditions and timelines:** • NA	**RR conditions and timelines:** • Allowed (e.g. member coverage could not have been known), and/or facility may submit Post Service Claim Review request.	**RR conditions and timelines** • Allowed (e.g. member coverage could not have been known), and/or facility may submit Post Service Claim Review request.	**RR conditions and timelines:** • RR available for retro eligibility circumstances.
Methods to promote consistent application of criteria: • DHS Quality Assurance Review teams review a representative sample of PCSPs as part of quality assurance and case review activities to assure that PCSPs meet program standards. • Additionally, OHA staff review a percentage of files to assure quality and compliance.	**Methods to promote consistent application of criteria:** • DHS Quality Assurance Review teams review a representative sample of PCSPs as part of quality assurance and case review activities to assure that PCSPs meet program standards. • Additionally, OHA staff review a percentage of files to assure quality and compliance.	**Methods to promote consistent application of criteria:** • Annual IRR testing	**Methods to promote consistent application of criteria:** • Annual IRR testing	**Methods to promote consistent application of criteria**: • Nurses are trained on the application of the HERC guidelines, which is spot-checked through ongoing supervision. Whenever possible, practice guidelines from clinical professional organizations such as the American Medical Association or the American Psychiatric Association, are used to establish PA

FFS/HCBS 1915(c)(i) MH/SUD	FFS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Methods to promote consistent application of criteria (KEPRO): • Clinical team meetings in which randomly monthly audited charts are reviewed/discussed by peers using KEPRO Compliance Department Approved audit tool. • Results of the audit are compared, shared and discussed by the team and submitted to Compliance Department monthly for review and documentation. Individual feedback is provided to each clinician during supervision on their PA as well as PCP reviews.				frequency for services in the FFS system.

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

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Data reviewed to determine UM application: • N/A **IRR standard:** • N/A	**Data reviewed to determine UM application**: • N/A **IRR standard:** • N/A	**Data reviewed to determine UM application:** • IRR measures, denial rates, appeal monitoring and rates, results of hearings to review denials later overturned by judge **IRR standard:** • IRR standard of 80%	**Data reviewed to determine UM application:** • IRR measures, denial rates, appeal monitoring and rates, results of hearings to review denials later overturned by judge **IRR standard:** • IRR standard of 80%	American Psychiatric Association, are used to establish PA frequency. **Data reviewed to determine UM application**: • A physician-led group of clinical professionals conducts an annual review to determine which services receive or retain a PA; items reviewed include: – Utilization – Approval/denial rates – Documentation/ justification of services – Cost data **IRR standard:** • N/A

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Results of criteria application (appeal overturn rates): • (c): 0 appeal overturns • (i) (KEPRO) 11% appeal overturn rate (1 out of 9 hearings)	**Results of criteria application (appeal overturn rates):** • (c) for I/DD: 0 appeal overturns • (c) for APD plus (k) and (j): 0.8% appeal overturn rate	**Results of criteria application (appeal overturn rates):** • 0	**Results of criteria application (appeal overturn rates):** • 42% OP and IP combined.	**Results of criteria application (appeal overturn rates):** • 0 appeal overturns

7. Compliance Determination for Benefit Packages CCO A and B

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

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

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

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

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

Non-HCBS CCO MH/SUD OP benefit reviews are conducted by qualified clinicians who evaluate clinical information that is submitted via fax[3] relative to InterQual, ASAM, HERC, or OARs. CCO MH/SUD requires submission of a form and a clinical summary with additional documentation such as documentation tied to practice guidelines or an updated treatment plans and progress and clinical notes. CCO M/S documentation requirements are non-specific (i.e., a form and information supporting medical necessity) and submitted via web portal. Timelines for authorization decisions are the same for MH/SUD and M/S and defined in OARs. Failure to obtain authorization may result in non-payment for MH/SUD and M/S services; although an exception process allows RR for CCO benefits and standard appeal processes apply. There are no differences in processes for children and adults that are not tied to practice guidelines. 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.

In general, non-HCBS CCO MH/SUD service authorizations are tied to the service type and individualized. For example, ABA authorization covers 3-6 months of services. Similarly, M/S authorizes DME for an average of 3 months. Service authorization lengths are based on ASAM and InterQual. The CCO allows MH/SUD and M/S facilities to submit requests for post service claim reviews. The CCO MH/SUD and M/S criteria 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. MH/SUD and M/S report appeal overturn rates of 0 and 42% respectively. UM strategy and evidence are no more stringently applied to MH/SUD than to M/S OP benefits in operation or in writing.

[3] The CCO is working on developing a web portal for MH/SUD documentation submission.

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

8. Compliance Determination for Benefit Packages CCO E and G

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

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

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

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

Non-HCBS CCO MH/SUD benefit reviews are conducted by qualified clinicians who evaluate clinical information that is submitted via fax relative to InterQual, ASAM, HERC, and OARs. CCO MH/SUD requires submission of a form and a clinical summary with additional documentation such as documentation tied to practice guidelines or an updated treatment plans and progress and clinical notes. FFS M/S

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

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

I In general, non-HCBS CCO MH/SUD service authorizations are tied to the service type and individualized. For example, ABA authorization covers 3-6 months of services. Service authorization lengths are based on HERC, ASAM and InterQual guidelines. FFS M/S authorization lengths range from 6 months to one year. These lengths are tied to HERC. The CCO allows MH/SUD facilities to submit requests for post service claim reviews CCO MH/SUD MNC application is evaluated using IRR testing to a standard of 80%. FFS M/S application is spot-checked through supervision and chart review. The CCO and State review utilization and other data to determine if UM requires adjustment. MH/SUD and M/S reported appeal overturn rates of 0. UM strategy and evidence are no more stringently applied to MH/SUD than to M/S OP benefits in operation or in writing.

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

PRIOR AUTHORIZATION FOR PRESCRIPTION DRUGS

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

1. To which benefits is the NQTL assigned?

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

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• Prior authorization is applied to prescription drugs to promote appropriate and safe treatment of funded conditions and to encourage use of preferred agents. • Prior authorization is applied to prescription drugs due to cost trends far outpacing revenue and/or other medical cost trends.	• To promote appropriate and safe treatment of funded conditions.	• Prior authorization is applied to prescription drugs to promote appropriate and safe treatment of funded conditions and to encourage use of preferred agents. • Prior authorization is applied to prescription drugs due to cost trends far outpacing revenue and/or other medical cost trends.

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• Evidence for applying PA criteria to a drug includes: – FDA prescribing guidelines – Medical literature – Best practices – Professional guidelines	• FDA prescribing guidelines, medical evidence, best practices, professional guidelines, and P&T Committee review and recommendations. • Federal and state regulations/OAR and the Prioritized List.	• Evidence for applying PA criteria to a drug includes: – FDA prescribing guidelines – Medical literature – Best practices – Professional guidelines

CCO MH/SUD	FFS MH Carve Out	CCO M/S
– CMS accepted compendia (Micromedex)		– CMS accepted compendia (Micromedex)

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
• PA requests can be mailed or faxed (more typical) to the Pharmacy Call Center. The standard PA form is one page long. Most PA criteria require chart notes. • All PA requests are responded to within 24 hours. • The PA criteria are developed by pharmacists in consultation with the P&T Committee. • Failure to obtain PA in combination with an absence of medical necessity results in a rejected claim/no payment.	• PA requests are typically faxed to the Pharmacy Call Center, but requests can also be submitted through the online portal, by phone, or by mail. • The standard PA form is one page long, except for nutritional supplement requests. Most PA criteria require clinical documentation such as chart notes. • All PA requests are responded to within 24 hours. • The PA criteria are developed by pharmacists in consultation with the P&T Committee. • Failure to obtain PA in combination with an absence of medical necessity results in no provider reimbursement.	• PA requests can be mailed or faxed (more typical) to the Pharmacy Call Center. The standard PA form is one page long. Most PA criteria require chart notes. • All PA requests are responded to within 24 hours. • The PA criteria are developed by pharmacists in consultation with the P&T Committee. • Failure to obtain PA in combination with an absence of medical necessity results in a rejected claim/no payment.

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

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• Approximately 48% of MH/SUD drugs are subject to PA criteria for clinical reasons. • Providers can appeal denials on behalf of a member, and members have appeal and fair hearing rights. • The appeal overturn rate for CY 2017 was 24%. • The CCO assesses stringency through review of PA denial/approval and appeal rates.	• Approximately 17% of MH drugs are subject to PA criteria for clinical reasons. • The State allows providers to submit additional information for reconsideration of a denial. • Providers can appeal denials on behalf of a member, and members have fair hearing rights. • The appeal overturn rates for MH carve out drugs was 8:2 (25%). • The State assesses stringency through review of PA denial/approval and appeal rates; number of drugs requiring PA; number of PA requests; and pharmacy utilization data/reports. • PA criteria are reviewed as needed due to clinical developments, literature, studies, and FDA medication approvals.	• Approximately 28% of M/S drugs are subject to PA criteria for clinical reasons. • Providers can appeal denials on behalf of a member, and members have appeal and fair hearing rights. • The appeal overturn rate for CY 2017 was 25%. • The CCO assesses stringency through review of PA denial/approval and appeal rates.

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• Evidence for applying PA criteria to a drug includes: – FDA prescribing guidelines – Medical literature – Best practices – Professional guidelines	• FDA prescribing guidelines, medical evidence, best practices, professional guidelines, and P&T Committee review and recommendations. • Federal and state regulations/OAR and the Prioritized List.	• Evidence for applying PA criteria to a drug includes: – FDA prescribing guidelines – Medical literature – Best practices – Professional guidelines

– CMS accepted compendia (Micromedex)		– CMS accepted compendia (Micromedex)

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 CCO also applies PA for MH/SUD or M/S drugs due to drug cost trends far outpacing revenue and/or other medical cost trends. The State applies PA to certain MH FFS carve out drugs to promote appropriate 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 may also be submitted by mail (with additional modes available for MH FFS 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 and appeal 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, B, E, and G for Adults and Children
Classification: Inpatient and Outpatient
CCO: JCC

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

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• CCO closes its network to additional MH/SUD providers when it determines there is no need for additional providers, based on need for additional providers, market forces, available alternatives, and network adequacy • When CCO closes its network to new providers, it is done to enhance efficiency, promote efficient provider monitoring, and improve provider relations.	• N/A	• CCO closes its network to additional M/S providers when it determines there is no need for additional providers. • When CCO closes its network to new providers, it is done to enhance efficiency, promote efficient provider monitoring, and improve provider relations.	• N/A

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

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Providers denied admission into the network due to network closure may not be able to participate as an in-	• N/A	• Providers denied admission into the network due to network closure may not be able to participate as an in-	• N/A

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
network provider and receive in-network rates. • Provider requests for network inclusion are reviewed for need based on the network adequacy of the current provider network. When the CCO determines that particular provider types are not needed, requests to join the network are declined. All requests are reviewed by the BH QM Committee, which generally only approves those with specialty qualifications. • CCO monitors time and distance standards to access services and member complaints/grievances to inform decisions about network adequacy. • CCO Behavioral Health Quality Committee is responsible for the decision-making process to close the network. • CCO considers particular service/provider types, geographic-specific needs, provider to enrollee ratios,		network provider and receive in-network rates. • Provider Relations tracks open and closed specialties using a spreadsheet to track whether network adequacy requirements for specific specialties are met. When certain specialties or provider types are closed, requests to join the CCO's network are declined. The spreadsheet is maintained and updated periodically, and available to all PR staff who might field requests for inclusion in the panel. • CCO evaluates need for providers to support decisions to close the network. Provider need is determined by evaluating network adequacy using CMS time and distance standards and evaluating access through review of member complaints and PCP capacity reporting. • Providers that are denied the opportunity to participate in	

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
provider specialties or special expertise in making the determination to close the network. • Providers that are denied the opportunity to participate in CCO's network may not challenge CCO's decision. • Exceptions are made for providers who demonstrate specialized services that fill a need. • Additionally, the CCO covers services provided to members from out of network providers, reimbursing the out of network provider at the Medicaid rate, which is lower than the contracted rate.		CCO's network may not challenge CCO's decision. • Exceptions might occur when an OP provider in a specialty not otherwise needed joins the large IPA in the region. • Additionally, the CCO covers services provided to members from out of network providers to ensure access to needed services, reimbursing the out of network provider at the Medicaid rate, which is lower than the contracted rate.	

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• 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 this NQTL. • It is unknown exactly how many providers were impacted by CCO's decision to close all or part of its network to new providers in the last contract year as no requests were received formally.	• N/A	• 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 this NQTL. • Twelve providers were impacted (no contract offered) by CCO's decision to close all or part of its network to new providers in the last contract year.	• N/A

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• The CCO reviews the following data/information to determine how strictly to apply the criteria/considerations to close the CCO network to new providers: – Capacity reports – Access complaints – Time to appointments	• N/A	• The CCO reviews the following data/information to determine how strictly to apply the criteria/considerations to close the CCO network to new providers: – Capacity reports – Access complaints – Time to appointments	• N/A

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
– Inpatient rates – Complaints and grievances – Other data that indicate a need • Volume of SCA requests from a single provider		– Inpatient rates – Complaints and grievances – Other data that indicate a need • Multiple SCA requests from a single provider	

7. Compliance Determination for Benefit Packages CCO A and B

Comparability of Strategy and Evidence: The CCO may close its network to inpatient providers of M/S services, but does not close its network to inpatient providers of MH/SUD services. The CCO may close its network to outpatient providers of M/S and MH/SUD services when the CCO determines there is no need for additional providers based upon network adequacy and provider sufficiency. When the CCO closes its network to either MH/SUD or M/S providers, it is done to enhance efficiency, promote efficient provider monitoring and improve 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 does not apply a limitation for inpatient MH/SUD providers and accordingly does not require further analysis. The CCO's strategy and evidence for closing the network to outpatient providers when the CCO determines that it has met network adequacy and sufficiency standards are comparable for providers of outpatient MH/SUD and M/S services.

Comparability and Stringency of Processes: All requests for network admission of providers of MH/SUD and M/S services are reviewed for need based on the network adequacy of the current provider network. When the CCO determines that particular provider types are not needed, requests to join the network are declined. For both MH/SUD and M/S providers, the CCO has processes in place to track and determine network needs (e.g., specialties, service gaps), and particular provider types that are not needed. Monitoring for both MH/SUD and M/S includes reviewing time and distance standards, and evaluating access to care through complaint and grievance data. The CCO, for both MH/SUD and M/S providers, considers particular services/types and specialties when making the determination to close the network to new providers. Providers that are denied into the network due to network closure may not participate as an in-network provider or receive in-network rates. A provider who is denied admission into

the CCO's network because of network closure cannot challenge the determination. Exceptions are made for providers who demonstrate a unique or specialized service that fills a particular need. Based upon these findings, the CCO's network closure processes for providers of MH/SUD services are comparable and applied no more stringently than to providers of M/S services.

Stringency of Strategy and Evidence: When the CCO decides to close the network to particular specialties/provider types, all new providers applying for those particular specialties/provider types are subject to the NQTL. This is applied both to providers of MH/SUD and M/S services in a comparable way. In operation, for MH/SUD providers, the CCO reported that no requests were formally received to apply for admission to provider types that were closed. In contrast, the CCO denied 12 M/S providers on the basis that the network was closed to those provider types. The CCO monitors similar metrics related to decisions to close the network across MH/SUD and M/S, reviewing information such as capacity reports, access complaints, appointment timeliness, inpatient rates, complaints and grievance and volume of SCAs from a single provider. As a result, the strategies and evidentiary standards for network closure are no more stringently applied to MH/SUD providers than to M/S providers.

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

8. Compliance Determination for Benefit Packages CCO E and G

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

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

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

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

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

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
1. Ensure members receive safe, medically necessary care		1. Ensure members receive safe, medically necessary care	

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

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• All network providers must meet credentialing and re-credentialing requirements. • Credentialing is performed according to NCQA standards, using the uniform Oregon Practitioner Credentialing and Re-credentialing Application, all	• 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.	• All network providers must meet credentialing and re-credentialing requirements. • Credentialing is performed according to NCQA standards, using the uniform Oregon Practitioner Credentialing and Re-credentialing Application, all	• 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.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
supporting documents, an Admission plan, and an S&R policy and whether or not they perform deliveries. • Providers may submit supporting documentation by email, mail, fax, courier and hand delivery. • CCO's credentialing process involves staff review, Medical Director review and the Credentialing Committee. • CCO's credentialing process averages approximately 30 days. • CCO's Credentialing Committee is responsible for reviewing required information and the Network and Quality Committee of the Board of Directors is responsible for making ultimate provider credentialing decisions. • CCO performs re-credentialing every three years at minimum. • Providers who do not meet credentialing/re-credentialing requirements cannot contract	• Providers must complete forms and documentation required for their provider type. This includes information demonstrating the provider meets provider enrollment requirements such as NPI, tax ID, disclosures, and licensure/certification. • The provider enrollment forms vary from 1 to 19 pages, depending on the provider type. Supporting documentation includes the provider's IRS letter, licensure, SSN number, and/or Medicare enrollment as applicable to the provider type. • The enrollment forms and documentation can be faxed in or completed and submitted electronically to the State's provider enrollment unit. • The State's provider enrollment process includes checking the forms for completeness, running the provider name against	supporting documents, an Admission plan, and an S&R policy and whether or not they perform deliveries. • Providers may submit supporting documentation by email, mail, fax, courier and hand delivery. • CCO's credentialing process involves staff review, Medical Director review and the Credentialing Committee. • CCO's credentialing process averages approximately 30 days. • CCO's Credentialing Committee is responsible for reviewing required information and Network and Quality Committee of the Board of Directors is responsible for making ultimate provider credentialing decisions. • CCO performs re-credentialing every three years at minimum. • Providers who do not meet credentialing/re-credentialing requirements cannot contract	• Providers must complete forms and documentation required for their provider type. This includes information demonstrating the provider meets provider enrollment requirements, such as NPI, tax ID, disclosures, and licensure/certification. • The provider enrollment forms vary from 1 to 19 pages, depending on the provider type. Supporting documentation includes the provider's IRS letter, licensure, SSN number, and/or Medicare enrollment as applicable to the provider type. • The enrollment forms and documentation can be faxed in or completed and submitted electronically to the State's provider enrollment unit. • The State's provider enrollment process includes checking the forms for completeness, running the

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
with the CCO, cannot participate in network and do not receive the CCO's contracted rate, which is typically more than what is paid to an OON provider (DMAP fee schedule). • Providers who are adversely affected by credentialing or re-credentialing decisions may challenge the decision through the Fair Hearing process.	exclusion databases, and verifying any licenses, certifications or equivalents. • The State's enrollment process averages 7 to 14 days. • State staff in the provider enrollment unit are responsible for reviewing information and making provider enrollment decisions. • The State reviews all provider enrollment every three years, as required by Federal regulations. • Providers who are not enrolled/re-enrolled are not eligible for Medicaid reimbursement. • Providers who are denied enrollment or re-enrollment may appeal the decision to the State.	with the CCO, cannot participate in network and do not receive the CCO's contracted rate, which is typically more than what is paid to an OON provider (DMAP fee schedule). • Providers who are adversely affected by credentialing or re-credentialing decisions may challenge the decision through the Fair Hearing process.	provider name against exclusion databases, and verifying any licenses, certifications or equivalents. • The State's enrollment process averages 7 to 14 days. • State staff in the provider enrollment unit are responsible for reviewing information and making provider enrollment decisions. • The State reviews all provider enrollment every three years, as required by Federal regulations. • Providers who are not enrolled/re-enrolled are not eligible for Medicaid reimbursement. • Providers who are denied enrollment or re-enrollment may appeal the decision to the State.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• All providers/provider types must be credentialed to participate in the CCO's network. • Providers who are not credentialed may be OON providers; they can deliver services and be paid DMAP rates. • No providers were denied admission or terminated from the network in the last contract year as a result of credentialing or re-credentialing.	• All providers/provider types are subject to enrollment/re-enrollment requirements. • There are no exceptions to meeting provider enrollment/re-enrollment requirements. • Less than 1% of providers were denied admission, and .005% of providers were terminated last CY for failure to meet enrollment/re-enrollment requirements.	• All providers/provider types must be credentialed to participate in the CCO's network. • Providers who are not credentialed may deliver services and be paid DMAP rates • Far less than 1% of providers were denied admission or terminated from the network in the last contract year as a result of credentialing or re-credentialing.	• All providers/provider types are subject to enrollment/re-enrollment requirements. • There are no exceptions to meeting provider enrollment/re-enrollment requirements. • Less than 1% of providers were denied admission, and .005% of providers were terminated last CY for failure to meet enrollment/re-enrollment requirements.

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
– CCO contract requirements – Monitoring of provider performance based on grievance rates – National accreditation standards (NCQA) • CCO monitors the following data/information to determine how strictly to apply credentialing/re-credentialing criteria: – Network adequacy data, such as access to care and provider specialties. – Grievances.		– CCO contract requirements – Monitoring of provider performance based on grievance rates – National accreditation standards (NCQA) • CCO monitors the following data/information to determine how strictly to apply credentialing/re-credentialing criteria: – Network adequacy data, such as access to care and provider specialties. – Grievances.	

7. Compliance Determination for Benefit Packages CCO A and B

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

Comparability and Stringency of Processes: All providers of MH/SUD and M/S services must successfully meet credentialing and re-credentialing requirements in order to be admitted to and continue to participate in the CCO's network. The information and documentation new providers are required to complete and submit as part of the credentialing process is substantially the same, including the uniform Oregon Practitioner Credentialing and Re-credentialing Application, an Admission plan, and a seclusion and restraint policy. Both MH/SUD and M/S

providers are given several methods of submitting their application and supporting documentation, including by fax, by mail, electronically, and hand courier. The CCO's credentialing process involves review by staff, the Medical Director and the Credentialing Committee.

The credentialing process for both MH/SUD and M/S providers averages 30 days. The CCO's Credentialing Committee is responsible for reviewing required information and Network and Quality Committee of the Board of Directors is responsible for making ultimate provider credentialing decisions. Re-credentialing for both MH/SUD and M/S providers is conducted every three years at a minimum. Failure for MH/SUD and M/S providers to meet credentialing and re-credentialing requirements results in exclusion from the CCO's network and from receiving the CCO's contracted rate. MH/SUD and M/S providers who are adversely affected by credentialing or re-credentialing decisions may challenge the decision through the Fair Hearing process.

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

Stringency of Strategy and Evidence: All MH/SUD and M/S providers are subject to meeting credentialing and re-credentialing requirements. Providers who do not meet credentialing and re-credentialing requirements cannot participate in the network. 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 providers and less than 1% of M/S providers denied admission into the network or terminated.

The CCO monitors similar circumstances related to applying credentialing and re-credentialing requirements for MH/SUD and M/S providers, including reviewing network adequacy data, such as access to care and provider specialties, and grievances. As a result, the strategies and evidentiary standards for credentialing and re-credentialing are no more stringently applied to MH/SUD providers than to M/S providers.

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

8. Compliance Determination for Benefit Packages CCO E and G

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

PROVIDER ADMISSION — PROVIDER EXCLUSIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Compliance Determination for Benefit Packages CCO A and B

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

8. Compliance Determination for Benefit Packages CCO E and G

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

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

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

1. To which benefits is the NQTL assigned?

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

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

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

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

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

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• CCO has an open 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. • For most services, OOS providers are not covered	• Non-emergency OOS services are not covered unless the service meets the OAR criteria. • The OAR criteria for OOS coverage of non-emergency services include the service is not available in the State of Oregon or the client is OOS and requires covered services. • Requests for non-emergency OOS services are made	• CCO 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.	• Non-emergency OOS services are not covered unless the service meets the OAR criteria. • The OAR criteria for OOS coverage of non-emergency services include the service is not available in the State of Oregon or the client is OOS and requires covered services. • Requests for non-emergency OOS services are made

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
unless they are contracted as part of a contiguous network area close to service area borders. • Non-emergency OOS services by non-contract providers are not covered unless medically necessary services are not available in-State. • Requests for non-emergency OOS services are made through the prior authorization process. • The timeframe for approving or denying a non-emergency OOS request is the same as for other prior authorizations (14 days for standard requests). • The CCO establishes a single case agreement (SCA) with an OON/OOS provider if the provider will not accept DMAP rates. • The CCO's process for establishing a SCA includes contacting the OON/OOS provider to collect information	through the State prior authorization process. • The timeframe for approving or denying a non-emergency OOS request is the same as for other prior authorizations (14 days for standard and 72 hours for urgent). • OOS providers must enroll with Oregon Medicaid. • The State pays OOS providers the Medicaid FFS rate.	• For most services, OOS providers are not covered unless they are contracted as part of a contiguous network area close to service area borders. • Non-emergency OOS services by non-contract providers (OOS) are not covered unless medically necessary services are not available in-State. • Requests for non-emergency OOS services are made through the prior authorization process. • The timeframe for approving or denying a non-emergency OOS request is the same as for other prior authorizations (14 days for standard requests). • The CCO establishes a single case agreement (SCA) with an OON/OOS provider if the provider will not accept DMAP rates. • The CCO's process for establishing a SCA includes contacting the OON/OOS	through the State prior authorization process. • The timeframe for approving or denying a non-emergency OOS request is the same as for other prior authorizations (14 days for standard and 72 hours for urgent). • OOS providers must enroll with Oregon Medicaid. • The State pays OOS providers the Medicaid FFS rate.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
and negotiating the terms of the SCA. • The average length of time to negotiate a SCA is 2 to 3 days. • Only providers enrolled in Oregon Medicaid can qualify as an OON/OOS provider. • The rate the CCO pays OON/OOS providers includes the Medicaid FFS rate, a percentage of the Medicaid FFS rate, and a negotiated rate.		provider to collect information and negotiating the terms of the SCA. • The average length of time to negotiate a SCA is 2 to 3 days. • Only providers enrolled in Oregon Medicaid can qualify as an OON/OOS provider. • The rate the CCO pays OON/OOS providers includes the Medicaid FFS rate, a percentage of the Medicaid FFS rate, and a negotiated rate.	

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
request or non-payment of an OON/OOS claim. • In CY 2017 the CCO received 2 to 3 non-emergency OON/OOS requests; none of which was denied (0% appeal overturn rate). • The CCO evaluates the number of SCAs on an ad hoc basis to determine whether the network should be expanded or a particular OON/OOS provider should be recruited to be a network provider.	• Members/providers may appeal the denial of an OOS request. • The State measures the stringency of the application of OOS requirements by reviewing OOS denial/appeal rates.	request or non-payment of an OON/OOS claim. • The CCO was unable to determine the number of OON/OOS requests that were received, denied, appealed, or overturned on appeal for CY 2017. • The CCO evaluates the number of SCAs on an ad hoc basis to determine whether the network should be expanded or a particular OON/OOS provider should be recruited to be a network provider.	• Members/providers may appeal the denial of an OOS request. • The State measures the stringency of the application of OOS requirements by reviewing OOS denial/appeal rates.

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

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

7. Compliance Determination for Benefit Packages CCO A and B

Comparability of Strategy and Evidence: The CCO 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. For both non-emergency MH/SUD and M/S OOS benefits, the CCO (and the

State for FFS MH/SUD OOS benefits) requires prior authorization to determine medical necessity and to ensure no in-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 MH/SUD and 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 the average length of time to negotiate a SCA is two to three days. The rate the CCO pays MH/SUD and M/S includes the Medicaid FFS rate, a percentage of the Medicaid FFS rate, and a negotiated rate. Based on this, the processes for MH/SUD and M/S non-emergency OON/OOS benefits are comparable and applied no more stringently to MH/SUD non-emergency OON/OOS benefits.

Stringency of Strategy and Evidence: For both MH/SUD and M/S, if a request for a non-emergency 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 request for payment of a non-emergency MH/SUD or M/S OON/OOS benefit does not meet the CCO's criteria, which are based on OAR and the CCO contract, payment for the service will be denied by the CCO. For both MH/SUD and M/S, members and providers may appeal the denial of 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 in CY 2017 it received 2 to 3 non-emergency OON/OOS requests for MH/SUD benefits and approved all requests. The CCO was unable to provide similar information for M/S OON/OOS requests. The strategies and evidentiary standards for OON/OOS are no more stringently applied to MH/SUD benefits than to M/S benefits.

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

8. Compliance Determination for Benefit Packages CCO E and G

Comparability of Strategy and Evidence: The State provides OOS coverage to provide needed MH/SUD and M/S benefits when they are not available in-State. Similarly, the CCO provides OOS coverage to provide needed MH/SUD benefits when they are not available in-State. For both non-emergency MH/SUD and M/S OOS benefits, the State (and the CCO for MH/SUD OOS benefits) requires prior authorization to determine medical necessity and to ensure no in-State providers are available to provide the benefit. The State's OOS coverage requirements are based on OAR. The CCO's OON/OOS coverage requirements are based on OAR and the CCO contract. As a result, the strategy and evidence for OON/OOS coverage of non-emergency inpatient and outpatient benefits are comparable for MH/SUD and M/S benefits.

Comparability and Stringency of Processes: Requests for non-emergency OOS FFS MH/SUD and M/S benefits are made through the State's prior authorization process and are reviewed for medical necessity and in-State coverage. The prior authorization timeframes (14 days for standard requests and 72 hours for urgent requests) apply. Similarly, the CCO reviews requests for non-emergency OOS MH/SUD services through its prior authorization process, and the prior authorization timeframes (14 days for standard requests and 72 hours for urgent requests) apply. OOS FFS MH/SUD and M/S providers are reimbursed the Medicaid FFS rate. If the OOS provider is not enrolled in Oregon Medicaid, the provider must enroll in Oregon Medicaid. The CCO also requires OON/OOS MH/SUD providers to be enrolled with Oregon Medicaid. If the OON/OOS MH/SUD provider does not agree to the DMAP rate, then the CCO will establish a single case agreement (SCA). While requiring a SCA is an additional step for CCO MH/SUD providers, it is the provider's choice to not accept the DMAP rate, and this option is not available to M/S providers in FFS. The CCO pays OON/OOS MH/SUD providers the Medicaid FFS rate, a percentage of the Medicaid FFS rate, or a negotiated rate. Based on this, the processes for MH/SUD non-emergency OON/OOS services are comparable and applied no more stringently to non-emergency MH/SUD OON/OOS benefits than to M/S benefits.

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