HEALTH WEALTH CAREER

UMPQUA HEALTH ALLIANCE (UMPQUA)

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

INPATIENT UTILIZATION MANAGEMENT

NQTL: Utilization Management (PA, CR, RR)
Benefit Package: A and B for Adults and Children
Classification: Inpatient (IP)
CCO: Umpqua

Benefit package A and B: MH/SUD benefits in columns 1 (CCO MH/SUD) and 2 (FFS MH/SUD) compared using strategies1- 3 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 managed by the CCO.

1. To which benefits is the NQTL assigned?

CCO MH/SUD	FFS MH/SUD	CCO M/S[1]
• (1, 2, 3) PA and CR are required for planned non-emergency admissions to acute IP (in and out-of-network (OON)), PRTS, subacute. • (1, 2, 3) Emergency admissions require notification within 48 hours of admission and subsequent CR. • (1, 2, 3) Extra-contractual and experimental/investigational/ unproven benefit requests (i.e., exceptions) are submitted through a PA-like process.	• (1, 3) PA (only) for MH/SUD procedures performed in a medical facility (e.g., gender reassignment surgery authorizations for benefit packages E and G), experimental/investigational, and extra-contractual benefits are conducted by OHA consistent with the information in column 4 for benefit packages E and G. • (1-4) A level-of-care review is required for SCIP, SAIP and subacute care that is conducted by an OHA designee. (CCO notification is required for emergency admissions to subacute.) • (1-4) PA for SCIP, SAIP and subacute admission is obtained through a peer-to-	• (1, 2, 3) PA and CR are required for planned non-emergency admissions to acute IP (in and out-of-network (OON)). • (1, 2, 3) Emergency admissions require notification within 48 hours of admission and subsequent CR. • (1, 2, 3) Skilled nursing facility benefits (first 20 days) require PA. • (1, 2, 3) Extra-contractual and experimental/investigational/ unproven benefit requests (i.e., exceptions) are submitted through a PA-like process.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S[1]
	peer review between an HIA psychiatrist and the referring psychiatrist. • (1-4) CR and RR for SCIP and SAIP are performed by HIA. • (1-3) CR and RR for subacute care are conducted by the CCO. (See column 1.) • (1-4) 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.) • (1-4) PA and CR for AFH, SRTF, SRTH, YAP, RTF, and RTH are performed by KEPRO.	

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
• (1) To ensure coverage, medical necessity and prevent unnecessary overutilization (e.g., in violation of relevant OARs and associated Health Evidence Review Commission (HERC) guidelines[2]). • (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. • (3) To comply with federal and State requirements.	• (1) UM is assigned to ensure medical necessity of services/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).	• (1) To ensure coverage, medical necessity and prevent unnecessary overutilization (e.g., in violation of relevant OARs and associated Health Evidence Review Commission (HERC) guidelines). • (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. • (3) To comply with federal and State requirements.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
	• (3) To comply with federal and State requirements. • (4) Most MH residential services were excluded from the capitated arrangements with the CCOs due to the high cost and unpredictability of services and associated risk.	

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
• (1 and 2) ASAM, HERC PL and guidelines[3]. • (1) UM and claims reports are reviewed for trends in overutilization on a quarterly basis relative to own data and MCG benchmarks. Data are reviewed for outliers (UM) and disease states that might require intervention (CM). Forwarded to quality committee or a benefit workgroup to review requirements. May also be forwarded to network if needed. • (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.,	• (1, 2, 3) HERC PL and guidelines. (HERC provides outcome evidence and clinical indications for certain diagnoses that may be translated into UM requirements.) • (1) Medical literature demonstrates high cost of unnecessary medical care (i.e., 30% of medical costs). (Institute of Medicine Report, (2012). Also see Fisher, Elliott S., MD, MPH, Wennberg, David E., MD, MPH, Stukel, Therese A., PhD et al., The Implications of Regional Variations in Medicare Spending: Part 2. Health Outcomes and Satisfaction with Care, Center for the Evaluative Clinical Sciences, Dartmouth Medical School, VA Outcomes Group, White River Junction VT, Center for Outcomes Research and Evaluation, Maine Medical Center, &	• (1 and 2) HERC PL and guidelines. • (1) IP is high cost service. Inpatient utilization and over and underutilization reports are reviewed at UM committee. • (1) Medical literature demonstrates high cost of unnecessary medical care (i.e. 30% of medical costs). (Institute of Medicine Report, (2012). Also see Fisher, Elliott S., MD, MPH, Wennberg, David E., MD, MPH, Stukel, Therese A., PhD et al., The Implications of Regional Variations in Medicare Spending: Part 2. Health Outcomes and Satisfaction with Care, Center for the Evaluative Clinical Sciences, Dartmouth Medical School, VA Outcomes Group, White River Junction VT, Center for Outcomes Research and

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
MD, MPH, Stukel, Therese A., PhD et al., The Implications of Regional Variations in Medicare Spending: Part 2. Health Outcomes and Satisfaction with Care, Center for the Evaluative Clinical Sciences, Dartmouth Medical School, VA Outcomes Group, White River Junction VT, Center for Outcomes Research and Evaluation, Maine Medical Center, & Institute for the Evaluative Clinical Sciences, Toronto, Canada, Financial support was provided by grants from the Robert, Wood Johnson Foundation, the National Institutes of Health (Grant Number CA52192) and the National Institute of Aging (Grant Number 1PO1AG19783-01), 2002, pp 1-32. • (2) Oregon Performance Plan (OPP) requires that BH services be provided in least restrictive setting possible. The OPP is a DOJ-negotiated Olmsted settlement. Also see Roberts, E., Cumming, J & Nelson, K., A Review of Economic Evaluations of Community Mental Health Care, Sage Journals, Oct. 1, 2005, 1-13. Accessed May 25, 2018. http://journals.sagepub.com/doi/10.1177/1077558705279307	Institute for the Evaluative Clinical Sciences, Toronto, Canada, Financial support was provided by grants from the Robert, Wood Johnson Foundation, the National Institutes of Health (Grant Number CA52192) and the National Institute of Aging (Grant Number 1PO1AG19783-01), 2002, pp 1-32. • (2) The Oregon Performance Plan (OPP) requires that BH services be provided in the least restrictive setting possible. The OPP is a DOJ-negotiated Olmsted settlement.	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. • (1 and 2) MCG and InterQual • (2) Benefit has multiple interventions of varying costs that may be successful.

CCO MH/SUD	FFS MH/SUD	CCO M/S
• (2) Inherent restrictiveness of residential settings and dangers associated with seclusion and restraint. Also see Cusack, K.J., Frueh, C., Hiers, T., et. al., *Trauma within the Psychiatric Setting: A Preliminary Empirical Report,* Human Services Press, Inc., 2003. 453-460. • (3) Applicable State and federal requirements.	• (3) PRTS CONS: OAR 410-172-0690 and 42 CFR 441.156. • (3) OARs and other applicable federal and State requirements. • (4) Cost and utilization reports	• (3) Applicable State and federal 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
Timelines for authorizations: • PA form should be submitted prior to service delivery for elective admissions and provider should wait for authorization before delivering the service. • Notification of emergency admissions is required 48 hours from admission date (or as soon as possible following admission). • CR is conducted telephonically by an RN or LPC with collaborating documentation as needed. Authorization is made within 2 business days once supporting documentation has been received. • For youth residential, most referrals originate with CCO and require a Certificate of Need (CON) be completed	**Timelines for gender reassignment surgery authorizations (for benefit packages E and G):** **(OHA)** • Standard requests are to be processed within 14 days. **Timelines for child residential authorizations**: **(OHA)** • OHA provides the initial authorization (level-of-care review) within 3 days of requests for SCIP, SAIP or subacute. **(HIA)** • Authorization requests for PRTS are submitted prior to admission or within 14 days of an emergency admission. An	**Timelines for authorizations:** • PA form should be submitted prior to service delivery for elective admissions and provider should wait for authorization before delivering the service. • Notification of emergency admissions is required 48 hours from admission date (or as soon as possible following admission). • CR documentation can be completed by fax, telephone or online, RN or LP makes an authorization decision usually within 2 business day when clinical information is provided.

CCO MH/SUD	FFS MH/SUD	CCO M/S
by HealthInsight (usually takes 1 week to complete). (See column 2.) **Documentation requirements:** • A form is 1 page, which can be faxed or submitted online. Diagnosis, CPT code and MNC rationale are required.	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. **Documentation requirements (OHA):** • PA documentation requirements for non-residential MH/SUD benefits in benefit packages E and G include a form that consists of a cover page. Diagnostic and CPT code information and a rationale for medical necessity must be provided, plus any additional supporting documentation. • The documentation requirement for level-of-care assessment for SCIP, SAIP and subacute is a psychiatric evaluation. Other information may be reviewed when available. **Documentation requirements for PRTS CONS and CR for SCIP and SAIP (HIA)**: • PRTS CONS requires documentation that supports the justification for child residential services including:	**Documentation requirements:** • A form is 1 page, which can be faxed or submitted online. Diagnosis, CPT code and MNC rationale are required.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
Method of document submission: • Fax or online.	**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. • 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.	**Method of document submission:** • Fax or online.

CCO MH/SUD	FFS MH/SUD	CCO M/S
Qualifications of reviewers: • CR is conducted by an RN or LPC. • Denials are reviewed by a board certified psychiatrist or the Medical Director.	**Qualifications of reviewers (OHA)**: • OHA M/S staff conduct PA and CR (if applicable) for gender reassignment surgery (for benefit packages E and G). (See processes, strategies and evidentiary standards in column 4.) • The OHA designee is a licensed, masters'-prepared therapist that reviews psychiatric evaluations to approve or deny the level-of-care requested. Psychiatric consultation is available if needed. **Qualifications of reviewers (HIA)**: • Two LCSWs with QMHP designation make residential authorization decisions. • Two psychiatrists make CONS determinations. **Qualifications of reviewers (KEPRO)**: • KEPRO QMHPs must meet minimum qualifications (see below) and demonstrate the 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	**Qualifications of reviewers:** • RN or LP makes a CR authorization decision. • Denials are reviewed by a Medical Director.

CCO MH/SUD	FFS MH/SUD	CCO M/S
Criteria: • Authorization decisions are based on guidelines such as ASAM, HERC and OAR guidelines. The CCO is evaluating the purchase of MCG or InterQual for implementation by end of year.	DSM diagnosis, and write and supervise the implementation of a PCSP. • A QMHP must meet one of the follow conditions: – Bachelor's degree in nursing and licensed by the State or Oregon; – Bachelor's degree in occupational therapy and licensed by the State of Oregon; – Graduate degree in psychology; – Graduate degree in social work; – 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 Statute, OAR, federal regulations, and evidence-based guidelines from private and professional associations.	**Criteria:** • Authorization decisions are based on guidelines such as MCG, InterQual, UpToDate, HERC PL, HERC guidelines, and OAR.

CCO MH/SUD	FFS MH/SUD	CCO M/S
	• 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.	
Reconsideration/RR: • UR staff can waive PA requirements for residential, but this is very rare due to CCO initiating most referrals. • Medical Director can make exceptions to the process including determining if RR will be considered.	**Reconsideration/RR (OHA)**: • A provider may request review of an OHA denial decision. The review occurs in weekly Medical Management Committee (MMC) meetings. (Applies to non-residential MH/SUD services in benefit packages E and G.) • Exception requests for experimental and other non-covered benefits (for benefit packages E and G) may be granted at the discretion of the MMC, which is led by the HSD medical director. • If a provider requests review of an OHA designee level-of-care determination, HIA may conduct the second review. **Reconsideration/RR (HIA)**:	**Reconsideration/RR:** • Medical Director can make exceptions to the process including determining if RR will be considered.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
Consequences for failure to authorize: • Failure to obtain authorization can result in non-payment.	**Consequences for failure to authorize (OHA)**: • Failure to obtain authorization for non-residential MH/SUD services 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)**: Failure to obtain authorization can result in non-payment for benefits for which it is required.	**Consequences for failure to authorize:** • Failure to obtain authorization can result in non-payment.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
Frequency of review (and method of payment): • CR is conducted telephonically 1 business day after initial notification and	**Frequency of review (and method of payment) (OHA)**:	**Frequency of review (and method of payment):** • CR ranges from 3-7 days based on the situation. (Providers are paid by DRG.)

CCO MH/SUD	FFS MH/SUD	CCO M/S
then up to daily reviews based on the situation with an average of 1-3 days. (Providers are paid by per diem.) • CR for subacute is every 7-10 days, SUD residential and PRTS every 30 days based on MCG benchmarks. **RR conditions and timelines:** • Medical Director can make exceptions to the process including determining if RR will be considered. • UR staff can retrospectively review within 90 days of discharge.	• Gender reassignment surgery (for benefit packages E and G) is authorized as a procedure. • The initial authorization for SCIP, SAIP and subacute is 30 days. **Frequency of review (and method of payment) (HIA)**: • Child residential services are paid by per diem. • Child residential services authorizations are conducted every 30-90 days. **Frequency of review (and method of payment) (KEPRO)**: • Adult residential and YAP authorizations are conducted at least once per year. In practice reviews average every 6 months. **RR conditions and timelines (OHA)**: • RR for non-residential MH/SUD services in benefit packages E and G is only available for retro eligibility situations (e.g., the person became eligible during the stay). **RR conditions and timelines (HIA):** • No policy **RR conditions and timelines (KEPRO)**: • The request for authorization is received within 30 days of the date of service.	• Skilled nursing facilities are reviewed at a minimum of every 7 days after initial approval up to the allowed 20 days. **RR conditions and timelines:** • Medical Director can make exceptions to the process including determining if RR will be considered. • UR staff can retrospectively review within 90 days of discharge.

CCO MH/SUD	FFS MH/SUD	CCO M/S
	• 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: • Consistency of application of MNC is measured through chart review. Will move to IRR when MCG criteria are implemented for authorization decisions.	**Methods to promote consistent application of criteria (OHA)**: • Nurses are trained on the application of the HERC PL and guidelines, which is spot-checked through ongoing supervision. Whenever possible, practice guidelines from clinical professional organizations such as the American Medical Association or the American Psychiatric Association, are used to establish PA frequency for services in the FFS system. (Applicable to non-residential MH/SUD services in benefit packages E and G.) • There is only one OHA designee reviewer for level-of-care review for SCIP, SAIP, and subacute and no specific criteria, so N/A. **Methods to promote consistent application of criteria (HIA):** • Parallel chart reviews for the two reviewers. (No criteria.)	**Methods to promote consistent application of criteria:** • Consistency of application of MNC is measured through chart review.

CCO MH/SUD	FFS MH/SUD	CCO M/S
	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
Evidence for UM frequency: • ASAM, HERC, OAR, per diem payment. The CCO plans to purchase either the MCG or InterQual MH/SUD criteria, but already has access to MCG length of stay benchmark information.	**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	**Evidence for UM frequency:** • MCG, HERC, OAR, InterQual, DRG

CCO MH/SUD	FFS MH/SUD	CCO M/S
	provider of complementary and alternative medicine, a behavioral health representative and two consumer representatives. The Commission is charged with maintaining a priority list of services, developing or identifying evidence-based health care guidelines and conducting comparative effectiveness research. • HERC guidelines of which there are fewer for MH/SUD than M/S. This is because 1) 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).	
Data reviewed to determine UM application: • Number of PA/CR requests and 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.	**Data reviewed to determine UM application**: • Number of PA/CR requests and denials

CCO MH/SUD	FFS MH/SUD	CCO M/S
	(Applicable to non-residential MH/SUD services in benefit packages E and G.) **Data reviewed to determine UM application (HIA)**: N/A **Data reviewed to determine UM application (KEPRO):** N/A	
IRR standard: • N/A due to size of operation	**IRR standard:** • OHA: N/A • HIA: N/A • KEPRO: N/A	**IRR standard:** • N/A due to size of operation
Results of criteria application: • 0 denials and appeals	**Results of criteria application**: • OHA: 0 appeal overturns • HIA: 0 appeal overturns • KEPRO: 0 appeal overturns	**Results of criteria application:** • 130 denials and 0 appeals (IP and OP)

7. Compliance Determination for Benefit Packages A and B

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

Comparability of Strategy and Evidence: UM is assigned to MH/SUD and M/S IP benefits primarily using three strategies: 1) To ensure coverage, medical necessity and prevent unnecessary overutilization (e.g., in violation of relevant OARs, the HERC PL and guidelines). Evidence of MH/SUD overutilization includes HERC, research demonstrating 30% of IP costs are unnecessary; and for MH/SUD and M/S

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

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

Qualified individuals conduct UM applying OARs, HERC, ASAM; and MCG and InterQual for CCO M/S. *The CCO plans to purchase the MH/SUD module for MCG or InterQual and implement it by the end of the year.* 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 are reviewed by a board certified psychiatrist or a Medical Director. 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 provides RR for both MH/SUD and M/S. Upon provider request, the OHA designee obtains RR by HIA. HIA allows reconsideration of CONS determinations, but reported they do not have an RR policy for HIA's CR denials for child residential services. For adult residential and YAP services, KEPRO allows reconsideration of denials with the submission of additional documentation within 10 days of the denial. For OHA and KEPRO, the review of a denial decision occurs in a weekly MMC meeting. *OHA intends to standardize RR processes when feasible*. Providers may appeal a MH/SUD and M/S denial decision by the CCO. OHA FFS reviews denials through the fair hearing process, but HIA and the OHA designee have not encouraged use of this process. *OHA plans to confirm all notices of action, appeal and fair hearing processes are consistent with federal requirements.* Failure to obtain authorization may result in non-coverage, although SCIP, SAIP

and subacute services may be covered by general fund dollars. Inclusive of OHA and CCO 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 based on the situation, but, on average, is conducted 1-3 days for MH/SUD IP hospital (paid per diem) and 3-7 days for M/S IP hospital (paid DRG). This difference in review frequency is tied to the reimbursement approach that incentivizes overutilization for MH/SUD and underutilization for M/S. Concurrent review for CCO MH/SUD residential (e.g., SUD, subacute and PRTS) occurs every 7-30 days based on MCG benchmark information. FFS child residential is reviewed every 30-90 days while FFS adult residential and YAP are reviewed no less than annually, but in practice averages 6 months. The CCO reviews SNF weekly during the first 20 days of the benefit. Evidence for the frequency of CCO review includes ASAM for SUD and MCG for MH and M/S IP. *OHA plans to task the FFS subcontractors with review of CR residential frequencies relative to the most recent research to confirm MH/SUD review frequency is directly tied to evidence rather than historical standard practice*. The CCO offers RR within 90 days of discharge for both MH/SUD and M/S. KEPRO makes RR available for 30 days post-admission. The OHA designee and HIA do not have standard policies describing when RR is available. In addition, it was discovered that there are conflicting State rules regarding RR timelines. *OHA plans to standardize the availability of RR, including the conditions under which it is permissible and the timeframes. OHA will align OAR requirements and RR offerings by contractors.* The CCO and State review utilization data to determine if PA or CR should be added or adjusted for MH/SUD and M/S IP benefits. For both MH/SUD and M/S the CCO conducts chart review to promote consistency of criteria application. 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 no appeals for MH/SUD or M/S. 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 and CCO action plans, the UM processes, strategies and evidentiary standards are comparable and no more stringently applied to MH/SUD IP benefits than to M/S IP benefits, in writing or in operation, in the child or adult benefit packages.

Below are the OHA action plans:

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

Below is the CCO-specific action plan:

1. *The CCO plans to purchase the MCG or InterQual MH/SUD criteria to strengthen the evidence for authorization decisions. The criteria will be implemented by the end of 2018.*

OUTPATIENT UTILIZATION MANAGEMENT

NQTL: Utilization Management (PA, CR, RR)
Benefit Package: A and B for Adults and Children
Classification: Outpatient (OP)
CCO: Umpqua

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 column 4 (CCO M/S). 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
• (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) • (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)	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 • (1) 1915(c) Medically Involved Children's NF waiver • (1) 1915(k) Community First Choice State Plan option • (1) 1915(j): Self-directed personal assistance	• (2, 4) PA: Psychological testing • (2, 4) OT/PT/ST (after initial 8 visits) • (2, 4) PA and CR: ABA • (4, 5) Experimental • (2, 3, 4, 5) OOS/OON	PA is required for: • (2, 3, 4) MRI • (2, 3, 4) DME • (2, 3, 4) Prosthetics/medical supplies • (2, 3, 4) Chiropractic services • (2, 3,4) OT/PT/ST (after initial 8 visits) • (2, 5) Experimental • (2, 3, 4, 5) OOS/OON

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
• (1) The State requires PA of HCBS in order to meet federal requirements regarding PCSPs and ensure services are provided in accordance with a participant's PCSP and in the least restrictive setting.	• (1) The State requires PA of HCBS in order to meet federal requirements regarding PCSPs and ensure services are provided in accordance with a participant's PCSP and in the least restrictive setting.	• (2) To ensure coverage, medical necessity and prevent unnecessary overutilization. • (3) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. • (4) Limited capacity/high demand service • (5) Compliance with OARs and applicable federal requirements.	• (2) To ensure coverage, medical necessity and prevent unnecessary overutilization. • (3) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. • (4) Limited capacity/high demand service • (5) Compliance with OARs and applicable federal requirements.

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
• (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	• (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	• (2) MCG, OARs, HERC PL and guidelines, and federal guidelines. • (2, 4) UM and claims reports are reviewed for trends in overutilization on a quarterly basis. • (2, 4) Annual cost and utilization reports. • (2) Medical literature demonstrates high cost of	• (2) MCG, OARs, HERC PL and guidelines, and federal guidelines. • (2, 4) UM and claims reports are reviewed for trends in overutilization on a quarterly basis. • (2) Annual cost and utilization reports. • (2) Medical literature demonstrates high cost of

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
possible as do federal requirements regarding 1915(c) and 1915(i) services.	are provided in the least restrictive setting possible.	unnecessary medical care (i.e. 30% of medical costs). (Institute of Medicine Report, (2012). • (3) Oregon Performance Plan (OPP) requires that BH services be provided in least restrictive setting possible. The OPP is a DOJ-negotiated Olmsted settlement. • (3) HERC guidelines re safety concerns. MCG and ASAM. • (4) Difficulty finding available appointments • (5) Applicable federal guidelines and OARs	unnecessary medical care (i.e. 30% of medical costs). (Institute of Medicine Report, (2012). • (3) HERC guidelines re safety concerns. MCG and InterQual. • (4) Difficulty finding available appointments • (5) Applicable federal guidelines and OARs

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
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:** • PA form should be submitted prior to service delivery. Non urgent requests are processed within 14 days.	**Timelines for authorizations:** • PA form should be submitted prior to service delivery (or after designated number of PT/ST/OT visits) and provider should wait for authorization before delivering the service. Non urgent requests are processed within 14 days.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
			• A new PA is required when the initial number of units/dates is exhausted.
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:** • Psych Testing PA requires a 1 page form. Diagnosis, CPT code and MNC rationale are required. • CR for psychiatric day treatment and skills training is done in joint face-to-face meetings. There is no other formal PA.	**Documentation requirements:** • PA form is 1 page which can be faxed or submitted online. Diagnosis, CPT code and MNC rationale are required.
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	**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	**Method of document submission:** • Fax or online.	**Method of document submission:** • Fax or online.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
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. **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	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. **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	**Qualifications of reviewers:** • For psych testing, nurse may authorize services, but only physicians can issue denials.	**Qualifications of reviewers:** • Nurse may authorize services, but only physicians can issue denials.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
AND two years human services related experience; or – Three years of human services- related experience. (i) **Qualifications of reviewers**: • KEPRO QMHPs must meet minimum qualifications (see below) and demonstrate the ability to conduct and review an assessment, including identifying precipitating events, gathering histories of mental and physical health, substance use, past mental health services and criminal justice contacts, assessing family, cultural, social and work relationships, and conducting/reviewing a mental status examination, complete a DSM diagnosis, write and supervise the implementation of a PCSP. • A QMHP must meet one of the following conditions: – Bachelor's degree in nursing and licensed by the State or Oregon;	AND two years human services related experience; or – Three years of human services- related experience.		

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
– 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: • (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.	**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:** • Authorization decisions are made using ASAM HERC guidelines and OARs. The CCO plans to purchase MCG or InterQual to implement by the end of the year.	**Criteria:** • PA includes eligibility and benefit coverage confirmation and MNC review • Authorization decisions are made using MCG, UpToDate, HERC guidelines and OARs.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
• (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. **Reconsideration/RR**: • (c) N/A • (i) Within 10 days of a denial, the provider may send additional documentation to KEPRO for reconsideration. • (i) A provider may request review of a denial decision, which occurs in weekly MMC meetings or KEPRO's own comparable MMC meeting. **Consequences for failure to authorize**: • Failure to obtain authorization may result in non-payment.	**Reconsideration/RR**: • N/A **Consequences for failure to authorize**: • Failure to obtain authorization may result in non-payment.	**Reconsideration/RR:** • There is an opportunity for a peer-to-peer discussion between the provider and the Medical Director or psychiatrist after a notice of action has been issued. • UR staff can retrospectively review within 90 days of completion. **Consequences for failure to authorize:** • Failure to obtain authorization can result in non-payment.	**Reconsideration/RR:** • There is an opportunity for a peer to peer discussion between the provider and the Medical Director after a notice of action has been issued. • UR staff can retrospectively review within 90 days of completion. **Consequences for failure to authorize:** • Failure to obtain authorization can result in non-payment.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
Appeals: • Notice and fair hearing rights apply.	**Appeals**: • Notice and fair hearing rights apply.	**Appeals:** • Standard appeal rights apply.	**Appeals:** • Standard appeal rights apply.

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
Frequency of review: • PCSPs are reviewed and revised as needed, but at least every 12 months.	**Frequency of review:** • PCSPs are reviewed and revised as needed, but at least every 12 months.	**Frequency of review:** • CR is completed every 30 days during staff/team meeting for TLC day treatment and skills training. The Medical Director attends every 90 days. The average LOS for TLC Day Treatment is 192. The ALOS for skills training is 154 days. There is no PA requirement for these services. • Psych testing is authorized for the code and number of units requested by the provider. • PT/ST/OT is authorized consistent with HERC requirements. • For Psych Testing, Medical Director can make exceptions to the UM process. Case can be reviewed more frequently if deemed necessary by the	**Frequency of review:** • Length of authorization ranges from 3 months to 1 year depending on the service. • Medical director can make exceptions to the process.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
		Contracted vendor or board certified psychiatrist	
RR conditions and timelines: • (c) N/A • (i) Within 10 days of a denial, the provider may send additional documentation to KEPRO for reconsideration • (i) A provider may request review of a denial decision, which occurs in weekly Medical Management meetings or KEPRO's own comparable MM meeting.	**RR conditions and timelines:** • N/A	**RR conditions and timelines:** • UR staff can retrospectively review within 90 days of discharge.	**RR conditions and timelines:** • UR staff can retrospectively review within 90 days of discharge.
Methods to promote consistent application of criteria: • For 1915(c), DHS Quality Assurance Review teams review a representative sample of PCSPs as part of quality assurance and case review activities to assure that PCSPs meet program standards. • Additionally, OHA staff review a percentage of 1915(c)	**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	**Method to promote consistent application of criteria:** • Consistency of application of MNC is measured through chart review.	**Method to promote consistent application of criteria:** • Consistency of application of MNC is measured through chart review.

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

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
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. **Data reviewed to determine UM application**: • N/A	**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. **Data reviewed to determine UM application**: • N/A	**Evidence for UM frequency:** • ASAM, MCG benchmark information, HERC guidelines, OARs • Per OAR 309-022-0140 (3) (h) "The interdisciplinary team shall conduct a review of progress and transfer criteria at least every 30 days from the date of entry and shall document the member's present, progress, and changes made. • For Psychiatric Day Treatment Services, the review is conducted every 30 days, and the licensed provider shall participate in the review at least every 90 days." **Data reviewed to determine UM application:** • Number of PA requests and denials	**Evidence for UM frequency:** • UpToDate, MCG, HERC guidelines, OARs **Data reviewed to determine UM application:** • Number of PA requests • Denial and appeal overturn rates

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S
IRR standard: • N/A **Results of criteria application (appeal overturn rates)**: • (c): 0 appeal overturns. • (i) (KEPRO) 11% appeal overturn rate (1 out of 9 hearings).	**IRR standard:** • N/A **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.	**IRR standard:** • NA **Results of criteria application (appeal overturn rates):** • Appeal overturn rates for MH/SUD in 2017 were 0.	**IRR standard:** • NA **Results of criteria application (appeal overturn rates):** • 2017 appeal overturn rates for M/S were 0 (IP and OP combined).

7. Preliminary Compliance Determination for OP Benefit Packages CCO A and B

OP Benefits: UM applies to FFS MH/SUD and M/S HCBS benefits and 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 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. UM is also utilized to preserve scarce resources that are apparent due to the difficulty of finding in-network providers to provide certain services. These strategies and evidence are comparable.

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

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

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

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

Non-HCBS MH/SUD OP psychiatric day treatment and skills training are reviewed monthly consistent with OARs. PT/ST/OT are reviewed consistent with HERC requirements. Most OP M/S services are authorized for 3 months to one year. Service authorization lengths are based on HERC, OARs, and MCG benchmark information. CCO makes RR available for MH/SUD and M/S for 90 days after discharge. *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.* CCO MH/SUD and M/S MNC application is evaluated through chart reviews. The CCO reviews utilization data to determine if UM requires adjustment. The CCO reported a 0% appeal overturn rate for both MH/SUD and M/S. Inclusive of OHA and CCO action plans, the UM strategy and evidence are no more stringently applied to MH/SUD than to M/S OP benefits in operation or in writing.

Compliance Determination: Inclusive of OHA and CCO action plans for IP 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: Umpqua

1. To which benefits is the NQTL assigned?

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

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• To promote appropriate and safe treatment of funded conditions and to encourage use of preferred and cost-effective agents.	• To promote appropriate and safe treatment of funded conditions.	• To promote appropriate and safe treatment of funded conditions and to encourage use of preferred and cost-effective agents.

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• PA requirements created by pharmacists and in consultation with the P&T Committee, UM Committee or Clinical Advisory Panel, and based on best practices, professional guidelines, the Prioritized List, and applicable OARs.	• FDA prescribing guidelines, medical evidence, best practices, professional guidelines, and P&T Committee review and recommendations. • Federal and state regulations/OAR and the Prioritized List.	• PA requirements created by pharmacists and in consultation with the P&T Committee, UM Committee or Clinical Advisory Panel, and based on best practices, professional guidelines, the Prioritized List, and applicable OARs.

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
• Providers, patients or pharmacies can request PA by contacting the CCO by phone, fax or provider portal. • Providers and patients are not required to submit a standardized form, although one is available to providers, pharmacies or patients upon request. Most PA criteria require documentation, such as chart notes, to support medical appropriateness and FDA approved use and dosing. • All PA requests are responded to within 24 hours. • The CCO's call center is available 24 hours per day, every day, to answer questions. CCO pharmacy staff are on call weekends and holidays to review any urgent requests that come in when the CCO is closed. • The PA criteria are developed by pharmacists and in consultation with the P&T Committee. • Failure to obtain PA with an absence of medical necessity results in no provider reimbursement.	• PA requests are typically faxed to the Pharmacy Call Center, but requests can also be submitted through the online portal, by phone, or by mail. • The standard PA form is one page long, except for nutritional supplement requests. Most PA criteria require clinical documentation such as chart notes. • All PA requests are responded to within 24 hours. • The PA criteria are developed by pharmacists in consultation with the P&T Committee. • Failure to obtain PA in combination with an absence of medical necessity results in no provider reimbursement.	• Providers, patients or pharmacies can request PA by contacting the CCO by phone, fax or provider portal. • Providers and patients are not required to submit a standardized form, although one is available to providers, pharmacies or patients upon request. Most PA criteria require documentation, such as chart notes, to support medical appropriateness and FDA approved use and dosing. • All PA requests are responded to within 24 hours. • The CCO's call center is available 24 hours per day, every day, to answer questions. CCO pharmacy staff are on call weekends and holidays to review any urgent requests that come in when the CCO is closed. • The PA criteria are developed by pharmacists and in consultation with the P&T Committee. • Failure to obtain PA with an absence of medical necessity results in no provider reimbursement.

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 three months to a year, depending on medical appropriateness and safety, as recommended by the P&T Committee, Pain Committee, Clinical Advisory Panel, or Utilization Management Committee. • Approximately 39% of MH/SUD drugs are subject to PA criteria for clinical reasons. • Providers may provide additional information for a reconsideration of a denial. • Providers and patients may appeal any denial; patients may request a hearing. All appeals are reviewed by a Plan Medical Director for redetermination. • The appeal overturn rate for CY 2017 was 0%. • The CCO assesses stringency through review of the number of PA requests, PA denial/approval rates, and pricing reports. • PA criteria are reviewed for appropriateness on an ad hoc basis	• The State approves PAs for up to 12 months, depending on medical appropriateness and safety, as recommended by the P&T Committee. • Approximately 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.	• Typically, the frequency range is three months to a year, depending on medical appropriateness and safety, as recommended by the P&T Committee, Pain Committee, Clinical Advisory Panel, or Utilization Management Committee. • Approximately 50% of M/S drugs are subject to PA criteria for clinical reasons. • Providers may provide additional information for a reconsideration of a denial. • Providers and patients may appeal any denial; patients may request a hearing. All appeals are reviewed by a Plan Medical Director for redetermination. • The appeal overturn rate for CY 2017 was 11%. • The CCO assesses stringency through review of the number of PA requests, PA denial/approval rates, and pricing reports. • PA criteria are reviewed for appropriateness on an ad hoc basis

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
• PA requirements created by pharmacists and in consultation with the P&T Committee, UM Committee or Clinical Advisory Panel, and based on best practices, professional guidelines, the Prioritized List, and applicable OARs.	• FDA prescribing guidelines, medical evidence, best practices, professional guidelines, and P&T Committee review and recommendations. • Federal and state regulations/OAR and the Prioritized List.	• PA requirements created by pharmacists and in consultation with the P&T Committee, UM Committee or Clinical Advisory Panel, and based on best practices, professional guidelines, the Prioritized List, and applicable OARs.

7. Compliance Determination for Benefit Packages CCO A and B

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

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

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

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

PROVIDER ADMISSION — CLOSED NETWORK

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

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

CCO MH/SUD	FFS MH/SUD	CCO 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.

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

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
• Network sufficiency standards are required by 42 CFR 438.206. • Requirements related to the selection and retention of providers are specified in 42 CFR 438.214.	• N/A	• Network sufficiency standards are required by 42 CFR 438.206. • Requirements related to the selection and retention of providers are specified in 42 CFR 438.214.

CCO MH/SUD	FFS MH/SUD	CCO M/S
• 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.		• 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.

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
• New providers that are denied admission into the network due to network closure will not be able to participate in the CCO network and may not be reimbursed for services provided to CCO members. • The organization conducts a network adequacy study to determine if the panel is sufficient. Historically that decision has been led by the COO and presented to the Board for approval of a closed network. The CCO always considers new provider applications and considers their unique skill set when making decisions. • CCO considers the following criteria to evaluate the network: provider availability requirements, time and distance standards, members to PCP ratios, grievance analysis, special requests and	• N/A	• New providers that are denied admission into the network due to network closure will not be able to participate in the CCO network and may not be reimbursed for services provided to CCO members. • The organization conducts a network adequacy study to determine if the panel was sufficient. Historically that decision has been led by the COO and presented to the Board for approval of a closed network. The CCO always considers new provider applications and considers their unique skill set when making decisions. • CCO considers the following criteria to evaluate network: provider availability requirements, time and distance standards, members to PCP ratios, grievance analysis, special requests and

CCO MH/SUD	FFS MH/SUD	CCO M/S
accommodations, utilization trends, requests for out of network services, community needs assessments, requests for second opinions, CAHPS, access to care and satisfaction survey results when making the determination to close the network. • Providers that are denied the opportunity to participate in CCO's network may not challenge CCO's decision. • Exceptions may not be made.		accommodations, utilization trends, requests for out of network services, community needs assessments, requests for second opinions, CAHPS, access to care and satisfaction survey results when making the determination to close the network. • Providers that are denied the opportunity to participate in CCO's network may not challenge CCO's decision. • Exceptions may not be made.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
• When the CCO decides to close the network to particular specialties/ provider types, all new outpatient providers applying for those particular providers/provider types are subject to this NQTL. The NQTL is rarely applied, most recently Feb 2018. • One mental health provider was impacted by CCO's decision to close all or part of its network to new providers in the last contract year.	• N/A	• When the CCO decides to close the network to particular specialties/ provider types, all new outpatient providers applying for those particular providers/provider types are subject to this NQTL. The NQTL is rarely applied, most recently Feb 2018. • Three dermatology providers were impacted by CCO's decision to close all or part of its network to new providers in the last contract year.

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
• The CCO reviews the following data/information to determine how strictly to apply the criteria/considerations to close the CCO network to new providers: – Member access to care measures (e.g., timely access, distance) – Provider to member ratios – Provider availability – CCO considers the following criteria to evaluate the network: provider availability requirements, time and distance standards, member to PCP ratios, grievance analysis, special requests and accommodations, utilization trends, requests for out of network services, community needs assessments, requests for second opinions, CAHPS, access to care and satisfaction survey results when making the determination to close the network.	• N/A	• The CCO reviews the following data/information to determine how strictly to apply the criteria/considerations to close the CCO network to new providers: – Member access to care measures (e.g., timely access, distance) – Provider to member ratios – Provider availability – CCO considers the following criteria to evaluate the network: provider availability requirements, time and distance standards, member to PCP ratios, grievance analysis, special requests and accommodations, utilization trends, requests for out of network services, community needs assessments, requests for second opinions, CAHPS, access to care and satisfaction survey results when making the determination to close the network.

7. Compliance Determination for Benefit Packages CCO A and B

Comparability of Strategy and Evidence: The CCO does not close its network to new providers of MH/SUD and M/S inpatient services, but may close its network to new providers of MH/SUD and M/S outpatient services. When the CCO closes its network to new MH/SUD and M/S providers, it is done to balance member access needs with safety and quality concerns and with cost effectiveness/cost control.

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 OP provider types are not needed, requests to join the network are declined and the provider may not be reimbursed for provided services. For both MH/SUD and M/S providers, the CCO evaluates the need for providers through a network adequacy study and presents the information to the Board to make a decision on whether or not to close the network. Additionally, the following is used to evaluate whether or not to close the CCO's network: provider availability requirements, time and distance standards, member to PCP ratios, a grievance analysis, special requests and accommodations, utilization trends, requests for out of network services, community needs assessments, requests for second opinions, CAHPS, access to care and satisfaction survey results. Neither MH/SUD nor M/S providers may challenge the CCO's decision; no exceptions are allowed. 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 MH/SUD and M/S OP providers applying for those particular specialties/provider types are subject to the NQTL, although this NQTL is rarely applied. In operation, MH/SUD and M/S providers have been comparably impacted by the application of a closed network, with one MH/SUD provider impacted by the CCO's decision to close all or part of its network and minimal M/S providers impacted.

The CCO monitors similar metrics related to how stringently the CCO applies network closure to MH/SUD and M/S providers, reviewing information such as access standards, provider to member ratios, provider availability requirements, time and distance standards, member to PCP ratios, a grievance analysis, special requests and accommodations, utilization trends, requests for out of network services, community needs assessments, requests for second opinions, CAHPS, access to care and satisfaction survey results. 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.

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

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

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

CCO MH/SUD	FFS MH/SUD	CCO 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

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

CCO MH/SUD	FFS MH/SUD	CCO 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

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

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

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
• All providers must meet credentialing and re-credentialing requirements. • Providers must complete and provide OPCA/OPRCA. • Providers may submit supporting documentation by fax, paper and email. • CCO's credentialing process involves the following: after receipt of the completed OPCA/OPRCA, and ensuring no adverse information was identified, (i.e., felony convictions) the CCO then performs primary source verification of the following: State license, clinical privilege, 24 hour coverage, malpractice insurance, malpractice history, board certification, education, DEA certificate as applicable, impairments as applicable, HHS-OIG	• All providers are eligible to enroll as a provider and receive reimbursement provided they meet all relevant Federal and State licensing and other rules and are not on an exclusionary list. • Providers must complete forms and documentation required for their provider type. This includes information demonstrating the provider meets provider enrollment requirements such 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	• All providers must meet credentialing and re-credentialing requirements. • Providers must complete and provide OPCA/OPRCA. • Providers may submit supporting documentation by fax, paper and email. • CCO's credentialing process involves the following: after receipt of the completed OPCA/OPRCA, and ensuring no adverse information was identified, (i.e., felony convictions) the CCO then performs primary source verification of the following: State license, clinical privilege, 24 hour coverage, malpractice insurance, malpractice history, board certification, education, DEA certificate as applicable, impairments as applicable, HHS-OIG

CCO MH/SUD	FFS MH/SUD	CCO M/S
LEIE, SAM, NPDB work history. Upon completion of the review, information is submitted to the credentialing committee to approve or deny application. The provider is notified via letter of the credentialing committee's decision. • CCO's credentialing process averages 15-90 days. • CCO's Credentialing Committee is responsible for reviewing required information and making provider credentialing decisions. • CCO performs re-credentialing every three years after the providers initial credentialing. • Providers who do not meet credentialing/re-credentialing requirements may be denied payment for care and denied participation as an in-network provider. • Providers who are adversely affected by credentialing or re-credentialing decisions may challenge the decision by requesting appeal within 30 days of the adverse action to the credentialing committee. The provider will be advised of the process and their hearing rights. The provider is permitted to introduce additional information to the credentialing committee for consideration or reversal of previous	number, and/or Medicare enrollment as applicable to the provider type. • The enrollment forms and documentation can be faxed in or completed and submitted electronically to the State's provider enrollment unit. • The State's provider enrollment process includes checking the forms for completeness, running the provider name against exclusion databases, and verifying any licenses, certifications or equivalents. • The State's enrollment process averages 7 to 14 days. • State staff in the provider enrollment unit are responsible for reviewing information and making provider enrollment decisions. • 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.	LEIE, SAM, NPDB work history. Upon completion of the review, information is submitted to the credentialing committee to approve or deny application. The provider is notified via letter of the credentialing committee's decision. • CCO's credentialing process averages 15-90 days. • CCO's Credentialing Committee is responsible for reviewing required information and making provider credentialing decisions. • CCO performs re-credentialing every three years after the providers initial credentialing. • Providers who do not meet credentialing/re-credentialing requirements may be denied payment for care and denied participation as an in-network provider. • Providers who are adversely affected by credentialing or re-credentialing decisions may challenge the decision by requesting appeal within 30 days of the adverse action to the credentialing committee. The provider will be advised of the process and their hearing rights. The provider is permitted to introduce additional information to the credentialing committee for consideration or reversal of previous

CCO MH/SUD	FFS MH/SUD	CCO M/S
decisions. The fair hearing process will be conducted an ad hoc committee composed of 5 providers appointed by the credentialing committee consisting of current CCO panel providers.		decisions. The fair hearing process will be conducted an ad hoc committee composed of 5 providers appointed by the credentialing committee consisting of current CCO panel providers.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
• All providers/provider types must be credentialed. • There are no exceptions to meeting these requirements. • No providers were denied admission or terminated from the network in the last contract year as a result of credentialing and 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. • There are exceptions to meeting these requirements. • No providers were denied admission or terminated from the network in the last contract year as a result of credentialing and re-credentialing.

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
• 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 (select all that apply): – State law and Federal regulations – State contract requirements CCO contract	• 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 (select all that apply): – State law and Federal regulations – State contract requirements CCO contract.

CCO MH/SUD	FFS MH/SUD	CCO M/S
– Monitoring of provider performance – National accreditation standards (NCQA) • CCO does not monitor data/information to determine how strictly to apply credentialing/ re-credentialing criteria but notes that there is a relatively low termination/denial rate		– Monitoring of provider performance – National accreditation standards (NCQA) • CCO does not monitor data/information to determine how strictly to apply credentialing/ re-credentialing criteria but notes that there is a relatively low termination/denial rate

7. Compliance Determination for Benefit Packages CCO A and B

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

Comparability and Stringency of Processes: All providers of MH/SUD and M/S services must successfully meet credentialing and re-credentialing requirements in order to be admitted to and continue to participate in the CCO's network. New providers of MH/SUD and M/S services must complete and submit substantially the same information and documentation as part of the credentialing process. Providers complete the Oregon Practitioner Credentialing and Re-credentialing application and supporting documents that are verified by the CCO. Documents/information include the State license, clinical privilege, 24 hour coverage, malpractice insurance, malpractice history, board certification, education, DEA certificate as applicable, impairments as applicable, List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM) database of excluded providers, and National Practitioner Data Bank (NPDB) and provider work history. Both MH/SUD and M/S providers are offered several methods of submitting their application and supporting documentation, including by email, mail and fax.

The CCO's credentialing process involves Credentialing Committee review/verification of required information and credentialing decision-making. Providers are notified via letter of the Credentialing Committee's decision. The credentialing process for both MH/SUD and M/S providers averages between 15-90 days. Re-credentialing for both MH/SUD and M/S providers is conducted every three years, as required by OAR and the national accreditation standards used by the CCO (NQCA). MH/SUD and M/S providers who fail to meet credentialing and re-

credentialing requirements are denied from participating in the CCO's network and may not be reimbursed for care. Both MH/SUD and M/S providers may challenge a credentialing/re-credentialing decision through the appeal and fair hearing process. Based upon these findings, the CCO's credentialing and re-credentialing 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: All MH/SUD and M/S providers are subject to meeting credentialing and re-credentialing requirements; there are no exceptions. In operation, MH/SUD and M/S providers have been comparably impacted by the application of credentialing and re-credentialing requirements, with no MH/SUD or M/S providers terminated from the network or denied admission in the last contract year.

The CCO does not monitor metrics related to applying credentialing and re-credentialing requirements for MH/SUD and M/S providers but notes that there is a relatively low termination/denial rate. As a result, the strategies and evidentiary standards for credentialing and re-credentialing are no more stringently applied to MH/SUD providers than to M/S providers.

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

PROVIDER ADMISSION — PROVIDER EXCLUSIONS

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

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

CCO MH/SUD	FFS MH/SUD	CCO 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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
• 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
• 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
• 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
• 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
• 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.

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

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

1. To which benefits is the NQTL assigned?

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
• CCO seeks to maximize use of in-network providers because our provider network consists of local providers that have been credentialed and contracted with the CCO. • The purpose of providing OON/OOS coverage is to provide needed services when they are not available in-network/in-State. • The purpose of prior authorizing non-emergency OON/OOS benefits is to determine the medical necessity of the requested benefit and the availability of an in-network/in-State provider.	• The State seeks to maximize use of in-State providers because the State has determined that they meet applicable requirements, and they have a provider agreement with the State, which includes agreement to comply with Oregon Medicaid requirements and accept DMAP rates. • The purpose of providing OOS coverage is to provide needed services when the service is not available in the State of Oregon or the client is OOS and requires covered services. • The purpose of prior authorizing non-emergency OOS services is to ensure the criteria in OAR 410-120-1180 are met.	• CCO seeks to maximize use of in-network providers because our provider network consists of local providers that have been credentialed and contracted with the CCO. • The purpose of providing OON/OOS coverage is to provide needed services when they are not available in-network/in-State. • The purpose of prior authorizing non-emergency OON/OOS benefits is to determine the medical necessity of the requested benefit and the availability of an in-network/in-State provider.

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

CCO MH/SUD	FFS MH/SUD	CCO 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.

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
• Except as otherwise required by OHA, non-emergency OON/OOS services are not covered unless medically necessary services are not available within network/within the State. • The CCO's criteria for non-emergency OON/OOS coverage include special needs of the member, specialty services not available in-network/in-State, and/or availability of a qualified provider. • Requests for non-emergency OON/OOS services are made through the prior authorization process. • The timeframe for approving or denying a non-emergency OON/OOS request is the same as for other prior authorizations (14 days for standard requests). • The CCO establishes a single case agreement (SCA) with an OON/OOS	• Non-emergency OOS services are not covered unless the service meets the OAR criteria. • The OAR criteria for OOS coverage of non-emergency services include the service is not available in the State of Oregon or the client is OOS and requires covered services. • Requests for non-emergency OOS services are made through the State 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.	• Except as otherwise required by OHA, non-emergency OON/OOS services are not covered unless medically necessary services are not available within network/within the State. • The CCO's criteria for non-emergency OON/OOS coverage include special needs of the member, specialty services not available in-network/in-State, and/or availability of a qualified provider. • Requests for non-emergency OON/OOS services are made through the prior authorization process. • The timeframe for approving or denying a non-emergency OON/OOS request is the same as for other prior authorizations (14 days for standard requests). • The CCO establishes a single case agreement (SCA) with an OON/OOS

CCO MH/SUD	FFS MH/SUD	CCO M/S
provider if the provider declines to accept the Medicaid FFS (DMAP) rate. • The CCO's process for establishing a SCA includes contacting the provider and collecting pertinent information including claims address and tax ID and negotiating the terms of the SCA. • The average length of time to negotiate a SCA is 14 to 30 days. • Only providers enrolled in Oregon Medicaid can qualify as an OON/OOS provider. • The CCO pays OON/OOS providers: – The Medicaid FFS rate; – A percentage of the Medicaid FFS rate; or – A negotiated rate.		provider if the provider declines to accept the Medicaid FFS (DMAP) rate. • The CCO's process for establishing a SCA includes contacting the provider and collecting pertinent information including claims address, tax ID and negotiating the terms of the SCA. • The average length of time to negotiate a SCA is 14 to 30 days. • Only providers enrolled in Oregon Medicaid can qualify as an OON/OOS provider. • The CCO pays OON/OOS providers: – The Medicaid FFS rate; – A percentage of the Medicaid FFS rate; or – A negotiated rate.

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S
• Members/providers may appeal the denial of an OON/OOS request. • The CCO does not have data on non-emergency OON/OOS requests for CY 2017 because MH/SUD was managed by a different contractor (changed contractors). • The CCO measures the stringency of the application of OON/OOS requirements though claims data analysis. • The CCO evaluates the number of SCAs annually to determine whether the network should be expanded or a particular OON/OOS should 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.	• Members/providers may appeal the denial of an OON/OOS request. • In CY 2017 the CCO received 3,516 non-emergency OON/OOS requests; 396 (11%) requests were denied; and 13 of denied requests were overturned on appeal (3% appeal overturn rate). • The CCO measures the stringency of the application of OON/OOS requirements through claims data analysis. • The CCO evaluates the number of SCAs annually to determine whether the network should be expanded or a particular OON/OOS should be recruited to be a network provider.

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

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

7. Compliance Determination for Benefit Packages CCO A and B

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

For both non-emergency MH/SUD and M/S OON/OOS benefits, the CCO (and the State for FFS MH/SUD OOS benefits) requires prior authorization to determine medical necessity and to ensure no in-network/in-State providers are available to provide the benefit. OON/OOS

coverage requirements are based on Federal and State requirements, including OAR (for both the State and the CCO) and the CCO contract (for the CCO). As a result, the strategy and evidence for OON/OOS coverage of non-emergency inpatient and outpatient benefits are comparable for MH/SUD and M/S benefits.

Comparability and Stringency of Processes: Requests for non-emergency OON/OOS CCO MH/SUD and M/S benefits are made through the CCO's prior authorization process and are reviewed for medical necessity and in-network/in-State coverage. The prior authorization timeframes (14 days for standard requests and 72 hours for urgent requests) apply. Similarly, the State reviews requests for non-emergency OOS MH/SUD services through its prior authorization process, and the prior authorization timeframes (14 days for standard requests and 72 hours for urgent requests) apply. OOS providers are reimbursed the Medicaid FFS rate. If the OOS MH/SUD provider is not enrolled in Oregon Medicaid, the provider must enroll in Oregon Medicaid. Similarly, the CCO requires OON/OOS providers to be enrolled with Oregon Medicaid. If the OON/OOS MH/SUD or M/S provider does not agree to the DMAP rate, then the CCO will establish a single case agreement (SCA). The CCO's process for establishing a SCA is the same for MH/SUD and M/S providers and includes collecting information necessary to complete the SCA and negotiating the terms of the SCA. The average time to negotiate a SCA is 14 to 30 days. Both MH/SUD and M/S OON/OOS providers are paid the Medicaid FFS rate, a percentage of the Medicaid FFS rate, or a negotiated rate. Based on this, the processes for MH/SUD and M/S non-emergency OON/OOS benefits are comparable and applied no more stringently to MH/SUD non-emergency OON/OOS benefits.

Stringency of Strategy and Evidence: For both MH/SUD and M/S, if a request for a non-emergency OON/OOS benefit does not meet applicable criteria, which are based on Federal and State requirements, it will not be authorized, and payment for the service will be denied by the CCO/State. Members and providers may appeal the denial of OON/OOS authorization requests to the CCO/State as applicable. Neither the State nor the CCO was able to provide statistics regarding OON/OOS requests for MH/SUD; however, the CCO states that approximately 11% of M/S OON/OOS claims were denied in CY 2017 and approximately 3% of those denials were denied on appeal. 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.