August 2018

Oregon Health Authority Fee for Service (FFS)

NQTL Report

Mental Health Parity (CMS 2333-F)
Non-Quantitative Treatment Limitation (NQTL) Report

Oregon Health Authority
HEALTH SYSTEMS DIVISION

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 Medicaid/CHIP 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 three NQTLs for OHA's Fee-For-Service (FFS) system:

- **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.
- **Out-of-state standards:** Out-of-state standards affect how members access 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 the FFS system, OHA:

- Populated the applicable NQTL questionnaire with information gathered by OHA in Phase 1.
- Identified specific additional information needed and documented updates to the questionnaire.
- Finalized the information in the questionnaire.

Based on information collected in questionnaires (see sections 1-6 for each NQTL below), OHA drafted compliance determinations regarding whether each NQTL met parity requirements and developed action plans to address potential parity concerns. Mercer reviewed the preliminary compliance determinations and draft action plans with OHA, and OHA made the final compliance determination, including any applicable action plans (see section 7 as applicable, for each NQTL below).

The following documents OHA's analysis of NQTLs applied by OHA's FFS system 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 section 7, as applicable, for each NQTL below). Note that, as applicable, the OHA 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 (Prior Authorization (PA), Concurrent Review (CR), Retrospective Review (RR))
Benefit Package: FFS benefits for Adults and Children in FFS
Classification: Inpatient (IP)

1. To which benefits is the NQTL assigned?

FFS MH/SUD	FFS M/S
• (1, 4) PA (only) for MH/SUD procedures performed in a medical facility (e.g., gender reassignment surgery authorizations, experimental/investigational, and extra-contractual benefits are conducted by OHA consistent with the information in column 2). • (2, 4) A level-of-care review is required for SCIP, SAIP and subacute care that is conducted by an OHA designee. • (1, 4) PA for SCIP, SAIP and subacute admission is obtained through a peer-to-peer review between an HIA psychiatrist and the referring psychiatrist. • (1, 2, 4) CR and RR for SCIP and SAIP are performed by HIA. • (1, 2, 4) CR and RR for subacute care are conducted by HIA. • (1, 2, 4) PA, inclusive of a Certificate of Need (CONS) process, and CR, is conducted by HIA for PRTS. • (1, 2, 4) PA, CR for AFH, SRTF, SRTH, YAP, RTF, and RTH are performed by KEPRO.	• (1, 2, 4) PA and CR are required for in-state and OOS planned surgical procedures (including transplants) and associated imaging, rehabilitation and professional surgical services delivered in an inpatient setting and listed in OAR 410-130-0200, Table 130-0200-1; rehabilitation, and long term acute care (LTAC). (Notification is required for all IP admissions.) • (1, 2, 4) PA, CR and RR for Behavior Rehabilitation Services (BRS) are performed by OHA, DHS or OYA designee. • (1, 2, 4) PA and CR of skilled nursing facility (SNF) services. • (1, 4) Requests for extra-contractual and experimental/investigational /unproven benefits (i.e., exceptions) are submitted through a PA-like process.

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

FFS MH/SUD	FFS M/S
• (1) UM is assigned to ensure medical necessity of services/prevent overutilization (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) of these high cost services.	• (1) PA and CR are assigned to prevent overutilization (e.g., requests for care that are not medically necessary) (e.g., in violation of relevant OARs, the Health Evidence Review Commission (HERC) PL and guidelines).

FFS MH/SUD	FFS M/S
• (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual (e.g., matching the level of need to the least restrictive setting using the LOCUS – Level-of-Care Utilization System and LSI – Level of Service Inventory). • (4) To comply with federal and State requirements.	• (2) Ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. • (4) To comply with federal and State requirements.

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

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

FFS MH/SUD	FFS M/S
• (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. • (4) PRTF CONS: OAR 410-172-0690 and 42 CFR 441.156. • (4) OARs and other applicable federal and State requirements.	• (4) Applicable federal and State requirements

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

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

FFS MH/SUD	FFS M/S
Documentation requirements (OHA): • PA documentation requirements for non-residential MH/SUD benefits include a form that consists of a cover page. Diagnostic and CPT code information and a rationale for medical necessity must be provided, plus any additional supporting documentation. • The documentation requirement for level-of-care assessment for SCIP, SAIP and subacute is a psychiatric evaluation. Other information may be reviewed when available. **Documentation requirements for PRTF CONS and CR for PRTF, SCIP and SAIP (HIA)**: • PRTS CONS requires documentation that supports the justification for child residential services, including: (a) A cover sheet detailing relevant provider and recipient Medicaid numbers; (b) Requested dates of service; (c) HCPCS or CPT Procedure code requested; and (d) Amount of service or units requested; (e) A behavioral health assessment and service plan meeting the requirements described in OAR 309-019-0135 through 0140; or (f) Any additional supporting clinical information supporting medical justification for the services requested; (g) For substance use disorder services (SUD), the Division uses the American Society of Addiction Medicine (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 PRTS, SCIP or SAIP.	**Documentation requirements**: • PA documentation requirements include a form that consists of a cover page. Diagnostic and CPT code information and a rationale for medical necessity must be provided, plus any additional supporting documentation.

FFS MH/SUD	FFS M/S
Documentation requirements (KEPRO): • Documentation may include assessment, service plan, plan-of-care, Level-of-Care Utilization System (LOCUS), Level of Service Inventory (LSI) or other relevant documentation. **Method of document submission (OHA):** • For non-residential MH/SUD services, paper (fax) or online PA requests are submitted prior to the delivery of services for which PA is required. • For SCIP, SAIP and subacute level-of-care review, the OHA designee may accept information via fax, mail or 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, email or via portal, but documentation must still be faxed if the request is through portal. Telephonic clarification may be obtained.	**Method of document submission**: • Paper (fax) or online PA requests are submitted prior to the delivery of services for which PA is required.
Qualifications of reviewers (OHA): • OHA M/S staff conduct PA and CR (if applicable) for gender reassignment surgery. (Please see processes, strategies and evidentiary standards for M/S benefits.)	**Qualifications of reviewers**: • Nurses may authorize and deny authorization requests relative to OAR, HERC PL guidelines and associated notes, and other industry guidelines (e.g., AIM for radiology).

FFS MH/SUD	FFS M/S
• The OHA designee is a licensed, master's-prepared therapist that reviews psychiatric evaluations to approve or deny the level-of-care requested. Psychiatric consultation is available if needed. **Qualifications of reviewers (HIA)**: • Two LCSWs with QMHP designation make residential authorization decisions. • Two psychiatrists make CONS determinations. **Qualifications of reviewers (KEPRO)**: • KEPRO QMHPs must meet minimum qualifications (see below) and demonstrate the ability to conduct and review an assessment, including identifying precipitating events, gathering histories of mental and physical health, substance use, past mental health services and criminal justice contacts, assessing family, cultural, social and work relationships, and conducting/reviewing a mental status examination, complete a DSM diagnosis, and write and supervise the implementation of a PCSP. • 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).	

FFS MH/SUD	FFS M/S
Criteria (OHA): • Authorizations for non-residential MH/SUD services are based on the HERC PL and guidelines, Oregon Statute, OAR, federal regulations, and evidence-based guidelines from private and professional associations. • The OHA designee reviews requests relative to 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.	**Criteria**: • Authorizations are based on the HERC PL and guidelines, Oregon Statute, OAR, federal regulations, evidence-based guidelines from private and professional associations such as the Society of American Gastrointestinal and Endoscopic Surgeons and InterQual, where no State or federal guidelines exist.
Reconsideration/RR (OHA): • A provider may request review of an OHA denial decision for non-residential MH/SUD services. The review occurs in weekly Medical Management Committee (MMC) meetings. • Exception requests for experimental and other non-covered benefits may be granted at the discretion of the MMC, which is led by the HSD medical director. • If a provider requests review of an OHA designee level-of-care determination, HIA may conduct the second review**.** **Reconsideration/RR (HIA)**: • If the facility requests a reconsideration of a CONS denial, a second psychiatrist (who did not make the initial decision) will review the documentation and discuss with the facility in a formal meeting.	**Reconsideration/RR**: • A provider may request review of a denial decision. The review occurs in weekly MMC meetings. • Exception requests for experimental and other non-covered benefits may be granted at the discretion of the MMC, which is led by the HSD medical director.

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

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

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

FFS MH/SUD	FFS M/S
Frequency of review (and method of payment) (OHA): • Gender reassignment surgery is authorized as a procedure. • The initial authorization for SCIP, SAIP and subacute is 30 days. **Frequency of review (and method of payment) (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 authorizations are conducted at least once per year. **RR conditions and timelines (OHA)**: • RR for non-residential MH/SUD services 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.	**Frequency of review (and method of payment)**: • Most IP claims are paid DRG; as a result, CR is infrequently used. • CR is conducted monthly for LTAC and rehabilitation. • The State conducts CR for SNF at a frequency that is determined by the care manager, but not less than one time a year. • Authorization lengths are individualized by condition and are valid for up to a year. • Procedural authorizations are valid for 3 months. **RR conditions and timelines**: • RR is only available for retro eligibility situations (e.g., the person became eligible during the stay).

FFS MH/SUD	FFS 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 (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 non-residential MH/SUD services. • There is only one OHA designee reviewer for level-of-care review for SCIP, SAIP, and subacute and no specific criteria, so N/A. **Methods to promote consistent application of criteria (HIA):** • Parallel chart reviews for the two reviewers. (No criteria.) **Methods to promote consistent application of criteria (KEPRO)**: • Monthly clinical team meetings in which randomly audited charts are reviewed/discussed by peers using 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 authorization as well as plan-of-care reviews.	**Methods to promote consistent application of criteria**: • Nurses are trained on the application of the HERC PL and guidelines, which is spot-checked through ongoing supervision. Whenever possible, practice guidelines from clinical professional organizations such as the American Medical Association or the American Psychiatric Association, are used to establish PA frequency for services in the FFS system.

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

FFS MH/SUD	FFS M/S
Evidence for UM frequency (OHA (and designee for level-of-care review), HIA and KEPRO): • PA length and CR frequency are tied to HERC PL and guidelines, OAR, CFRs, reviewer expertise and timelines for expectations of improvement. • The Commission that develops HERC consists of 13 appointed members, which include five physicians, a dentist, a public health nurse, a pharmacist and an insurance industry representative, a provider of complementary and alternative medicine, a behavioral health representative and two consumer representatives. The Commission is charged with maintaining a priority list of services, developing or identifying evidence-based health care guidelines and conducting comparative effectiveness research. • HERC guidelines of which there are fewer for MH/SUD than M/S. This is because 1) 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 (OHA)**: • Denial/appeal overturn rates; number of PA requests; stabilization of cost trends; and number of hearings requested. These data are reviewed in contractor reports, on a quarterly basis by the State. (Applicable to non-residential MH/SUD services.) **Data reviewed to determine UM application (HIA)**: N/A	**Evidence for UM frequency**: • PA length and CR frequency are tied to HERC PL and guidelines, DRGs, OAR, CFRs, reviewer expertise and timelines for expectations of improvement. • The Commission that develops HERC consists of 13 appointed members, which include five physicians, a dentist, a public health nurse, a pharmacist and an insurance industry representative, a provider of complementary and alternative medicine, a behavioral health representative and two consumer representatives. The Commission is charged with maintaining a priority list of services, developing or identifying evidence-based health care guidelines and conducting comparative effectiveness research. • HERC guidelines of which there are more M/S than MH/SUD because 1) there are more technological procedures (e.g., surgery, devices, procedures and diagnostic tests); and 2) the literature is more robust. **Data reviewed to determine UM application**: • A physician led group of clinical professionals conducts an annual review to determine which services receive or retain PA. Items reviewed include: – Utilization

Data reviewed to determine UM application (KEPRO): N/A **IRR standard:** • OHA: N/A • HIA: N/A • KEPRO: N/A **Results of criteria application:** • OHA: 0 appeal overturns. • HIA: 0 appeal overturns. • KEPRO: 0 appeal overturns.	– Approval/denial rates – Documentation/ justification of services – Cost data **IRR standard**: • N/A **Results of criteria application**: • 0 appeal overturns.

7. Compliance Determination for FFS

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

Comparability of Strategy and Evidence: UM is assigned to MH/SUD and M/S IP benefits primarily using three strategies: 1) To ensure coverage, medical necessity and prevent unnecessary overutilization (e.g., in violation of relevant OARs, HERC PL or guidelines). Evidence of MH/SUD overutilization includes HERC and research demonstrating 30% of IP costs are unnecessary. 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. 4) To comply with federal and State requirements. As a result, the strategies and evidence are comparable.

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

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

Stringency of Strategy and Evidence: FFS child residential is reviewed every 1-3 months while FFS adult residential and YAP are reviewed no less than annually, but in practice average 6 month reviews. SNF is also reviewed no less than annually. LTAC and rehab hospital (M/S IP) are reviewed monthly. *OHA plans to task FFS residential subcontractors with review of CR frequencies relative to the most recent research to confirm MH/SUD review frequency is directly tied to evidence rather than historical standard practice*. KEPRO makes RR available for 30 days post-admission. FFS MH/SUD only allows RR for retro-eligibility circumstances. The OHA designee and HIA do not have standard policies describing when RR is available. In addition, it was discovered that there are conflicting State rules regarding RR timelines. *OHA plans to*

standardize the availability of RR, including the conditions under which it is permissible and the timeframes. OHA will align OAR requirements and RR offerings by contractors. The State reviews utilization data to determine if PA or CR should be added or adjusted for MH/SUD and M/S IP benefits. HIA conducts IRR and parallel chart reviews for its two reviewers and KEPRO team meetings include random chart audits using a compliance tool followed by team discussion. HIA and the OHA designee do not have specific criteria against which decisions are made. FFS M/S conducts spot-checks through supervision to assess criteria application. *While not a parity concern for FFS, OHA plans to institute a more formalized measurement of criteria application when feasible.* There were 0 appeal overturns for MH/SUD and M/S in 2017. Inclusive of OHA action plans, the strategy and evidence are no more stringently applied to MH/SUD than to M/S in writing or in operation.

Compliance Determination: Inclusive of OHA IP 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 notices of action and appeal and fair hearing processes are consistent with federal requirements.*

OUTPATIENT UTILIZATION MANAGEMENT

NQTL: Utilization Management
Benefit Package: FFS benefits for Adults and Children in FFS
Classification: Outpatient (OP)

1. To which benefits is the NQTL assigned?

FFS/HCBS 1915(c)(i) MH/SUD	FFS MH/SUD OHA	FFS/HCBS (c)(k)(j) M/S	FFS M/S OHA
• (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)	• (2) Applied Behavior Analysis (ABA) • (2) OT, PT, ST for MH conditions	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	The following services are managed by OHA: • (2, 3) Out of hospital births • (2) Home health services • (2) OT, PT, ST, and audiology for M/S conditions (and autistic disorder, which is also managed according to the processes, strategies and evidentiary standards described for FFS/MS OP) • (2, 3) Imaging • (2) DME

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

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

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS MH/SUD OHA	FFS/HCBS (c)(k)(j) M/S	FFS M/S OHA
• (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 least restrictive setting possible as do federal requirements regarding 1915(c) and 1915(i) services.	• (2) HERC PL • (2) OAR 410-172-0650 for ABA services. • (2) PA requests with insufficient documentation demonstrate MNC is not being met or HERC PL guidelines are not being followed.	• (1) Federal requirements regarding PCSPs for 1915(c), 1915(k), and 1915(j) services (e.g., 42 CFR 441.301, 441.468, and 441.540) and the applicable approved 1915(c) waiver application/State plan amendment. • (1) Federal requirements regarding 1915(c) and 1915(i) services require that HCBS are provided in the least restrictive setting possible.	• (2) HERC PL • (2) PA requests with insufficient documentation demonstrate MNC are not being met or HERC PL guidelines are not being followed. • (3) HERC Guidelines - Recommended limits on services for member safety.

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS MH/SUD OHA	FFS/HCBS (c)(k)(j) M/S	FFS M/S OHA
Timelines for authorizations: • A PCSP must be approved within 90 days from the date a completed application is submitted. **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, or Level-of-Care Utilization System (LOCUS), Level of Service Inventory (LSI) or other relevant documentation. The PCSP is developed by the member's treatment team in consultation with the member.	**Timelines for authorizations**: • Urgent requests are processed in 72 hours and immediate requests in 24 hours. Routine requests are processed in 14 days. **Documentation requirements**: • Form is 1 cover page. Require diagnostic and CPT code and rationale for medical necessity plus any additional supporting documentation. • In addition, as part of the supporting documentation ABA must have an evaluation and referral for treatment from a licensed practitioner described in OAR 410-172-0760 (1)(a-d) and a treatment plan from a licensed health care professional described in 410-172-0650(B).	**Timelines for authorizations**: • A PCSP must be approved within 90 days from the date a completed application is submitted. **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.	**Timelines for authorizations**: • Urgent requests are processed in 72 hours and immediate requests in 24 hours. Routine requests are processed in 14 days. **Documentation requirements**: • A cover page form is required. In addition, diagnostic information, a CPT code(s), a rationale for medical necessity plus any additional supporting documentation are required.

FFS/HCBS 1915(c)(i) MH/SUD	FFS MH/SUD OHA	FFS/HCBS (c)(k)(j) M/S	FFS M/S OHA
Method of document submission: • All 1915(c) services must be included in a participant's PCSP and approved by a qualified case manager at the local case management entity (CME) prior to service delivery. • Information is obtained during a face-to-face meeting, often at the individual's location. • (i) Providers submit authorization requests to KEPRO by mail, fax, email or via portal, but documentation must still be faxed if request is submitted via portal.	**Method of document submission**: • Paper (fax) or online PA/POC submitted prior to the delivery of services.	**Method of document submission**: • All 1915(c), 1915(k), and 1915(j) services must be included in a participant's PCSP and approved by a qualified case manager at the local case management entity (CME) prior to service delivery. • Information is obtained during a face-to-face meeting, often at the individual's location.	**Method of document submission**: • Paper (fax) or online PA/POC submitted prior to the delivery of services.
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	**Qualifications of reviewers:** • For ABA services, physicians review services. • For the OT, PT, ST services, nurses may authorize and deny services.	**Qualifications of reviewers**: • A case manager must have at least: – A bachelor's degree (BA) in behavioral science, social science, or a closely related field; or – A BA in any field AND one year of human	**Qualifications of reviewers:** • Nurses may authorize and deny services.

FFS/HCBS 1915(c)(i) MH/SUD	FFS MH/SUD OHA	FFS/HCBS (c)(k)(j) M/S	FFS M/S OHA
services related experience; or – An associate's degree (AA) in a behavioral science, social science, or a closely related field AND two years human services related experience; or – Three years of human services related experience. (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,		services related experience; or – An associate's degree (AA) in a behavioral science, social science, or a closely related field AND two years human services related experience; or – Three years of human services related experience.	

FFS/HCBS 1915(c)(i) MH/SUD	FFS MH/SUD OHA	FFS/HCBS (c)(k)(j) M/S	FFS M/S OHA
and write and supervise the implementation of a PCSP. • A QMHP must meet one of the following conditions: – Bachelor's degree in nursing and licensed by the State or Oregon; – Bachelor's degree in occupational therapy and licensed by the State of Oregon; – Graduate degree in psychology; – Graduate degree in social work; – Graduate degree in recreational, art, or music therapy; – Graduate degree in a behavioral science field; or – A qualified Mental Health Intern, as defined in 309-019-0105(61).			

FFS/HCBS 1915(c)(i) MH/SUD	FFS MH/SUD OHA	FFS/HCBS (c)(k)(j) M/S	FFS M/S OHA
Criteria: • (c) Qualified case managers approve or deny services in the PCSP consistent with waiver and OAR requirements. • Once a PCSP is approved, services in the PCSP are entered into the payment management system by the CME staff as authorizations. • (i) QMHPs approve or deny services in the PCSP consistent with State plan and OAR requirements. • QMHPs enter prior authorizations into the MMIS based on the member's PCSP.	**Criteria**: Authorizations are based on applicable HERC guidelines, Oregon Statute, Oregon Administrative rules, federal regulations, and evidence based guidelines from private and professional associations such as the American Psychiatric Association, where no State or federal guidelines exist.	**Criteria**: • Qualified case managers approve or deny services in the PCSP consistent with waiver/state plan and OAR requirements. • Once a PCSP is approved, it is entered into the payment management system as authorization by the CME staff.	**Criteria:** Authorizations are based on applicable HERC PL and guidelines, Oregon Statute, Oregon Administrative rules, federal regulations, and evidence-based guidelines from private and professional associations such as the Society of American Gastrointestinal and Endoscopic Surgeons where no State or federal guidelines exist.
Reconsideration/RR: • (c) NA • (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	**Reconsideration/RR**: • A provider may request review of a denial decision, which occurs in weekly MMC meetings or KEPRO's own comparable MMC meeting.	**Reconsideration/RR**: • NA	**Reconsideration/RR**: • A review of a denial decision can be requested and is reviewed in weekly MMC meetings.

FFS/HCBS 1915(c)(i) MH/SUD	FFS MH/SUD OHA	FFS/HCBS (c)(k)(j) M/S	FFS M/S OHA
meetings or KEPRO's own comparable MMC meeting. **Consequences for failure to authorize**: • Failure to obtain authorization may result in non-payment. **Appeals**: • Notice and fair hearing rights apply.	**Consequences for failure to authorize**: • Failure to obtain authorization may result in non-payment **Appeals**: • Members may request a hearing on any denial decision.	**Consequences for failure to authorize**: • Failure to obtain authorization may result in non-payment. **Appeals**: • Notice and fair hearing rights apply.	**Consequences for failure to authorize**: • Failure to obtain authorization may result in non-payment. **Appeals**: • Members may request a hearing on any denial decision.

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS MH/SUD OHA	FFS/HCBS (c)(k)(j) M/S	FFS M/S OHA
Frequency of review: • PCSPs are reviewed and revised as needed, but at least every 12 months.	**Frequency of review:** • PA is granted for different LOS depending on the service and can be adjusted. Auths for extensive services usually range from 6 months to 1 year. • PT, ST, OT is usually for one year (i.e., 30 visits) • ABA is usually multiple service codes approved for 6 months.	**Frequency of review:** • PCSPs are reviewed and revised as needed, but at least every 12 months.	**Frequency of review**: • PA is granted for different authorization periods depending on the service and can be adjusted. Authorizations for extensive services usually range from 6 months to 1 year. • PT, ST, OT authorizations are usually for one year (i.e., 30 visits) • Exceptions may be made at the discretion of the MMC,

FFS/HCBS 1915(c)(i) MH/SUD	FFS MH/SUD OHA	FFS/HCBS (c)(k)(j) M/S	FFS M/S OHA
	• Exceptions may be made at the discretion of the MMC, which is led by the HSD medical director.		which is led by the HSD medical director.
RR conditions and timelines: • (c) N/A • (i) Within 10 days of a denial, the provider may send additional documentation to KEPRO for reconsideration • (i) A provider may request review of a denial decision, which occurs in weekly Medical Management meetings or KEPRO's own comparable MM meeting.	**RR conditions and timelines:** • RR available for retro eligibility circumstances.	**RR conditions and timelines:** • N/A	**RR conditions and timelines:** • RR available for retro eligibility circumstances.
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.	**Methods to promote consistent application of criteria**: • For ABA, a sample of cases are reviewed for ability to address assessed member needs and whether OARs were met. • For OT, PT, ST, nurses are trained on the application of the HERC guidelines, which	**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.	**Methods to promote consistent application of criteria**: • Nurses are trained on the application of the HERC guidelines, which is spot-checked through ongoing supervision.

FFS/HCBS 1915(c)(i) MH/SUD	FFS MH/SUD OHA	FFS/HCBS (c)(k)(j) M/S	FFS M/S OHA
• Additionally, OHA staff review a percentage of 1915(c) participant files to assure quality and compliance. • For 1915(i), monthly clinical team meetings in which randomly audited charts are reviewed/discussed by peers using the KEPRO compliance 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,	is spot-checked through ongoing supervision.	• Additionally, OHA staff review a percentage of files to assure quality and compliance.	

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

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

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

Data reviewed to determine UM application: • N/A **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)	Association, are used to establish PA frequency. **Data reviewed to determine UM application**: • A physician-led group of clinical professionals conduct an annual review to determine which services receive or retain a PA; items reviewed include: – Utilization – Approval/denial rates – Documentation/ justification of services – Cost data **IRR standard:** • NA **Results of criteria application (appeal overturn rates):** • 0 appeal overturns	**Data reviewed to determine UM application**: • N/A **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	**Data reviewed to determine UM application**: • A physician-led group of clinical professionals conducts an annual review to determine which services receive or retain a PA; items reviewed include: – Utilization – Approval/denial rates – Documentation/ justification of services – Cost data **IRR standard:** • NA **Results of criteria application (appeal overturn rates):** • 0 appeal overturns

7. Compliance Determination for FFS

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

Most non-HCBS FFS MH/SUD and M/S OP services are assigned UM to prevent services from being delivered in violation of relevant OARs, associated HERC guidelines or federal regulations and to confirm coverage. In addition, out of hospital births are assigned UM as it is a service associated with increased health and safety risks. Evidence for UM comes from the HERC PL, relevant OARs, and federal guidelines. Evidence for safety issues includes HERC guidelines. These strategies and evidence are compatible.

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

Benefit reviews are conducted by qualified clinicians that evaluate clinical information that supports medical necessity (which may include POCs) submitted via paper (fax) or online relative HERC, OARs and national guidelines. Timelines for authorization decisions are the same for MH/SUD and M/S and defined in OARs. Failure to obtain authorization may result in non-payment for MH/SUD and M/S services; although an exception process allows RR. Appeal processes apply for both MH/SUD and M/S. Accordingly, UM processes are comparable to, and no more stringently applied, to non-HCBS MH/SUD benefits than to M/S benefits.

Stringency of Strategy and Evidence: MH/SUD and M/S HCBS PCSPs are reviewed annually (or more frequently if needed) consistent with OARs and federal requirements. Quality review is conducted by KEPRO, DHS and OHA to assure PCSPs meet standards. In 2017, appeal overturn rates for 1915(i) services were 11% (1 of 9). Appeal overturn rates for 1915(c)(k)(j) services were less than 1%. Because the 11%

MH/SUD appeal overturn rate resulted from one overturned appeal, the difference in appeal overturn rates for MH/SUD and M/S is not meaningful. As a result, UM strategy and evidence are no more stringently applied to MH/SUD than to M/S OP benefits in operation or in writing for HCBS services.

Non-HCBS MH/SUD and M/S OP service authorizations range from 6 months to 1 year and are tied to HERC. Both MH/SUD and M/S application is spot-checked through supervision and chart review. At a minimum, the State reviews utilization and other data to determine if UM requires adjustment. MH/SUD and M/S reported appeal overturn rates of 0. As a result, the UM strategy and evidence are no more stringently applied to MH/SUD than to M/S OP benefits in operation or in writing.

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

PRIOR AUTHORIZATION FOR PRESCRIPTION DRUGS

NQTL: Prior Authorization for Prescription Drugs
Benefit Package: FFS benefits for Adults and Children in FFS
Classification: Prescription Drugs

1. To which benefits is the NQTL assigned?

FFS MH/SUD	FFS M/S
• A and F drug groups • MH carve out drugs do not have an enforceable preferred drug list. While certain higher cost-effect agents are listed as “preferred”, this is not enforced by PA.	• A, F, P, S drug groups • All M/S preferred agents are enforced with PA.

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

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

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

FFS MH/SUD	FFS M/S
• 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.	• 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.

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

FFS MH/SUD	FFS M/S
• 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.	• 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.

FFS MH/SUD	FFS M/S
• 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.	• 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.

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

FFS MH/SUD	FFS M/S
• The State approves PAs for up to 12 months, depending on medical appropriateness and safety, as recommended by the P&T Committee. • Approximately 18% of MH/SUD drugs are subject to PA criteria for clinical reasons. • The State allows providers to submit additional information for reconsideration of a denial. • Providers can appeal denials on behalf of a member, and members have fair hearing rights. • There were 11 client fair hearing requests for denied MH/SUD medications. Two were reversed after agency reconsideration, and none were reversed by hearing. • The State assesses stringency through review of PA denial/approval and appeal rates; number of drugs requiring PA; number of PA requests; and pharmacy utilization data/reports. • PA criteria are reviewed as needed due to clinical developments, literature, studies, and FDA medication approvals.	• The State approves PAs for up to 12 months, depending on medical appropriateness and safety, as recommended by the P&T Committee. • Approximately 18% of M/S drugs are subject to PA criteria for clinical reasons. • The State allows providers to submit additional information for reconsideration of a denial. • Providers can appeal denials on behalf of a member, and members have fair hearing rights. • There were nine client fair hearing requests for denied M/S medications. None were reversed after agency reconsideration or by hearing. • The State assesses stringency through review of PA denial/approval and appeal rates; number of drugs requiring PA; number of PA requests; and pharmacy utilization data/reports. • PA criteria are reviewed as needed due to clinical developments, literature, studies, and FDA medication approvals.

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

FFS MH/SUD	FFS M/S
• 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.	• 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.

7. Compliance Determination for FFS

Comparability of Strategy and Evidence: OHA applies prior authorization (PA) to certain MH/SUD drugs to promote appropriate and safe treatment and to certain M/S drugs to ensure the appropriate and cost-effective use of prescription drugs. While the State does not consider cost in developing PA criteria for MH drugs, this is less stringent than M/S so is not a parity concern. Evidence used by OHA 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 P&T Committee. PA requests for both MH/SUD and M/S drugs may be submitted by fax, phone, or online portal 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: For both MH/SUD and M/S drugs, the length of prior authorization depends on medical appropriateness and safety, as recommended by the P&T Committee based on evidence such as FDA prescribing guidelines, best practices, and professional guidelines. OHA assesses the stringency of strategy for both MH/SUD and M/S drugs through review of PA denial/approval and appeal rates. The percent of MH/SUD drugs subject to PA requirements is comparable to M/S drugs. In addition, the appeal overturn rates are comparable. As a result, the strategies and evidentiary standards for prior authorization of prescription drugs are applied no more stringently to MH/SUD drugs than to M/S drugs.

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

PROVIDER ADMISSIONS

NQTL: Provider Admission
Benefit Package: FFS benefits for Adults and Children in FFS
Classification: Inpatient and Outpatient

Managed care entities such as Oregon's Coordinated Care Organizations (CCO) may apply provider network admission limits under 42 CFR 438.206, 42 CFR 438.12 and 42 CFR 438.214. Provider network admission limits do not apply to FFS benefits. Consequently, Oregon is unable to analyze limits that structurally (network structure) apply only to benefits under managed care and do not apply to FFS benefits. For that reason, Oregon's analysis for provider admission has been completed for were managed benefits in benefit packages CCOA and CCOB (not the carved out MH/SUD services), and an analysis was not conducted for benefit packages CCOE/CCOG or FFS.

1. To which benefits is the NQTL assigned?

FFS MH/SUD	FFS M/S
• N/A	• N/A

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

FFS MH/SUD	FFS M/S
• N/A	• N/A

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

FFS MH/SUD	FFS M/S
• N/A	• N/A

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

FFS MH/SUD	FFS M/S
• N/A	• N/A

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

FFS MH/SUD	FFS M/S
• N/A	• N/A

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

FFS MH/SUD	FFS M/S
• N/A	• N/A

7. Compliance Determination for FFS

Provider network admission limits do not apply to FFS benefits; accordingly, parity was not analyzed.

OUT OF STATE (OOS)

NQTL: Out of State (OOS) Standards
Benefit Package: FFS benefits for Adults and Children in FFS
Classification: Inpatient and Outpatient

1. To which benefits is the NQTL assigned?

FFS MH/SUD	FFS M/S
• Out of State (OOS) Benefits	• Out of State (OOS) Benefits

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

FFS MH/SUD	FFS M/S
• 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.	• 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.

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

FFS MH/SUD	FFS M/S
• The State covers OOS benefits in accordance with OAR.	• The State covers OOS benefits in accordance with OAR.

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

FFS MH/SUD	FFS M/S
• 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.	• 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.

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

FFS MH/SUD	FFS M/S
• If a request for a non-emergency OOS benefit does not meet the OAR criteria, it will not be prior authorized. • If a non-emergency OOS benefit is not prior authorized, the service will not be covered, and payment for the service will be denied. • Members/providers may appeal the denial of an OOS request. • The State measures the stringency of the application of OOS requirements by reviewing OOS denial/appeal rates.	• If a request for a non-emergency OOS benefit does not meet the OAR criteria, it will not be prior authorized. • If a non-emergency OOS benefit is not prior authorized, the service will not be covered, and payment for the service will be denied. • Members/providers may appeal the denial of an OOS request. • The State measures the stringency of the application of OOS requirements by reviewing OOS denial/appeal rates.

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

FFS MH/SUD	FFS M/S
• OAR	• OAR

7. Compliance Determination for FFS

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

Comparability and Stringency of Processes: Requests for non-emergency OOS MH/SUD and M/S benefits are made through the State's prior authorization process and are reviewed for medical necessity and in-State coverage. The prior authorization timeframes (14 days for standard requests and 72 hours for urgent requests) apply. OOS MH/SUD and M/S providers are reimbursed the Medicaid FFS rate. If the OOS provider is not enrolled in Oregon Medicaid, the provider must enroll in Oregon Medicaid. Both MH/SUD and M/S OOS providers are paid the Medicaid FFS rate. The processes for MH/SUD and M/S non-emergency OOS benefits are comparable and applied no more stringently to MH/SUD non-emergency OOS benefits.

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

Oregon Health Authority

HEALTH SYSTEMS DIVISION

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