HEALTH WEALTH CAREER

CASCADE HEALTH ALLIANCE (CASCADE OR CHA)

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 Cascade 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
Benefit Package: A, B, E and G for Adults and Children
Classification: Inpatient (IP)
CCO: Cascade

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

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

1. To which benefits is the NQTL assigned?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• (1, 2, 3, 4) PA and CR are required for planned non-emergency admissions to acute IP (in and out-of-network (OON)), PRTS and subacute. • (1, 2, 3, 4) Emergency admissions require notification within 24-72 hours of admission and subsequent CR. • (1, 4) Extra-contractual and experimental/investigational/ unproven benefit requests (i.e., exceptions) are	• (1, 4) PA (only) for MH/SUD procedures performed in a medical facility (e.g., gender reassignment surgery authorizations for benefit packages E and G), experimental/investigational, and extra-contractual benefits are conducted by OHA consistent with the information in column 4 for benefit packages E and G. • (2, 4, 5) A level-of-care review is required for SCIP, SAIP and subacute care that is conducted by an OHA	• (1, 2, 3, 4) PA and CR are required for planned non-emergency admissions to IP hospital, (in and OON) and IP hospice/palliative care. • (1, 2, 3, 4) Emergency admissions require notification within 24-72 hours of admission and subsequent CR. • (1, 2, 3, 4) Skilled nursing facility benefits (first 20 days) require PA. • (1, 4) Extra-contractual and experimental/investigational/u	• (1, 2, 4) PA and CR are required for in-state and OOS planned surgical procedures (including transplants) and associated imaging, rehabilitation and professional surgical services delivered in an IP setting and listed in OAR 410-130-0200, Table 130-0200-1; rehabilitation, and long term acute care (LTAC). (Notification is required for all IP admissions.) • (1, 2, 4) PA, CR and RR for Behavior Rehabilitation

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

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

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

[1] 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.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• (1, 2 and 4) HERC PL and guidelines. • (1) UM and claims reports are reviewed for trends in overutilization on a quarterly basis • (1) Annual cost and utilization reports that confirm IP as a cost driver based on percentage of spend. • (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	• (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	• (1, 2 and 4) HERC PL and guidelines. • (1) UM and claims reports are reviewed for trends in overutilization on a quarterly basis • (1) Annual cost and utilization reports that confirm IP as a cost driver based on percentage of spend. • (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	• (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.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
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/d	Research and Evaluation, Maine Medical Center, & Institute for the Evaluative Clinical Sciences, Toronto, Canada, Financial support was provided by grants from the Robert, Wood Johnson Foundation, the National Institutes of Health (Grant Number CA52192) and the National Institute of Aging (Grant Number 1PO1AG19783-01), 2002, pp 1-32. • (2) The Oregon Performance Plan (OPP) requires that BH services be provided in the least restrictive setting possible. The OPP is a DOJ-negotiated Olmsted settlement.	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) Medical errors in a hospital is the third leading cause of death in the US. Makary, M. & Daniel, M. Medical Error - The Third Leading Cause of Death in the US, BMJ, 2016;353:i2139.	

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
oi/10.1177/1077558705279307 • (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) Network providers' credentials have been verified and they have contracted to accept the network rate. • (4) Applicable federal and State requirements.	• (4) PRTS CONS: OAR 410-172-0690 and 42 CFR 441.156. • (4) OARs and other applicable federal and State requirements. • (5) Cost and utilization reports	• (3) Network providers' credentials have been verified and they have contracted to accept the network rate. • (4) Applicable federal and State requirements.	• (4) Applicable federal and State requirements.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Timelines for authorizations: • Urgent/Emergent services required for psychiatric stabilization do not require PA. CHA requires notification of admission within 24-72 hours • Processing standards are 72 hours for urgent and standard admission authorization decisions are processed within 14 days.	**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 emergency admission is acceptable only under unusual and extreme circumstances, subject to RR by HIA. **Timelines for adult residential and YAP authorizations**:	**Timelines for authorizations:** • PA: Urgent or emergent hospital admissions do not require PA and are covered if MNC are met. • Hospitals are required to notify CHA within 24 hours of urgent admission. • Urgent requests are processed within 72 hours and routine requests are processed 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 are processed within 24 hours, urgent requests within 72 hours and standard requests within 14 days; although a backlog may develop.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Documentation requirements: • Provider is required to provide notification and reason for admission. Provider must also provide clinical documentation that shows medical necessity and length of stay. • Documentation requirements include service plans, the assessment, and any other documentation supplied by the provider to determine that members are getting the appropriate IP services.	**(KEPRO)** • OARs require emergency requests are 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:** • Provider is required to provide notification and reason for admission. Provider must also provide clinical documentation that shows medical necessity of admission and length of stay. • Documentation requirements include the history and physical (H&P), progress notes and discharge summary. • A 1-2 authorization request form is required for IP admissions. The form is available on the CHA website.	**Documentation requirements**: • PA documentation requirements include a form that consists of a cover page. Diagnostic and CPT code information and a rationale for medical necessity must be provided, plus any additional supporting documentation.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	Documentation requirements for PRTS CONS and CR for SCIP and SAIP (HIA): • PRTS CONS requires documentation that supports the justification for child residential services including: (a) A cover sheet detailing relevant provider and recipient Medicaid numbers; (b) Requested dates of service; (c) HCPCS or CPT Procedure code requested; and (d) Amount of service or units requested; (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		

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	(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.		
Method of document submission: • Documents can be faxed, emailed, or submitted through a provider portal. • PA allows the CCO to determine if the requested coverage is funded (above the HERC funding line). If it is unclear whether the coverage	**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.	**Method of document submission:** • Documents can be faxed or submitted through a provider portal. • PA allows the CCO to determine if the requested coverage is funded (above	**Method of document submission**: • Paper (fax) or online PA requests are submitted prior to the delivery of services for which PA is required.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
is funded, a medical necessity review using HERC guidelines is performed and reviewed with the Medical Director to determine coverage.	• 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.	the HERC funding line). If it is unclear whether the coverage is funded, a medical necessity review using HERC guidelines is performed and reviewed with the Medical Director to determine coverage.	

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Qualifications of reviewers: • Authorization decisions are made by appropriately licensed or certified staff relative to MCG and HERC. • Approval/denials are reviewed by a Utilization Review Analyst with final approval from the Chief Medical Officer for denials based on medical necessity.	**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	**Qualifications of reviewers:** • Authorization decisions are made by appropriately licensed or certified staff relative to MCG and HERC. • Approval/denials are reviewed by a Utilization Review Analyst with final approval from the Chief Medical Officer for denials based on medical necessity.	**Qualifications of reviewers**: • Nurses may authorize and deny authorization requests relative to OAR, HERC PL guidelines and associated notes, and other industry guidelines (e.g., AIM for radiology).

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	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;		

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Criteria: • OARs, HERC PL and guidelines, federal guidelines, MCG.	– 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. • 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)**:	**Criteria:** • OARs, HERC PL and guidelines, federal guidelines, MCG.	**Criteria**: • Authorizations are based on the HERC PL and applicable 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.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	• 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: • When eligibility was not able to be determined at the time of hospitalization, a 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:** • If eligibility cannot be determined at time of admit a RR may be considered.	**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.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Appeals: • Standard appeal and fair hearing processes apply.	**Reconsideration/RR (HIA)**: • If the facility requests a reconsideration of a CONS denial, a second psychiatrist (who did not make the initial decision) will review the documentation and discuss with the facility in a formal meeting. • No policy for CR denials. **Reconsideration/RR (KEPRO)**: • Within 10 days of a denial, the provider may send additional documentation to KEPRO for reconsideration. • 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:** • Standard appeal and fair hearing processes apply.	**Appeals**: • Members may request a hearing on any denial decision.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Consequences for failure to authorize: • There is not a penalty for failure to timely notify • Failure to obtain authorization (within 90 days of admission) can result in non-payment.	**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 in benefit packages E and G can result in non-payment for benefits for which it is required. • Failure to obtain notification for non-residential MH/SUD services in benefit packages E and G does not result in a financial penalty. • For SCIP, SAIP and subacute, if coverage is retroactively denied, general funds may be used to cover the cost of care. **Consequences for failure to authorize (HIA)**: • Non-coverage. **Consequences for failure to authorize (KEPRO)**:	**Consequences for failure to authorize:** • There is not a penalty for failure to timely notify • Failure to obtain authorization (within 90 days of admission) can result in non-payment.	**Consequences for failure to authorize**: • Failure to obtain authorization can result in non-payment for benefits for which it is required. • Failure to obtain notification does not result in a financial penalty.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	• 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 the NQTL applied?

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Frequency of review (and method of payment): • CR is required with clinical updates every 7 days, or more often if needed. • CR for respite occurs when 30 days have been exceeded in a year • Authorizations are automatic when a member is on a hold by the county.	**Frequency of review (and method of payment) (OHA)**: • Gender reassignment surgery (for benefit packages E and G) is authorized as a procedure. • The initial authorization for SCIP, SAIP and subacute is 30 days. **Frequency of review (and method of payment) (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	**Frequency of review (and method of payment):** • CR: CHA expects clinical updates every 7 days, or more often if needed. • CHA performs daily concurrent reviews of in network facilities. • OON facilities are expected to send treatment notes for review every 3-7 days. • Average CR frequency is 3-4 days with a max of 7 days.	**Frequency of review (and method of payment)**: • Most IP claims are paid DRG; as a result, CR is infrequently used. • CR is conducted monthly for LTAC and rehabilitation. • The State conducts CR for SNF after the first 20 days (which are managed by the CCO) 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.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
RR conditions and timelines: • Providers can submit a request for a RR within a 90-day time period.	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. • 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.	**RR conditions and timelines:** • Providers can submit a request for a RR within a 90-day time period.	**RR conditions and timelines**: • RR is only available for retro eligibility situations (e.g., the person became eligible during the stay).

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Methods to promote consistent application of criteria: • Chart audits are conducted for two high volume providers to confirm medical necessity determinations.	**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 (KEPRO)**:	**Methods to promote consistent application of criteria:** • Chart audits are conducted for hospital providers to confirm medical necessity determinations.	**Methods to promote consistent application of criteria**: Nurses are trained on the application of the HERC PL and guidelines, which is spot-checked through ongoing supervision. Whenever possible, practice guidelines from clinical professional organizations such as the American Medical Association or the American Psychiatric Association, are used to establish PA frequency for services in the FFS system.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	• Monthly clinical team meetings in which randomly audited charts are reviewed/discussed by peers using the KEPRO compliance department-approved audit tool. • Results of the audit are compared, shared and discussed by the team and submitted to the Compliance Department monthly for review and documentation. • Individual feedback is provided to each clinician during supervision on their authorization as well as plan-of-care reviews.		

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
Evidence for UM frequency: • ASAM criteria • Regional UM Guidelines • HERC PL and guideline notes • Oregon Health Authority OARs • MCG • Plan benefit coverage	**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	**Evidence for UM frequency:** • Regional UM Guidelines • HERC PL and guideline notes • Oregon Health Authority OARs • MCG • Plan benefit coverage • CHA authorization grid	**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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• CHA authorization grid	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		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.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
	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: • A review of all Notices of Action along with appeal and hearing rates. • Monthly utilization reports that compare requests for services to approval and denial rates. • The provider appeal process.	**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 in benefit packages E and G.) **Data reviewed to determine UM application (HIA)**: N/A **Data reviewed to determine UM application (KEPRO):** N/A	**Data reviewed to determine UM application:** • Utilization data • Denial/Appeal rates • Adherence to CHA authorization grid and contract requirements (PA only)	**Data reviewed to determine UM application**: • A physician led group of clinical professionals conducts an annual review to determine which services receive or retain PA. Items reviewed include: – Utilization – Approval/denial rates – Documentation/ justification of services – Cost data

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
IRR standard: • N/A **Results of criteria application:** • There were 0 appeals for MH/SUD in 2017.	**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	**IRR standard:** • N/A **Results of criteria application:** • 26% of M/S decisions were overturned on appeal in 2017.	**IRR Standard**: • N/A **Results of criteria application**: • 0 appeal overturns

7. Compliance Determination for Benefit Packages CCO A and B

IP Benefits: All non-emergent CCO MH/SUD and M/S IP admissions require PA or level-of-care approval. Emergency CCO MH/SUD and M/S IP admissions require notification within 24-72 hours 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 four 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, utilization reports that demonstrate over-utilization and high cost. 2) To ensure appropriate treatment in the least restrictive environment that maintains the safety of the individual. Although strategy (2) primarily applies to MH/SUD benefits, it is permissible because it is a requirement resulting from a DOJ-negotiated Olmstead settlement agreement. Safety issues for M/S are supported by HERC. 3) To maximize use of INN providers to promote cost-effectiveness. Maximizing network utilization only applies to MH/SUD and M/S benefits administered by the CCO.[2] Evidence for the cost-effectiveness of network utilization for both MH/SUD and M/S includes the contracted

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

fees and credentials verification process associated with network participation. 4) To comply with federal and State requirements. As a result, the strategies and evidence are comparable.

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

Qualified individuals conduct UM applying OARs, HERC, and MCG for CCO MH/SUD and M/S. The OHA designee reviews authorization requests to determine if the level-of-care is the least restrictive environment. HIA reviews care relative to policy. KEPRO develops PCSPs based on State plan and OAR requirements. *OHA plans to enhance the evidence base for child residential authorization decisions through additional research, resulting in admission and CR criteria development.* CCO MH/SUD and M/S requires all denials to be reviewed by the Chief Medical Officer. The OHA designee, who is a licensed MH professional, makes denial determinations for level-of-care review for certain child residential services. HIA denials are made by psychiatrists. KEPRO QMHPs develop PCSPs. *OHA plans to ensure that all denial decisions are made by professional peers*. The CCO makes RR available for MH/SUD and M/S when providers fail to obtain authorization. Upon provider request, the OHA designee obtains RR by HIA. HIA allows reconsideration of CONS determinations, but reported they do not have an RR policy for HIA's CR denials for child residential services. For adult residential and YAP services, KEPRO allows reconsideration of denials with the submission of additional documentation within 10 days of the denial. For OHA and KEPRO, the review of a denial decision occurs in a weekly MMC meeting. *OHA intends to standardize RR processes when feasible.* Providers may appeal a MH/SUD and M/S denial decision by the CCO. OHA FFS reviews denials through the fair hearing process, but HIA and the OHA designee have not encouraged use of this process. *OHA plans to confirm all notices of action, appeal and fair hearing processes are consistent with federal requirements.* Failure to obtain authorization may result in non-coverage, although SCIP, SAIP and subacute services may be covered by general fund dollars. Inclusive of OHA's action plans, the MH/SUD and M/S processes are comparable and no more stringently applied to MH/SUD benefits.

Stringency of Strategy and Evidence: Concurrent review is conducted every 7 days for MH/SUD IP hospital, while M/S acute IP hospital services are reviewed every 3-4 days with a max of 7 days. CCO MH/SUD residential (e.g., SUD, subacute and PRTS) frequency of review ranges from every 30 days to 6 months. FFS child residential is reviewed every 30-90 days while FFS adult residential and YAP are reviewed no less than annually, but in practice averages 6 months. The CCO reviews SNF weekly for the first 20 days. Evidence for the frequency of CCO review includes ASAM and MCG. *OHA plans to task the FFS residential subcontractors with review of CR frequencies relative to the most recent research to confirm MH/SUD review frequency is directly tied to evidence rather than historical standard practice.* When eligibility is not able to be determined at the time of hospitalization, CCO MH/SUD and M/S offer RR within 90 days of admission. 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 reviews 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 a 26% appeal overturn rate for M/S while MH/SUD (FFS and CCO) had 0 appeal overturns in 2017. Inclusive of OHA action plans, the strategy and evidence are no more stringently applied to MH/SUD than to M/S in writing or in operation.

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

Below are the OHA action plans:

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

8. Compliance Determination for Benefit Packages CCO E and G

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

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

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

Qualified individuals conduct MH/SUD CCO UM applying OARs, HERC, ASAM and MCG. OHA reviews authorization requests relative to HERC PL and guidelines and applicable practice guidelines from national organizations. The OHA designee reviews authorization requests to determine

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

Stringency of Strategy and Evidence: Concurrent review is conducted every 7 days for MH/SUD IP hospital (which is paid by per diem), while FFS M/S rarely conducts CR because most IP services are paid by DRG. CCO MH/SUD residential (e.g., SUD, subacute and PRTS) frequency of review ranges from every 30 days to 6 months. FFS child residential is reviewed every 1-3 months while FFS adult residential and YAP are reviewed no less than annually but in practice average 6 month reviews. SNF is also reviewed no less than annually after the first 20 days. LTAC and rehab hospital (M/S IP) are reviewed monthly. Evidence for the frequency of review for CCO MH/SUD is MCG. *OHA plans to task the FFS residential subcontractors with review of CR frequencies relative to the most recent research to confirm MH/SUD review frequency is directly tied to evidence rather than historical standard practice*. When eligibility is not able to be determined at the time of hospitalization, CCO MH/SUD offers RR within 90 days of admission. KEPRO makes RR available for 30 days post-admission. FFS MH/SUD only allows RR for retro-eligibility circumstances. The OHA designee and HIA do not have standard policies describing when RR is available. In addition, it was discovered that there are conflicting State rules regarding RR timelines. *OHA plans to standardize the availability of RR, including the conditions under which it is permissible and the timeframes. OHA will align OAR requirements and RR offerings by contractors*. The CCO and State review utilization data to determine if PA or CR should be added or adjusted for MH/SUD and M/S IP benefits. For MH/SUD the CCO conducts chart review to promote consistency of MNC application. HIA conducts IRR and parallel chart reviews for its two reviewers and KEPRO team meetings include random chart audits using a compliance tool followed by team discussion. HIA and the OHA designee do not have specific criteria against which decisions are made. FFS M/S conducts spot-checks through supervision to assess criteria application. *OHA plans to institute a more formalized measurement of criteria application when feasible even though this is not a parity issue in these benefit packages.* The CCO reported 0 appeal

overturns for MH/SUD in 2017. FFS M/S's appeal overturn rate was also 0. Inclusive of OHA action plans, the strategy and evidence are no more stringently applied to MH/SUD than to M/S in writing or in operation.

Compliance Determination: Inclusive of OHA action plans for benefit packages A and B, 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. There were no CCO-specific actions indicated.

OUTPATIENT UTILIZATION MANAGEMENT

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

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

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

1. To which benefits is the NQTL assigned?

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
• (1) 1915(c) Comprehensive DD waiver (operated/managed by DHS) • (1) 1915(c) Support Services DD waiver (operated/managed by DHS) • (1) 1915(c) Behavioral DD Model waiver (operated/managed by DHS)	The following services are managed by DHS: • (1) 1915(c) Comprehensive DD waiver • (1) 1915(c) Support Services DD waiver • (1) 1915(c) Behavioral DD Model waiver • (1) 1915(c) Aged & Physically Disabled waiver • (1) 1915(c) Hospital Model waiver	• (2, 4) PA required for all services from non-contracted providers services. • Contracted providers: – (2, 4) ABA – (2, 4) DBT – (2, 4) Child Intensive Community Treatment Services	• (2, 4) All services from non-contracted providers • Contracted – (2, 4) Selected specialist visits (including rheumatology, ENT, ophthalmology, allergy, audiologist, chiropractic,	The following services are managed by OHA: • (2, 3) Out of hospital births • (2) Home health services • (2) OT, PT, ST, and audiology for M/S conditions (and autistic disorder, which is also managed according to the processes, strategies and

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
• (1)1915(i)(HK) services for adults (home-based habilitation, behavioral habilitation and psychosocial rehab for persons with CMI) (managed by KEPRO under contract with OHA)	• (1) 1915(c) Medically Involved Children's NF waiver • (1) 1915(k) Community First Choice State Plan option • (1) 1915(j): Self-directed personal assistance	– (2, 4) Psychiatric Day Treatment for Youth – (2, 4) Psychological Testing – (2, 3, 4) Intensive outpatient (IOP) – (2, 3, 4) High Intensity Medically-Monitored SUD – (2, 3, 4) SUD clinically managed withdrawal. – (2, 3, 4) Services related to Gender Identity (other than psychotherapy) – (2) Adult Supported Employment	acupuncture, OT, ST, PT,). – (2, 3, 4) Most outpatient tests and treatments require PA including MRI's, PET scans – (2, 3, 4) Nearly all elective surgeries including bariatric services – (2, 3, 4) Chemotherapy and radiation – (2, 3, 4) Outpatient surgeries. – (2, 4) DME supplies, hearing aids, genetic counseling.	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/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
• (1) The State requires PA of HCBS in order to meet federal requirements regarding PCSPs and ensure services are provided in accordance with a participant's PCSP and in the least restrictive setting.	• (1) The State requires PA of HCBS in order to meet federal requirements regarding PCSPs and ensure services are provided in accordance with a participant's PCSP and in the last restrictive setting.	• (2) To prevent services being delivered in violation of relevant OARs and associated HERC PL and guidelines • (3) Services are associated with increased health or safety risks • (4) To ensure care is medically necessary and delivered in the least restrictive environment	• (2) To prevent services being delivered in violation of relevant OARs and associated HERC PL and guidelines • (3) Services are associated with increased health or safety risks • (4) To ensure care is medically necessary and delivered in the least restrictive environment	• (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/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
• (1) Federal requirements regarding PCSPs for 1915(c) and 1915(i) services (e.g., 42 CFR 441.301 and 441.725) and the applicable approved 1915(c) waiver	• (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)	• (2) OARs, HERC PL and guidelines, CHA, Prior Authorization Grid and Plan Coverage Benefits and federal guidelines.	• (2) OARs, HERC PL and guidelines, CHA, Prior Authorization Grid and Plan Coverage Benefits and federal guidelines.	• (2) HERC PL • (2) PA requests with insufficient documentation demonstrate MNC are not being met or HERC PL guidelines are not being followed.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
application/1915(i) State plan amendment. • (1) Oregon Performance Plan (OPP) requires that all BH services are provided in the least restrictive setting possible as do federal requirements regarding 1915(c) and 1915(i) services.	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.	• (3) HERC guidelines re safety concerns • (4) Oregon Performance Plan (OPP) requires that BH services be provided in least restrictive setting possible. The OPP is a DOJ-negotiated Olmsted settlement. • (4) MCG, ASAM	• (3) HERC guidelines re safety concerns • (4) MCG	• (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 CCO, member, and provider perspectives).

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Timelines for authorizations: • A PCSP must be approved within 90 days from the date a completed application is submitted.	**Timelines for authorizations**: • A PCSP must be approved within 90 days from the date a completed application is submitted.	**Timelines for authorizations:** • Referral standards for submission are 72 hours for urgent, and 14 days for routine determination.	**Timelines for authorizations:** • Referral standards for submission are 72 hours for urgent, and 14 days for routine determination.	**Timelines for authorizations**: • Urgent requests are processed in 72 hours and immediate requests in 24 hours. Routine requests are processed in 14 days.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Documentation requirements: • (c)The PCSP is based on a functional needs assessment and other supporting documentation. It is developed by the individual, the individual's team and the individual's case manager. • (i)The PCSP is based on an assessment, service plan, plan-of-care, Level-of-Care Utilization System (LOCUS), Level of Service Inventory (LSI) or other relevant documentation. The PCSP is developed by the member's treatment team in consultation with the member.	**Documentation requirements**: • The PCSP is based on a functional needs assessment and other supporting documentation. It is developed by the individual, the individual's team and the individual's case manager.	**Documentation requirements:** • Provider submits an authorization request using a one-page form. • Provider must also supply medical records that show the medical necessity of the treatment. This includes the CASII (Day Treatment), the LSI, and ASAM results when applicable.	**Documentation requirements:** • Provider submits an authorization request using a one-page form. • Provider must also supply medical records that show the medical necessity of the treatment.	**Documentation requirements**: • A cover page form is required. In addition, diagnostic information, a CPT code(s), a rationale for medical necessity plus any additional supporting documentation are required.

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Qualifications of reviewers: • (c) A case manager must have at least: – A bachelor's degree (BA) in behavioral science, social science, or a closely related field; or – A BA in any field AND one year of human services related experience; or – An associate's degree (AA) in a behavioral science, social science, or a closely related field AND two years human services related experience; or – Three years of human services-	**Qualifications of reviewers**: • A case manager must have at least: – A BA in behavioral science, social science, or a closely related field; or – A BA in any field AND one year of human services related experience; or – An associate's degree (AA) in a behavioral science, social science, or a closely related field AND two years human services related experience; or – Three years of human services-related experience.	**Qualifications of reviewers:** • Reviews and authorizations are conducted by an LCSW. • All unclear determinations are forwarded to an MD reviewer. • All denials must come from a MD reviewer, with the exception that a UM reviewer can approve authorizations as defined by the Medical Director when they do not require medical necessity determination (e.g., outside of global period, timely filing guideline).	**Qualifications of reviewers:** • Reviews and authorizations are conducted by a RN or certified coder. • All unclear determinations are forwarded to an MD reviewer. • All denials must come from a MD reviewer, with the exception that a UM reviewer can approve authorizations as defined by the Medical Director when they do not require medical necessity determination (e.g., outside of global period, timely filing guideline).	**Qualifications of reviewers:** • Nurses may authorize and deny services.

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

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
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. **Reconsideration/RR**: • (c) N/A • (i) Within 10 days of a denial, the provider	**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. **Reconsideration/RR**: • N/A	**Criteria:** • Authorizations are based on HERC PL and guidelines, MCG, ASAM and Oregon Statute **Reconsideration/RR:** RR is available for benefits within the most recent 90 days.	**Criteria:** • Authorizations are based on HERC PL and guidelines, MCG and Oregon Statute. **Reconsideration/RR:** RR is available for benefits within the most recent 90 days.	**Criteria:** • Authorizations are based on the HERC PL and guidelines, Oregon Statute, Oregon Administrative rules, federal regulations, and evidence-based guidelines from private and professional associations such as the Society of American Gastrointestinal and Endoscopic Surgeons where no State or federal guidelines exist. **Reconsideration/RR**: • A review of a denial decision can be requested and is

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
may send additional documentation to KEPRO for reconsideration. • (i) A provider may request review of a denial decision, which occurs in weekly MMC meetings or KEPRO's own comparable MMC meeting. **Consequences for failure to authorize**: • Failure to obtain authorization may result in non-payment. **Appeals**: Notice and fair hearing rights apply.	**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 can result in non-payment **Appeals:** • Members have appeal rights for all denied services.	**Consequences for failure to authorize:** • Failure to obtain authorization can result in non-payment. **Appeals:** • Members have appeal rights for all denied services.	reviewed in weekly MMC meetings. **Consequences for failure to authorize**: • Failure to obtain authorization may result in non-payment. **Appeals**: • Members may request a hearing on any denial decision.

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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Frequency of review: • PCSPs are reviewed and revised as needed, but at least every 12 months. **RR conditions and timelines:** • (c) N/A • (i) Within 10 days of a denial, the provider may send additional documentation to	**Frequency of review:** • PCSPs are reviewed and revised as needed, but at least every 12 months. **RR conditions and timelines:** • N/A	**Frequency of review:** • Depending on the services provided, the CR process after the initial authorization period ranges from 6-24 sessions to last for 90 days. **RR conditions and timelines** • RR allowed up to 90 days from date of service if appropriate documentation submitted to show medical necessity.	**Frequency of review:** • Home health is authorized every 3 months; • CPAP has an initial 3 month authorization to obtain compliance data before re-authorized; • "Life" jacket (external defibrillator) authorized every 30 days. • Otherwise, authorizations are for a year. **RR conditions and timelines** • RR allowed up to 90 days from date of service if appropriate documentation submitted to show medical necessity.	**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 which is led by the HSD medical director. **RR conditions and timelines:** • RR available for retro eligibility circumstances.

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
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. **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) participant	**Methods to promote consistent application of criteria:** • DHS Quality Assurance Review teams review a representative sample of PCSPs as part of quality assurance and case review activities to assure that PCSPs meet program standards. • Additionally, OHA staff review a percentage of files to assure	**Methods to promote consistent application of criteria:** • CCO MH/SUD MNC application is evaluated during chart review of facilities.	**Methods to promote consistent application of criteria:** • CCO MH/SUD MNC application is evaluated during chart review of facilities.	**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/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
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	quality and compliance.			

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
assessed member needs, whether the PCSPs are updated annually, whether OARs are met, 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 the NQTL is applied?

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
Evidence for UM frequency: • Federal requirements regarding PCSPs and 1915(c) and 1915(i) services (e.g., 42 CFR 441.301 and 441.725) and the applicable approved 1915(c) waiver application/1915(i) State plan amendment.	**Evidence for UM frequency**: • Federal requirements regarding PCSPs and 1915(c), 1915(k), and 1915(j) services (e.g., 42 CFR 441.301, 441.468, and 441.540) and the applicable approved 1915(c) waiver application/State plan amendment.	**Evidence for UM frequency:** • MCG, ASAM Criteria, Regional UM Guidelines, HERC PL and associated guideline notes, OARs, plan benefit coverage, State/federal law, and contracts.	**Evidence for UM frequency:** • MCG, Regional UM Guidelines, HERC PL and associated guideline notes, OARs, plan benefit coverage, State/federal law, and contracts.	**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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
				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	**Data reviewed to determine UM application**: • N/A	**Data reviewed to determine UM application:** • Denial/appeal overturn rates; Provider appeal process. Review of all Notices of Action along with appeal rates, hearing rates. Monthly utilization reports compare	**Data reviewed to determine UM application:** • Denial/Appeal rates, Utilization of services. • Downstream audits if deemed necessary.	**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

FFS/HCBS 1915(c)(i) MH/SUD	FFS/HCBS (c)(k)(j) M/S	CCO MH/SUD	CCO M/S	FFS M/S
		requests for services to approval and denial rates. • Downstream audits of MH/SUD service providers. **IRR standard:** • N/A **Results of criteria application (appeal overturn rates):** • 0 appeals for MH/SUD in 2017.	**IRR standard:** • N/A **Results of criteria application (appeal overturn rates):** • 27% OP appeal overturn rate for M/S in 2017.	– Approval/denial rates – Documentation/ justification of services – Cost data **IRR standard:** • N/A **Results of criteria application (appeal overturn rates):** • 0 appeal overturns
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			

7. Compliance Determination for Benefit Packages CCO A and B

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

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

Some non-HCBS CCO MH/SUD and M/S OP services are assigned UM to confirm coverage relative to the HERC PL and guidelines. Non-HCBS MH/SUD services are also reviewed to ensure services are medically necessary relative to MCG and offered in the least restrictive environment,

as required by the OPP Olmstead settlement for MH/SUD. A subset of CCO MH/SUD and M/S OP services are also assigned UM to assure the individual's safety. Evidence for safety issues includes HERC guidelines. These strategies and evidence are comparable.

Comparability and Stringency of Processes: HCBS MH/SUD benefits are administered by DHS and KEPRO while HCBS M/S benefits are administered by DHS. PCSPs for both M/S and MH/SUD must be developed within 90 days. The PCSP for both MH/SUD and M/S is based on an assessment and other relevant supporting documentation. It is developed by the individual, the individual's team and the individual's case manager. MH/SUD and M/S DHS reviewers must have a BA in a related field; a BA in any field plus one year experience; an AA with two years' experience; or three years' experience. KEPRO reviewers for 1915(i) services must have a nursing or OT license, a graduate degree in a related field or be a qualified MH intern. KEPRO's higher education requirements do not present a parity concern because they impact quality not the stringency of criteria application. MH/SUD and M/S review documentation relative to waiver application/State plan amendment requirements, and the approved PCSP is entered as service authorization. KEPRO offers reconsideration and RR, although DHS does not offer RR when services are not authorized. Failure to obtain authorization may result in non-payment for MH/SUD and M/S. Notice and fair hearing rights apply. Accordingly, UM processes are comparable and no more stringently applied to HCBS MH/SUD benefits than to M/S benefits.

Non-HCBS CCO MH/SUD and M/S OP benefit reviews are conducted by qualified clinicians who evaluate clinical information that is submitted via fax or web-portal, relative to MCG, ASAM, HERC, or OARs. CCO MH/SUD requires submission of specific level-of-care assessments (e.g., CASII, ASAM and LSI) while M/S level-of-care information is diagnosis-specific. Timelines for authorization decisions are the same for MH/SUD and M/S and defined in OARs. Failure to obtain authorization may result in non-payment for MH/SUD and M/S services; although an exception process allows RR for CCO benefits and standard appeal processes apply. There are no differences in processes for children and adults that are not tied to practice guidelines. Accordingly, UM processes are comparable to, and no more stringently applied, to non-HCBS CCO MH/SUD benefits than to M/S benefits.

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

In general, non-HCBS CCO MH/SUD service authorizations are intended to cover 3 months of services. M/S reported authorization lengths that vary from 30 days to a year, with most lasting 3 months. Authorization lengths are based on MCG® guidelines. CCO allows RR for both MH/SUD and M/S up to 90 days from date of service if appropriate documentation submitted to show medical necessity. CCO MH/SUD and M/S MNC

application is evaluated during chart review of facilities. At a minimum, the CCO reviews utilization and other data to determine if UM requires adjustment. MH/SUD and M/S report appeal overturn rates of 0 and 27% respectively. 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.

8. Compliance Determination for Benefit Packages CCO E and G

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

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

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

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

Non-HCBS CCO MH/SUD benefit reviews are conducted by qualified clinicians who evaluate clinical information that is submitted via fax or web-portal, relative to MCG and ASAM, HERC, and OARs. CCO MH/SUD requires submission of specific level-of-care assessments (e.g., CASII, ASAM and LSI). Similarly, FFS M/S benefit reviews are conducted by qualified clinicians that evaluate clinical information that supports medical necessity (which may include POCs) submitted via paper (fax) or online relative to OARs and HERC. Timelines for authorization decisions are the same for MH/SUD and M/S and defined in OARs. Failure to obtain authorization may result in non-payment for MH/SUD and M/S services; although an exception process allows RR for CCO MH/SUD and FFS M/S benefits. Appeal processes apply for both CCO MH/SUD and FFS M/S.

There are no differences in processes for children and adults that are not tied to practice guidelines. 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.

In general, non-HCBS MH/SUD service authorizations are intended to cover 3 months of services. Authorization lengths are based on MCG® guidelines. FFS M/S authorization lengths range from 6 months to one year. These lengths are tied to HERC. Although the frequency of review appears to be different for MH/SUD and M/S, because MH/SUD frequencies are tied to evidence, they are permissible. CCO allows RR for MH/SUD up to 90 days from date of service if appropriate documentation submitted to show medical necessity. FFS offers RR in retro eligibility circumstances. CCO MH/SUD MNC application is evaluated during chart review of facilities. Similarly, FFS M/S application is spot-checked through supervision and chart review. The CCO and State review utilization and other data to determine if UM requires adjustment. MH/SUD and M/S reported appeal overturn rates of 0. 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: A and B for Adults and Children
Classification: Prescription Drugs
CCO: Cascade

1. To which benefits is the NQTL assigned?

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

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• CCO will not authorize services for unfunded conditions on the Prioritized List, treatments that do not pair with the condition on the list, treatments that do not meet requirements in guideline notes or medications not on CCO formulary. • Prioritized list and formulary are used as a benefit management tool to ensure that the most cost-effective medication is used and that the most appropriate treatment is provided.	• To promote appropriate and safe treatment of funded conditions.	• CCO will not authorize services for unfunded conditions on the Prioritized List, treatments that do not pair with the condition on the list, treatments that do not meet requirements in guideline notes or medications not on CCO formulary. • Prioritized list and formulary are used as a benefit management tool to ensure that the most cost-effective medication is used and that the most appropriate treatment is provided.

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• Federal and state regulations and CCO contract requirements. • The Prioritized List.	• FDA prescribing guidelines, medical evidence, best practices, professional guidelines, and P&T Committee review and recommendations.	• Federal and state regulations and CCO contract requirements. • The Prioritized List.

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• FDA labeling, pharmaceutical guidelines, regional standards and review of emerging practices.	• Federal and state regulations/OAR and the Prioritized List.	• FDA labeling, pharmaceutical guidelines, regional standards and review of emerging practices.

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
• Provider must submit a prior authorization request by fax or electronically. • Provider must also submit medical records demonstrating medical necessity of treatment, and any records of paired/formulary treatment that have been tried. • If medical review staff determine request is not medically appropriate, case will be submitted to medical director for determination to authorize treatment by exception. • Requests are responded to within 24 hours. • The PA criteria are developed by pharmacists and in consultation with the P&T Committee. • Failure to obtain PA results in no authorization and no pharmacy 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.	• Provider must submit a prior authorization request by fax or electronically. • Provider must also submit medical records demonstrating medical necessity of treatment, and any records of paired/formulary treatment that have been tried. • If medical review staff determine request is not medically appropriate, case will be submitted to medical director for determination to authorize treatment by exception. • Requests are responded to within 24 hours. • The PA criteria are developed by pharmacists and in consultation with the P&T Committee. • Failure to obtain PA results in no authorization and no pharmacy reimbursement.

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

CCO MH/SUD	FFS MH Carve Out	CCO M/S
• PAs are authorized for six months to a year, depending on medical appropriateness and safety, as recommended by the P&T Committee. • Approximately 16% of MH/SUD drugs are subject to PA criteria for clinical reasons. • Providers can appeal on behalf of a client. Documentation is collected and a pharmacist or the medical director reviews to determine if it is appropriate and should be approved or denied. A client can always have a hearing as well. • There were zero appeals submitted for CY 2017. • The CCO assesses stringency through review of the number of PA requests, PA denial/approval rates, appeal overturn rates, and pharmacy utilization and pricing data and reports. • PA criteria are reviewed for appropriateness on a quarterly 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.	• PAs are authorized for six months to a year, depending on medical appropriateness and safety, as recommended by the P&T Committee. • Approximately 35% of M/S drugs are subject to PA criteria for clinical reasons. • Providers can appeal on behalf of a client. Documentation is collected and a pharmacist or the medical director reviews to determine if it is appropriate and should be approved or denied. A client can always have a hearing as well. • The appeal overturn rate for CY 2017 was 4.3%. • The CCO assesses stringency through review of the number of PA requests, PA denial/approval rates, appeal overturn rates, and pharmacy utilization and pricing data and reports. • PA criteria are reviewed for appropriateness on a quarterly 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
• Federal and state regulations and CCO contract requirements. • The Prioritized List. • FDA labeling, pharmaceutical guidelines, regional standards and review of emerging practices.	• 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.	• Federal and state regulations and CCO contract requirements. • The Prioritized List. • FDA labeling, pharmaceutical guidelines, regional standards and review of emerging practices.

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

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

Stringency of Strategy and Evidence: PAs for both MH/SUD (FFS and CCO) and M/S drugs are approved for up to 12 months, depending on medical appropriateness and safety, as recommended by the applicable P&T Committee based on evidence such as FDA prescribing guidelines, best practices, and professional guidelines. The CCO and the State assess the stringency of strategy through review of PA denial/approval and appeal rates; in addition, the CCO reviews pharmacy utilization and pricing data and 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, B, E, and G for Adults and Children
Classification: Inpatient and Outpatient
CCO: Cascade

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

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

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

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

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

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

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

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

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

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

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

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

7. Compliance Determination for Benefit Packages CCO A and B

The CCO does not close its network for new providers of MH/SUD inpatient or outpatient services. Accordingly, the NQTL does not apply and parity was not analyzed.

8. Compliance Determination for Benefit Packages CCO E and G

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

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

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• CCO requires all participating providers to be enrolled with Oregon Medicaid and meet CCO credentialing and re-credentialing requirements as outlined in CHA Operating Instruction 9-01.	• All FFS providers must be enrolled as a provider with Oregon Medicaid.	• CCO requires all participating providers to be enrolled with Oregon Medicaid and meet CCO credentialing and re-credentialing requirements as outline in CHA Operating Instructions 9-01.	• All FFS providers must be enrolled as a provider with Oregon Medicaid.
• The CCO requires verification of adequate supervision for certified addiction counselors; however these individuals are not independently licensed or independent billers. Rather, these requirements are applied as employees of licensed providers. Therefore, the CCO does not apply requirements in addition to State licensing.	• The State does not apply provider requirements in addition to State licensing.	• N/A	• The State does not apply provider requirements in addition to State licensing.

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

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Credentialing/re-credentialing requirements are supported by the following evidence: – State law and Federal regulations, including 42 CFR 438.214 and OAR 410-141-3120 – State contract requirements – Accreditation guidelines (URAC)	• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E - Provider Screening and Enrollment.	• Credentialing/re-credentialing requirements are supported by the following evidence: – State law and Federal regulations, including 42 CFR 438.214 and OAR 410-141-3120. – State contract requirements – Accreditation guidelines (URAC)	• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E - Provider Screening and Enrollment.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• All providers must meet credentialing and re-credentialing requirements to participate in the network. • Providers must complete and provide: – Signed Oregon Practitioners Credentialing Application (dated within 90 days of submission to CCO) – Active NPI – Licensure, certificate of current insurance, copy of DEA (if prescribing provider) – Signed Background Check (if new, initial credentialing; not required for re-credentialing) – Confirmation of CME for past 36 months (if re-credentialing) • Providers may submit supporting documentation by	• 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 number, and/or Medicare enrollment as applicable to the provider type.	• All providers must meet credentialing and re-credentialing requirements to participate in the network. • Providers must complete and provide: – Signed Oregon Practitioners Credentialing Application (dated within 90 days of submission to CCO) – Active NPI – Licensure, certificate of current insurance, copy of DEA (if prescribing provider – Signed Background Check (if new, initial credentialing; not required for re-credentialing) – Confirmation of CME for past 36 months (if re-credentialing) • Providers may submit supporting documentation via	• 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 number, and/or Medicare enrollment as applicable to the provider type.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
via mail, interoffice courier, email or fax. • CCO's credentialing process is identified in CHA Operating Instructions 9-01 and involves: 1. Primary source verification of: a. License b. DEA c. Hospital privileges (if providing services within hospital setting) d. Physician Assistant supervision 2. Secondary source verification of: a. Liability insurance b. Work history (including confirmation of any unexplained gaps in employment) c. Malpractice claims history d. Board certification and education	• 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.	email, interoffice courier, email or fax. • CCO's credentialing process is identified in CHA Operating Instructions 9-01 and involves: 1. Primary source verification of: a. Licensure or certification b. DEA c. Hospital privileges (if providing services within hospital setting) d. Physician Assistant supervision 2. Secondary source verification of: a. Liability insurance b. Work history (including confirmation of any unexplained gaps in employment) c. Malpractice claims history	• 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 averages7 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.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
e. Education (if not board certified or not confirmed/listed by licensing body) 3. Checking of sanctions via Office of Inspector General, System for Award Management 4. Checking for Medicare opt-out affidavits via CMS (if billing Medicare LOB). 5. Request and verification of three professional references • Providers must be able to bill Oregon Medicaid and not be on the exclusion list. • Providers must complete and provide: – Oregon Practitioners Credentialing Application – New Provider Information Form • Providers may submit supporting documentation via fax, mail, interoffice courier or email. • CCO's credentialing process averages 50 days for re-	• Providers who are denied enrollment or re-enrollment may appeal the decision to the State.	d. Board certification and education e. Education (if not board certified or hasn't been confirmed/listed by licensing body) 3. Checking of sanctions via Office of Inspector General, System for Award Management 4. Checking for Medicare opt-out affidavits via CMS (if billing Medicare LOB). 5. Request and verification of three professional references • Providers must be able to bill Oregon Medicaid and not be on the exclusion list. • Providers must complete and provide: – Oregon Practitioners Credentialing Application – New Provider Information Form • Providers may submit supporting documentation by	• Providers who are denied enrollment or re-enrollment may appeal the decision to the State.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
credentialing and 65 days for new/initial credentialing. • CCO's Chief Medical Officer and Quality Management Committee are responsible for reviewing required information and making provider credentialing decisions. • CCO performs re-credentialing every three years but requires facilities to provide annual updates on providers not directly credentialed with CCO. • Providers who do not meet credentialing/re-credentialing requirements will result in the provider not being admitted to the network. • Providers who are adversely affected by credentialing or re-credentialing decisions may challenge the decision by submitting written appeal to CHA and or OHA.		via fax, mail, interoffice courier or email. • CCO's credentialing process averages 50 days for re-credentialing and 65 days for new/initial credentialing. • CCO's Chief Medical Officer and Quality Management Committee are responsible for reviewing required information and making provider credentialing decisions. • CCO performs re-credentialing every three years but requires facilities to provide annual updates on providers not directly credentialed with CCO. • Providers who do not meet credentialing/re-credentialing requirements will result in the provider not being admitted to the network. • Providers who are adversely affected by credentialing or re-credentialing decisions may challenge the decision by submitting written appeal to CHA and or OHA.	

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• All providers/provider types must be credentialed. • There are no exceptions to meeting credentialing requirements to participate in the CCO's network; however, in the following circumstances, providers may be offered a single case agreement as an out of network provider pending credentialing: – Urgent member need – Provider in the process of credentialing – Emergency situation (e.g., flooding, fires) • 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 no exceptions to meeting credentialing requirements to participate in the CCO's network; however, in the following circumstances, providers may be offered a single case agreement as an out of network provider pending credentialing: – Urgent member need – Provider in the process of credentialing – Emergency situation (e.g., flooding, fires) • 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.

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Requirement to conduct credentialing for all new providers is established by State law and Federal regulations. • The frequency with which CCO performs re-credentialing is based upon: – State law and Federal regulations – State contract requirements Exhibit B – Part 8, section 18 – National accreditation standards of URAC.	• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E - Provider Screening and Enrollment. • The frequency with which the State re-enrolls providers is based on State law and Federal regulations.	• Requirement to conduct credentialing for all new providers is established by State law and Federal regulations. • The frequency with which CCO performs re-credentialing is based upon: – State law and Federal regulations – State contract requirements Exhibit B – Part 8. Section 18 – National accreditation standards of URAC.	• Provider enrollment is required by State law and Federal regulations, including 42 CFR Part 455, Subpart E - Provider Screening and Enrollment. • The frequency with which the State re-enrolls providers is based on State law and Federal regulations.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• CCO monitors the following data/information to determine how strictly to apply credentialing/re-credentialing criteria: – Provider appeals/disputes. – Network adequacy data, such as access to care, provider specialties. – Appropriateness of seclusion and restraint utilization by provider.	• N/A	• CCO monitors the following data/information to determine how strictly to apply credentialing/re-credentialing criteria: – Provider appeals/disputes. – Network adequacy data, such as access to care, provider specialties. – Appropriateness of seclusion and restraint utilization by provider.	• N/A

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. CCO 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 to ensure provider meets minimum competency standards. CCO credentialing and re-credentialing of both providers of MH/SUD and M/S services is supported by State law and Federal regulations, the CCO's contract with the State, and national accreditation guidelines (URAC). Based upon these findings, the CCO's strategy and evidence for conducting credentialing and re-credentialing are comparable for providers of MH/SUD and M/S services.

Comparability and Stringency of Processes: All providers of MH/SUD and M/S services must successfully meet credentialing and re-credentialing requirements in order to be admitted to and continue to participate in the CCO's network.

The information and documentation new providers are required to complete and submit as part of the credentialing process is the same for providers of MH/SUD and M/S services, including: a signed Oregon Practitioners Credentialing Application (dated within 90 days of submission to CCO), documentation of an active NPI, evidence of licensure, certificate of current insurance, copy of DEA (if prescribing provider), a signed background Check (for new, initial credentialing), and confirmation of CME for past 36 months (for re-credentialing). The CCO reported

requiring verification of adequate supervision for certified addiction counselors (who are not independently licensed or independent billers). However, this is not a limit on admission of the provider; rather, these are requirements applied to employees of a licensed provider.

The CCO's credentialing process for both MH/SUD and M/S providers includes the primary source verification of licensing, DEA status, hospital privileges (if applicable), and supervision of physician assistants. The process also includes secondary source certification including liability insurance, work history, malpractice claims, board certification and education, confirmation of supervision and education, sanctions check (Office of Inspector General), Medicare opt-out affidavits check, and a verification of three professional references. Providers must complete and provide the Oregon Practitioners Credentialing Application and the New Provider Information Form. Both MH/SUD and M/S providers are given several methods of submitting their application and supporting documentation, including by fax, by mail by interoffice courier or electronically.

The CCO's credentialing process for MH/SUD and M/S providers involves the CCO's Chief Medical Officer and Quality reviewing required information and making provider credentialing decisions. The credentialing process for both MH/SUD and M/S providers averages 50 days for re-credentialing and 65 days for new/initial credentialing. Re-credentialing for both MH/SUD and M/S providers is conducted every three years but requires facilities to provide annual updates on providers not directly credentialed with CCO. Failure for MH/SUD and M/S providers to meet credentialing and re-credentialing requirements results in exclusion from participating in the CCO's network. MH/SUD and M/S providers who are adversely affected by credentialing or re-credentialing decisions may challenge the decision through an appeal process to CHA and/or OHA.

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

Stringency of Strategy and Evidence: All MH/SUD and M/S providers must meet credentialing and re-credentialing requirements in order to participate in network; there are no exceptions. However, both MH/SUD and M/S providers may provide services and receive payment as an out of network provider in circumstances in which there is urgent member need, a provider is in the process of credentialing, or there is an emergency situation such as flooding or fires. 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 and M/S providers denied admission into the network or terminated from the network as a result of credentialing or re-credentialing in the last contract year.

The CCO monitors similar circumstances related to applying credentialing and re-credentialing requirements for MH/SUD and M/S providers, including reviewing provider appeals/disputes, network adequacy data, and appropriateness of seclusion and restraint utilization by provider. As

a result, the strategies and evidentiary standards for credentialing and re-credentialing are no more stringently applied to MH/SUD providers than to M/S providers.

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

8. Compliance Determination for Benefit Packages CCO E and G

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

PROVIDER ADMISSION — PROVIDER EXCLUSIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Compliance Determination for Benefit Packages CCO A and B

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

8. Compliance Determination for Benefit Packages CCO E and G

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

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

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

1. To which benefits is the NQTL assigned?

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• CCO seeks to maximize use of in-network providers because our provider network consists of local specialists and vendors 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	• 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	• CCO seeks to maximize use of in-network providers because our provider network consists of local specialists and vendors 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	• 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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
benefit and the availability of an in-network/in-State provider.	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.	benefit and the availability of an in-network/in-State provider.	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?

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

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

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
• Except as otherwise required by OHA, non-emergency OON/OOS services are not covered unless services are not available within network/in-State. • The CCO's criteria for non-emergency OON/OOS coverage include: – If services are not available locally.	• 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.	• Except as otherwise required by OHA, non-emergency OON/OOS services are not covered unless services are not available within network/in-State. • The CCO's criteria for non-emergency OON/OOS coverage include: – If services are not available locally.	• 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.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
– If services are not available in-State or the member is out of State. – If member requests a 2nd opinion from an OON provider. • The CCO developed its criteria for non-emergency OON/OOS coverage following OHA guidelines, CCO contract, and OAR. • 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 same as for other prior authorizations (14 days for standard and 72 hours for urgent). • The CCO establishes a single case agreement (SCA) with an OON/OOS provider if the provider is not willing to accept DMAP rates. • CCO will work with the individual provider to complete a single case agreement on the agreed upon rates	• 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.	– If services are not available in-State or the member is out of State. – If member requests a 2nd opinion from an OON provider. • The CCO developed its criteria for non-emergency OON/OOS coverage following OHA guidelines, CCO contract, and OAR. • 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 same as for other prior authorizations (14 days for standard and 72 hours for urgent). • The CCO establishes a single case agreement (SCA) with an OON/OOS provider if the provider is not willing to accept DMAP rates. • CCO will work with the individual provider to complete a single case agreement on the agreed upon rates	• 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.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
between the OON/OOS provider: 1. Utilization review works with CCO's internal claim and provider relations departments to complete the needed single case agreement authorization within 14 days. 2. The CCO and OON/OOS provider work together on OHP 3108 Encounter Only Enrollment form. This form is required for claim form billing, rendering, referring and operating. 3. Provider information is utilized to check sanctions on the rendering provider. 4. OON/OOS providers are required to supply all service codes (CPT, REV, HCPC, and CDT) and billable qualities for the SCA. 5. The CCO completes signed SCA. 6. Completed SCAs are attached to member		between the OON/OOS provider: 1. Utilization review works with CCO's internal claim and provider relations departments to complete the needed single case agreement authorization within 14 days. 2. The CCO and OON/ OOS provider work together on OHP 3108 Encounter Only Enrollment form. This form is required for claim form billing, rendering, referring and operating. 3. Provider information is utilized to check sanctions on the rendering provider. 4. OON/OOS providers are required to supply all service codes (CPT, REV, HCPC, and CDT) and billable qualities for the SCA. 5. The CCO completes signed SCA. 6. Completed SCAs are attached to member	

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
record and flagged for claims to assure payment terms comply with agreed rates. • The average length of time to negotiate a SCA is 14 days. • Only providers enrolled in Oregon Medicaid who are not on the exclusions list can qualify as an OON/OOS provider. • The CCO pays OON/OOS providers: – The Medicaid FFS rate; – A percentage of the Medicare rate; or – A negotiated rate.		record and flagged for claims to assure payment terms comply with agreed rates. • The average length of time to negotiate a SCA is 14 days. • Only providers enrolled in Oregon Medicaid who are not on the exclusions list can qualify as an OON/OOS provider. • The CCO pays OON/OOS providers: – The Medicaid FFS rate; – A percentage of the Medicare 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	FFS 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	• 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	• If a request for a non-emergency OOS benefit does not meet the OAR criteria, it will not be prior authorized. • If a non-emergency OOS benefit is not prior authorized, the service will not be covered, and payment for the service will be denied.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
not be covered, and payment for the service will be denied. • Members/providers may appeal the denial of an OON/OOS request. • In CY 2017 the CCO received 64 non-emergency OON/OOS requests; 6 requests were denied (9%); and zero denied OON/OOS requests were overturned on appeal. • The CCO measures the stringency of the application of OON/OOS requirements by reviewing OON/OOS denial/appeal rates and provider requests for reconsideration. • The CCO evaluates the number of SCAs to determine whether the network should be expanded. If CCO claims and provider relations department reports high volume of SCAs to one specialty it will be reported to provider contracting with a list of providers being used to seek out an in-network	• 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.	not be covered, and payment for the service will be denied. • Members/providers may appeal the denial of an OON/OOS request. • In CY 2017 the CCO received 2,393 non-emergency OON/OOS requests; 442 requests were denied (19%); and zero denied OON/OOS requests were overturned on appeal. • The CCO measures the stringency of the application of OON/OOS requirements by reviewing OON/OOS denial/appeal rates and provider requests for reconsideration. • The CCO evaluates the number of SCAs to determine whether the network should be expanded. If CCO claims and provider relations department reports high volume of SCAs to one specialty it will be reported to provider contracting with a list of providers being used to seek out an in-network	• Members/providers may appeal the denial of an OOS request. • The State measures the stringency of the application of OOS requirements by reviewing OOS denial/appeal rates.

CCO MH/SUD	FFS MH/SUD	CCO M/S	FFS M/S
contract. Evaluations are reviewed based on volume.		contract. Evaluations are reviewed based on volume.	

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

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

7. Compliance Determination for Benefit Packages CCO A and B

Comparability of Strategy and Evidence: The CCO seeks to maximize the use of in-network providers since in-network providers consist of local specialists/vendors that have been credentialed and contracted by 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 establishing the rate. The average time to negotiate a SCA is 14 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. While the State does not have statistics regarding OOS requests, the CCO states that approximately 9% of MH/SUD and 19% of M/S OON/OOS requests were denied, with a 0% appeal overturn rate for both. This indicates that OON/OOS standards are not applied more stringently to MH/SUD benefits. As a result, the strategies and evidentiary standards for OON/OOS are no more stringently applied to MH/SUD benefits than to M/S benefits.

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

8. Compliance Determination for Benefit Packages CCO E and G

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. Similarly, the CCO seeks to maximize the use of in-network providers since in-network providers consist of local specialists/vendors that have been credentialed and contracted by the CCO. The State provides OOS coverage to provide needed MH/SUD and M/S benefits when they are not available in-State. Similarly, the CCO provides OON/OOS coverage to provide needed MH/SUD benefits when they are not available in-network or in-State. For both non-emergency MH/SUD and M/S OOS benefits, the State (and the CCO for MH/SUD OON/OOS benefits) requires prior authorization to determine medical necessity and to ensure no in-State providers (and in-network providers for OON requests to the CCO) are available to provide the benefit. The State's OOS coverage requirements are based on OAR. The CCO's OON/OOS coverage requirements are based on OAR and the CCO contract. As a result, the strategy and evidence for OON/OOS coverage of non-emergency inpatient and outpatient benefits are comparable for MH/SUD and M/S benefits.

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

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

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